MEDI-CAL
May 2017
LOCAL ASSISTANCE ESTIMATE
for
FISCAL YEARS
2016-17 and 2017-18

Fiscal Forecasting Divison
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May 2017 Medi-Cal Estimate

Current Year (FY 2016-17) Projected Expenditures Compared to the November 2016 Estimate

(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 November 2016 Estimate are as follows:

Medical Care Services	Nov 2016 Estimate	May 2017 Estimate	Change	
			Amount	Percent
Total Funds	$95,375.8	$84,764.8	($10,611.0)	-11.1%
Federal Funds	$63,114.0	$54,229.7	($8,884.3)	-14.1%
General Fund	**$18,580.3**	**$17,972.1**	**($608.2)**	**-3.3%**
Other Non-Federal Funds	$13,681.5	$12,563.0	($1,118.5)	-8.2%

County Administration	Nov 2016 Estimate	May 2017 Estimate	Change	
			Amount	Percent
Total Funds	$4,268.9	$4,073.7	($195.2)	-4.6%
Federal Funds	$3,397.7	$3,208.0	($189.7)	-5.6%
General Fund	**$859.2**	**$852.7**	**($6.5)**	**-0.8%**
Other Non-Federal Funds	$12.0	$13.0	$1.0	8.3%

Fiscal Intermediary	Nov 2016 Estimate	May 2017 Estimate	Change	
			Amount	Percent
Total Funds	$417.3	$403.3	($14.0)	-3.4%
Federal Funds	$296.8	$287.8	($9.0)	-3.0%
General Fund	**$120.5**	**$115.5**	**($5.0)**	**-4.1%**
Other Non-Federal Funds	$0.0	$0.0	$0.0	n/a

Total Expenditures	Nov 2016 Estimate	May 2017 Estimate	Change	
			Amount	Percent
Total Funds	$100,062.0	$89,241.8	($10,820.2)	-10.8%
Federal Funds	$66,808.5	$57,725.6	($9,083.0)	-13.6%
General Fund	**$19,560.0**	**$18,940.2**	**($619.8)**	**-3.2%**
Other Non-Federal Funds	$13,693.5	$12,576.0	($1,117.5)	-8.2%

Note: Totals may not add due to rounding.

May 2017 Medi-Cal Estimate

Current Year (FY 2016-17) 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 2016-17 Appropriation	May 2017 Estimate	Change Amount	Change Percent
Total Funds	$85,766.1	$84,764.8	($1,001.3)	-1.2%
Federal Funds	$54,213.2	$54,229.7	$16.5	0.0%
General Fund	**$16,786.7**	**$17,972.1**	**$1,185.4**	**7.1%**
Other Non-Federal Funds	$14,766.2	$12,563.0	($2,203.2)	-14.9%

County Administration	FY 2016-17 Appropriation	May 2017 Estimate	Change Amount	Change Percent
Total Funds	$4,169.1	$4,073.7	($95.4)	-2.3%
Federal Funds	$3,298.2	$3,208.0	($90.2)	-2.7%
General Fund	**$861.4**	**$852.7**	**($8.7)**	**-1.0%**
Other Non-Federal Funds	$9.5	$13.0	$3.5	36.8%

Fiscal Intermediary	FY 2016-17 Appropriation	May 2017 Estimate	Change Amount	Change Percent
Total Funds	$367.1	$403.3	$36.2	9.9%
Federal Funds	$260.3	$287.8	$27.5	10.6%
General Fund	**$106.9**	**$115.5**	**$8.6**	**8.0%**
Other Non-Federal Funds	$0.0	$0.0	$0.0	n/a

Total Expenditures	FY 2016-17 Appropriation	May 2017 Estimate	Change Amount	Change Percent
Total Funds	$90,302.3	$89,241.8	($1,060.5)	-1.2%
Federal Funds	$57,771.6	$57,725.6	($46.1)	-0.1%
General Fund	**$17,755.0**	**$18,940.2**	**$1,185.3**	**6.7%**
Other Non-Federal Funds	$14,775.7	$12,576.0	($2,199.7)	-14.9%

Note: Totals may not add due to rounding.

May 2017 Medi-Cal Estimate

Budget Year (FY 2017-18) Projected Expenditures Compared to Current Year (FY 2016-17)

(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 2016-17 Estimate	FY 2017-18 Estimate	Change Amount	Change Percent
Total Funds	$84,764.8	$100,629.4	$15,864.6	18.7%
Federal Funds	$54,229.7	$64,392.9	$10,163.2	18.7%
General Fund	**$17,972.1**	**$17,478.6**	**($493.5)**	**-2.7%**
Other Non-Federal Funds	$12,563.0	$18,757.9	$6,194.9	49.3%

County Administration	FY 2016-17 Estimate	FY 2017-18 Estimate	Change Amount	Change Percent
Total Funds	$4,073.7	$4,574.3	$500.6	12.3%
Federal Funds	$3,208.0	$3,601.6	$393.6	12.3%
General Fund	**$852.7**	**$960.6**	**$107.9**	**12.7%**
Other Non-Federal Funds	$13.0	$12.1	($0.9)	-6.9%

Fiscal Intermediary	FY 2016-17 Estimate	FY 2017-18 Estimate	Change Amount	Change Percent
Total Funds	$403.3	$423.2	$19.9	4.9%
Federal Funds	$287.8	$268.7	($19.1)	-6.6%
General Fund	**$115.5**	**$154.5**	**$39.0**	**33.8%**
Other Non-Federal Funds	$0.0	$0.0	$0.0	n/a

Total Expenditures	FY 2016-17 Estimate	FY 2017-18 Estimate	Change Amount	Change Percent
Total Funds	$89,241.8	$105,627.0	$16,385.2	18.4%
Federal Funds	$57,725.6	$68,263.2	$10,537.7	18.3%
General Fund	**$18,940.2**	**$18,593.7**	**($346.6)**	**-1.8%**
Other Non-Federal Funds	$12,576.0	$18,770.0	$6,194.0	49.3%

Note: Totals may not add due to rounding.

May 2017 Medi-Cal Estimate

Budget Year (FY 2017-18) Projected Expenditures Compared to the November 2016 Estimate

(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 November 2016 Estimate are as follows:

Medical Care Services	Nov 2016 Estimate	May 2017 Estimate	Change	
			Amount	Percent
Total Funds	$97,788.2	$100,629.4	$2,841.2	2.9%
Federal Funds	$62,976.9	$64,392.9	$1,416.0	2.2%
General Fund	**$18,118.3**	**$17,478.6**	**($639.7)**	**-3.5%**
Other Non-Federal Funds	$16,693.0	$18,757.9	$2,064.9	12.4%

County Administration	Nov 2016 Estimate	May 2017 Estimate	Change	
			Amount	Percent
Total Funds	$4,372.7	$4,574.3	$201.6	4.6%
Federal Funds	$3,502.1	$3,601.6	$99.5	2.8%
General Fund	**$858.8**	**$960.6**	**$101.8**	**11.9%**
Other Non-Federal Funds	$11.8	$12.1	$0.3	2.5%

Fiscal Intermediary	Nov 2016 Estimate	May 2017 Estimate	Change	
			Amount	Percent
Total Funds	$424.1	$423.2	($0.9)	-0.2%
Federal Funds	$271.1	$268.7	($2.4)	-0.9%
General Fund	**$152.9**	**$154.5**	**$1.6**	**1.0%**
Other Non-Federal Funds	($0.0)	$0.0	$0.0	n/a

Total Expenditures	Nov 2016 Estimate	May 2017 Estimate	Change	
			Amount	Percent
Total Funds	$102,585.0	$105,627.0	$3,042.0	3.0%
Federal Funds	$66,750.1	$68,263.2	$1,513.1	2.3%
General Fund	**$19,130.0**	**$18,593.7**	**($536.4)**	**-2.8%**
Other Non-Federal Funds	$16,704.8	$18,770.0	$2,065.2	12.4%

Note: Totals may not add due to rounding.

May 2017 Medi-Cal Estimate

Budget 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 Budget Year as compared to the Appropriation are as follows:

Medical Care Services	FY 2016-17 Appropriation	May 2017 Estimate	Change Amount	Change Percent
Total Funds	$85,766.1	$100,629.4	$14,863.3	17.3%
Federal Funds	$54,213.2	$64,392.9	$10,179.7	18.8%
General Fund	**$16,786.7**	**$17,478.6**	**$691.9**	**4.1%**
Other Non-Federal Funds	$14,766.2	$18,757.9	$3,991.7	27.0%

County Administration	FY 2016-17 Appropriation	May 2017 Estimate	Change Amount	Change Percent
Total Funds	$4,169.1	$4,574.3	$405.2	9.7%
Federal Funds	$3,298.2	$3,601.6	$303.4	9.2%
General Fund	**$861.4**	**$960.6**	**$99.2**	**11.5%**
Other Non-Federal Funds	$9.5	$12.1	$2.6	27.4%

Fiscal Intermediary	FY 2016-17 Appropriation	May 2017 Estimate	Change Amount	Change Percent
Total Funds	$367.1	$423.2	$56.1	15.3%
Federal Funds	$260.3	$268.7	$8.4	3.2%
General Fund	**$106.9**	**$154.5**	**$47.6**	**44.5%**
Other Non-Federal Funds	$0.0	$0.0	($0.0)	n/a

Total Expenditures	FY 2016-17 Appropriation	May 2017 Estimate	Change Amount	Change Percent
Total Funds	$90,302.3	$105,627.0	$15,324.7	17.0%
Federal Funds	$57,771.6	$68,263.2	$10,491.6	18.2%
General Fund	**$17,755.0**	**$18,593.7**	**$838.7**	**4.7%**
Other Non-Federal Funds	$14,775.7	$18,770.0	$3,994.3	27.0%

Note: Totals may not add due to rounding.

May 2017 Medi-Cal Estimate
Management Summary

Medi-Cal, California's Medicaid program, provides health care to 14 million Californians and utilizes Federal, State, and local government funding. Medi-Cal began in 1966 and celebrates 50 years in 2016. The Medi-Cal Local Assistance Estimate (Estimate) forecasts the current and budget year expenditures for the Medi-Cal program. Those expenditures are categorized as:

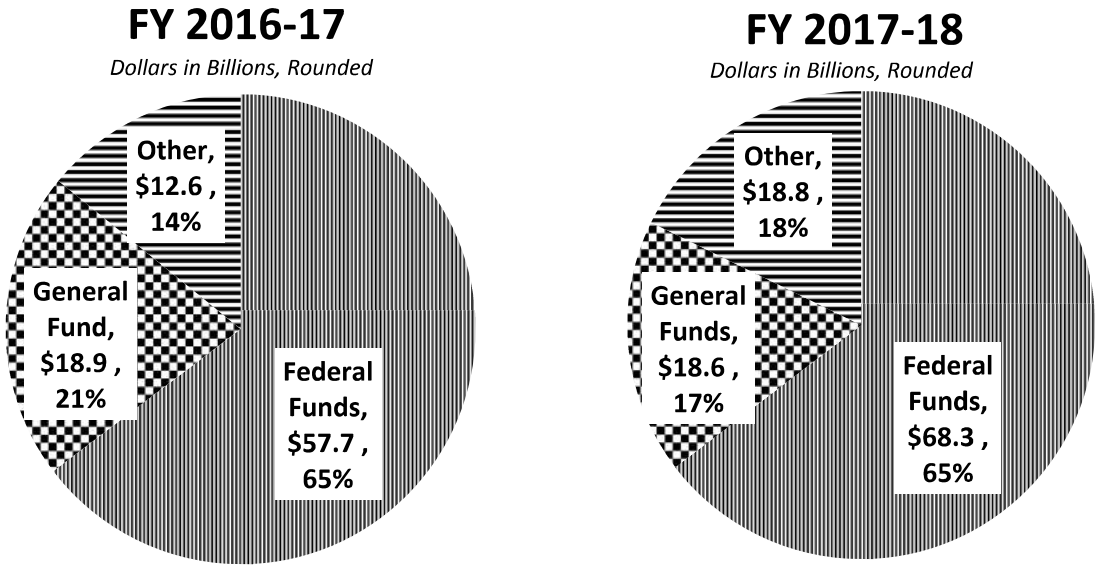
- Benefits: Expenditures for the care of Medi-Cal beneficiaries. These expenditures can be found in the following sections:
  - FFS Base
  - Base Policy Changes, and
  - Regular Policy Changes.

  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 $89.2 billion in FY 2016-17 and $105.6 billion in FY 2017-18. This does not include Certified Public Expenditures of local governments or General Fund of other state departments.



The May 2017 Estimate for FY 2016-17 is $1,185.3 million General Fund more than the FY 2016-17 Budget Appropriation.

FY 2016-17 General Fund

	Appropriation	November 2016	May 2017	Change from Appropriation	Change from November 2016
Medical Care Services	$16,786.7	$18,580.3	$17,972.1	($1,185.4)	$608.2
County Administration	$861.4	$859.2	$852.7	$8.7	$6.5
Fiscal Intermediary	$106.9	$120.5	$115.5	($8.6)	$5.0
Total	$17,755.0	$19,560.0	$18,940.3	($1,185.3)	$619.7

(Dollars in Millions, Rounded)

The Medi-Cal General Fund costs are estimated to decrease by $346.6 million between FY 2016-17 and FY 2017-18.

May 2017 General Fund

	FY 2016-17	FY 2017-18	Change
Medical Care Services	$17,972.1	$17,478.6	($493.5)
County Administration	$852.7	$960.6	$107.9
Fiscal Intermediary	$115.5	$154.5	$39.0
Total	$18,940.3	$18,593.7	($346.6)

(Dollars in Millions, Rounded)

The following pages briefly describe the significant changes in both FY 2016-17 and FY 2017-18.

Significant Items							
Dollars in Millions							
		Change from November 2016		**Change from November 2016**		**Change from FY 2016-17**	
		FY 2016-17		**FY 2017-18**		**FY 2017-18**	
Name	**PC**	**TF**	**GF**	**TF**	**GF**	**TF**	**GF**
BASE							
Managed Care Base PCs	96, 97, 99, 102	($437.8)	($238.3)	$143.8	$0.0	$1,108.1	$280.5
REGULAR							
Medi-Cal Inmate Programs	3, 6, 219	($150.7)	$9.3	$5.9	$0.0	$313.6	($9.3)
Non-OTLICP CHIP	10	$0.0	$219.1	$0.0	$18.2	$0.0	($533.0)
Non-Emergency Funding Adjustment	11	$0.0	$278.6	$0.0	$128.2	$0.0	($163.5)
CHIPRA - M/C for Children and Pregnant Women	13	$0.0	$72.1	$0.0	$16.0	$0.0	($5.3)
MEC Optional Expansion Adjustment	221	$0.0	$0.0	($515.3)	$225.9	($515.3)	$225.9
Title XXI Federal Match Reduction	209	$0.0	$0.0	($56.4)	($138.7)	($112.4)	$392.2
Behavioral Health Treatment (BHT)	29,31	($259.9)	($111.2)	($339.0)	($145.3)	($6.8)	($4.5)
BHT - BIS DDS Transition	229	$0.0	$0.0	$11.2	$4.9	$11.2	$4.9
New High Cost Treatments For Specific Conditions	55	$1.7	$0.5	$46.3	$5.7	$58.2	$11.7
Drug Rebates	57, 58, 61, 62, 123	($1,286.6)	($259.6)	$7.0	$21.5	$1,162.9	$223.0
Drug Medi-Cal Organized Delivery System Waiver	64	$1.6	$1.0	($81.3)	($114.5)	$559.0	$22.9
CMS Deferred Claims	222	$0.0	$14.9	$0.0	$12.4	$0.0	($2.5)
CMS Deferrals & Negative Balance Repayment	223	$0.0	$226.3	$0.0	$0.0	$0.0	($226.3)

		Change from November 2016		Change from November 2016		Change from FY 2016-17	
		FY 2016-17		FY 2017-18		FY 2017-18	
Name	PC	TF	GF	TF	GF	TF	GF
Health Insurer Fee	19	($85.2)	($28.8)	$56.6	$17.2	$282.1	$94.9
MCO Tax Mgd Care Plans	117	$0.0	$0.0	$0.0	($414.4)	$0.0	($229.8)
General Fund Reimb.from DPHs	119	$0.0	$25.0	$0.0	($148.1)	$0.0	($204.7)
Retro Managed Care Rate Adjustments	124	$2,781.2	($147.6)	($947.5)	$236.2	($4,379.4)	$400.3
Medi-Cal Nonmedical Transportation	225	$0.0	$0.0	$6.0	$1.7	$6.0	$1.7
CCI-Managed Care Payments	98	$433.3	$216.7	$1,505.8	$752.9	($106.2)	($53.1)
CCI-Transfer of IHSS Costs to DHCS	197	$0.0	($190.5)	$0.0	($366.3)	$0.0	$624.2
CCI-FFS Savings for Add'l Enrollment	210	$17.5	$8.7	$29.9	$14.9	($238.3)	($119.1)
AB 1629 Annual Rate Adjustments	128	($40.9)	($20.4)	$9.2	$4.6	$81.7	$40.8
LTC Rate Adjustment	132	($17.2)	($8.6)	($16.7)	($8.4)	$18.3	$9.1
10% Provider Payment Reductions	136, 146	($3.4)	($1.7)	($8.5)	($4.3)	$10.5	$5.2
GDSP Fee Increases	137, 138	($4.4)	($2.2)	$17.4	$8.7	$22.9	$11.5
Laboratory Rate Methodology Change	144	$21.7	$10.9	$18.9	$9.5	($21.7)	($10.8)
Radiology Rate Reductions	145	$32.5	$16.2	$62.5	$31.3	($6.7)	($3.3)
Graduate Medical Education Payments to DPHs	118, 215	$0.0	$0.0	$1,187.5	($29.7)	$1,187.5	($29.7)
Extend Hospital QAF	147, 198	($4,972.5)	$0.0	$2,171.2	$35.7	$8,546.8	($345.4)

		Change from November 2016		Change from November 2016		Change from FY 2016-17	
		FY 2016-17		FY 2017-18		FY 2017-18	
Name	PC	TF	GF	TF	GF	TF	GF
DP-NF Capital Project Debt Repayment	214	$0.0	$0.0	$0.0	$57.2	$0.0	$57.2
Proposition 56 Funding	11, 55, 64, 70, 96, 97, 99, 102,104, 135,167, 168, 171, 208	$0.0	$0.0	$19.8	$0.0	$1,257.2	$0.0
IMD Ancillary Services	77	$0.0	$20.2	$0.0	$9.0	$0.0	$2.9
OTHER ADMINISTRATION							
Performance Outcome Systems	19	($10.2)	($5.1)	$1.3	($0.6)	$15.0	$6.2

SIGNIFICANT ITEMS

BASE PCs

Managed Care Base PCs (PC 96, 97, 99, 102)

The Managed Care Base PCs estimate the managed care capitation costs of the four managed care models. These PCs, where appropriate, include the ACA expansion population, Title XXI 88/12 funding, and the impact of CCI. Additionally, these PCs include the ACA 95/5 and 94/6 funding. While caseload decreases slightly from the November Estimate, Hepatitis C costs are estimated to be significantly less.

REGULAR PCs

ELIGIBILITY
Medi-Cal Inmate Programs (PC 3, 6, 219)

The Medi-Cal Inmate Programs PCs estimate the cost of inpatient services for inmates who are deemed eligible for Medi-Cal. The Adult and Juvenile PCs from the November 2016 Estimate are reorganized as a State Inmate PC and a County Inmate PC; each with an adult and juvenile component. The County Inmate Reimbursement PC has been added to estimate the GF reimbursement from the counties.

Non-OTLICP CHIP (PC 10)

This funding adjustment substitutes Title XXI federal funding for a portion of the GF cost associated with Non-OTLICP CHIP populations. Additionally, costs related to the CS-3 Proxy have been revised and retroactive claiming corrections are included.

Non-Emergency Funding Adjustment (PC 11)

This funding adjustment shifts Title XIX and Title XXI FFP to 100% GF for non-emergency services for specified populations. This PC also now includes expenditure data for SB 75 undocumented children. Costs for SB 75 undocumented children were previously identified in the Undocumented Children Full Scope Expansion PC.

CHIPRA – M/C for Children and Pregnant Women (PC 13)

This funding adjustment substitutes Title XIX or Title XXI FFP for 100% GF for qualified immigrant children and pregnant women. As a result of a system update that removed this population from the related expenditure report, an ongoing adjustment is no longer needed; Consequently, the policy change only includes costs for remaining retroactive adjustments.

MEC Optional Expansion Adjustment (PC 221)

To be eligible for the ACA Optional Expansion eligibility category, an individual must not have Miminum Essential Coverage (MEC). Some Medi-Cal eligibles with MEC (Medicare Part A, specifically) have been incorrectly assigned to the Optional Expansion eligibility. Enrollment systems were corrected August 2016; this will eliminate future eligibles with MEC from being placed in the OE category. Existing eligibles will be assigned to an appropriate eligibility category upon Medi-Cal redetermination. In FY 2017-18, the Department will repay federal funds for these beneficiaries, as the OE category has a higher federal funding ratio than the eligibility category these beneficiaries should have been assigned.

AFFORDABLE CARE ACT
Title XXI Federal Match Reduction (PC 209)

Effective October 1, 2017, the Estimate assumes the ACA enhanced federal match of 88% for the Children's Health Insurance Program (CHIP) is no longer funded. This policy change reflects the added cost under the assumption that Congress will re-authorize the program but at the pre-ACA level of 65%.

BENEFITS
Behavioral Health Treatment (BHT) (PC 29 and 31)

The Department implemented BHT services under the federal interpretation of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) 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. These policy changes reflect updated fee-for-service and managed care costs for Medi-Cal BHT services.

Behavioral Health Treatment – BIS DDS Transition (PC 229)

This policy change transitions to Medi-Cal additional DDS Regional Center (RC) clients who have a diagnosis other than Autism Spectrum Disorder (ASD) and have been receiving BHT/Behavioral Intervention Services (BIS).

PHARMACY

New High Cost Treatments for Specific Conditions (PC 55)

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 Person's Program (GHPP.) This policy change estimates new high cost services and treatments recently approved by the FDA. CCS treatment and services currently approved by the FDA are Orkambi, Exondys 51, SPINRAZA, and DEFLAZACORT. Orkambi is currently the only GHPP approved treatment and service.

Drug Rebates (PC 57, 58, 61, 62, and 123)

Rebate estimates were updated based on actual pharmacy drug rebate collections data through December 2016. Managed care drug rebates include additional rebate collections through March 2017.

DRUG MEDI-CAL

Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver (PC 64)

DMC-ODS waiver services will include existing DMC treatment modalities and additional new and expanded services. Interim payments to the opt-in counties will be based on submitted certified public expenditures (CPEs) reimbursed at the approved interim rates and State-established Narcotic Treatment Program rates. An interim and final reconciliation will settle the payments to actual county costs. The Department estimates seven counties will implement the DMC-ODS waiver in FY 2016-17 and an additional nine counties in FY 2017-18.

1115 WAIVER

CMS Deferred Claims (PC 222)

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, Medi-Cal has 120 days to resolve with CMS but the state must immediately return the federal funds to CMS. This policy change estimates the repayment of deferred Designated Public Hospital (DPH) inpatient per-diem payments to CMS in FY 2016-17 and FY 2017-18.

CMS Deferrals & Negative Balance Repayment (PC 223)

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). As part of this agreement, the Department has identified $226.3 million owed to CMS.

MANAGED CARE

Health Insurer Fee (PC 19)

Health plans pay a health insurer fee which is based on their market share of premium revenue in the previous year. The change between years is due to the timing of payments and applying a growth factor on premium revenue.

MCO Tax Managed Care Plans (PC 117)

The savings to the GF in this PC increases in FY 2017-18 due to the timing of retroactive transfers.

General Fund Reimbursements from DPHs (PC 119)

Designated public hospitals reimburse the GF for costs for Seniors and Persons with Disabilities built into the managed care rates that were previously paid through fee-for-service. The change in the fiscal estimate reflects changes in timing of payments and reconciliations as well as changes in projected amounts.

Medi-Cal Nonmedical Transportation (PC 225)

Medi-Cal managed care nonmedical transportation service ensures necessary transportation for full-scope beneficiaries to and from providers, subject to utilization controls and federally permissible time and distance standards. Program implementation is July 1, 2017.

CCI (PC 98, 197, 210)

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 Prorgram (MSSP) services, and other Home and Community-Based Services (HCBS). Additionally, CCI includes Cal MediConnect, a type of health plan that combines Medicare and Medi-Cal benefits into a single plan. Savings in the Med-Cal estimate are generated from a savings percentage applied to Cal MediConnect rates. CCI has been implemented in seven pilot counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. The budget estimate of CCI projects that it will no longer be cost-effective; therefore, pursuant to the provisions of current law, the program will be discontinued in FY 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 eligibles and integration of long-term services and support, except In-Home Supportive Survices, into managed care. Changes from the prior estimate include a lower-than-expected number of beneficiaries enrolling in Cal MediConnect, an overall increase in CCI beneficiaries, and changes in rates.

PROVIDER RATES

AB 1629 Annual Rate Adjustments (PC 128)

AB 1629 requires the Department to implement a facility-specific rate methodology and impose a QAF on freestanding skilled nursing facilities (NF-Bs), including adult and pediatric subacute facilities. The QAF is used to offset some of the GF cost of the reimbursement rates. This policy change updates the cost of the AB 1629 rate increases, add-ons, and retroactive payments for NF-Bs based on actual utilization, and delays in implementation.

LTC Rate Adjustment (PC 132)

This policy change updates the cost of the rate adjustments for LTC facilities based on updated utilization, add-on costs, and schedule for retroactive recoupments.

10% Provider Payment Reductions (PC 136 and 146)

AB 97 requires the Department to implement up to a 10% payment reduction to various providers including pharmacy and durable medical equipment (DME)/medical dupplies providers. This is an update to the retroactive recoupment schedule for DME/medical supplies providers, and the prospective pharmacy non-drug product reduction amounts. In addition, the Department ended the 10% prospective reductions for fee-for-service pharmacy drug products for dates of service on or after April 1, 2017.

GDSP Fee Increases (PC 137 and 138)

The California Department of Public Health (CDPH) administers the Genetic Disease Screening Program (GDSP) which includes prenatal screening and screening for newborns. These policy changes update the costs associated with multiple fee increases based on updated caseload, new rates, and delays in rate implementation and retroactive recoupments.

Laboratory Rate Methodology Change (PC 144)

This policy change revises savings amounts and implementation dates for the AB 1494 10% reduction retroactive recoupment, the July 2015 new rate methodology retroactive recoupment, and the new rate methodology prospective savings.

Reduction to Radiology Rates (PC 145)

This policy change updates the retroactive recoupment savings amount, implementation, and schedule for the reduction to radiology rates. In addition, this policy change reflects savings based on proposed annual adjustments to prospective radiology reimbursement rates with implementation beginning January 2018.

SUPPLEMENTAL PAYMENTS
Graduate Medical Education Payments to DPHs (PC 118 and 215)

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. The non-federal share of the payments will be funded with intergovernmental transfers (IGTs). A 5% administrative fee will be assessed on the IGTs. Administrative fees assessed in excess of the administration costs will result in a savings to the General Fund.

Extend Hospital QAF (PC 147 and 198)

The Hospital Quality Assurance Fee (QAF) 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. AB 1607 (Chapter 27, Statutes of 2016) extended the Hospital QAF program through December 31, 2017. Proposition 52, approved by California voters on November 8, 2016, permanently extended the Hospital QAF program. The HQAF estimates has been updated based on the draft HQAF V fee and payment model for the 30-month period from January 1, 2017 to June 30, 2019.

DP-NF Capital Project Debt Repayment (PC 214)

CMS has deferred $57.2 million federal funds for ineligible costs related to Capital Project Debt supplemental payments that were made to two public Distinct Part Skilled Nursing Facilities (DP/NFs). The Department estimates repayment of the deferred amounts to CMS in FY 2017-18.

Proposition 56 Funding (PC 11, 55, 64, 70, 96, 97, 99, 102,104, 135,167, 168, 171, and 208)

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. Proposition 56 requires backfills to Proposition 99, Proposition 10, the Breast Cancer Fund, and to state and local governments to address revenue declines that result from the additional tax. After backfills, and specified allocations, Proposition 56 requires 82 percent of the remaining funds be transferred to the Healthcare Treatment Fund for the Department of Health Care Services to support new growth in Medi-Cal expenditures as compared to the 2016 Budget Act. The May Revision includes $1.3 billion for this purpose. This is an increase of $19.8 million compared to the Governor's Budget as a result of updated revenue projections.

IMD Ancillary Services (PC 77)

The Department must make payments to the CMS for inappropriately claimed ancillary services for Medi-Cal beneficiaries residing in Institutions for Mental Diseases (IMDs). CMS has estimated IMD deferrals of $3 million federal funds per quarter and pursuant to federal requirements, upon the deferral, the state must immediately return the federal funds to CMS. This policy change has been updated to repay CMS for IMD deferrals for service periods from October 2010 to June 2016 based on updated estimates in FY 2016-17 and FY 2017-18.

OTHER ADMINISTRATION PCs

Performance Outcomes System (OA 19)

The Department is required to develop a Performance Outcomes System for Early and Periodic Screening, Diagnostic, and Treatment 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. The Department has selected the Pediatric Symptom Checklist (PSC 35) and the Child and Adolescents Needs and Strengths (CANS) to be the tools used to measure child and youth functional outcomes.

General Information

This estimate is based on actual payment data through January 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 $892 million TF ($189 million General Funds) change in expenditures in FY 2016-17 and $1,056 million TF ($186 million General Funds) in FY 2017-18.

Medi-Cal Funding Summary

May 2017 Estimate Compared to November 2016 Estimate

Fiscal Year 2016 - 2017

TOTAL FUNDS

	Nov 2016 Estimate	May 2017 Estimate	Difference Incr./(Decr.)
MEDI-CAL Benefits:			
4260-101-0001/0890(3)	$70,131,120,000	$64,882,370,000	($5,248,750,000)
4260-101-0080 CLPP Funds	$725,000	$725,000	$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$112,172,000	$112,172,000	$0
4260-101-0233 Prop 99 Physician Srvc. Acct	$28,463,000	$28,463,000	$0
4260-101-0236 Prop 99 Unallocated Account	$57,925,000	$57,925,000	$0
4260-101-0313 Major Risk Medical Ins Fund	$3,404,000	$3,404,000	$0
4260-101-3168 Emergency Air Transportation Fund	$8,691,000	$8,116,000	($575,000)
4260-101-3305 Healthcare Treatment Fund	$0	$0	$0
4260-101-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$0	$0	$0
4260-102-0001/0890 Capital Debt	$120,518,000	$78,946,000	($41,572,000)
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	$182,175,000	$182,115,000	($60,000)
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	$23,876,000	$18,933,000	($4,943,000)
4260-113-0001/0890 Healthy Families	$2,797,781,000	$2,522,733,000	($275,048,000)
4260-601-0942142 Local Trauma Centers	$69,369,000	$70,291,000	$922,000
4260-601-0942 Home Health Program Account	$0	$0	$0
4260-601-3156 MCO Tax Fund	$302,009,000	$312,766,000	$10,757,000
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$1,313,419,000	$1,312,457,000	($962,000)
4260-601-3213 LTC QA Fund	$466,897,000	$481,448,000	$14,551,000
4260-601-3293 MCO Tax Fund 2016	$1,712,447,000	$1,712,448,000	$1,000
4260-601-7502 Demonstration DSH Fund	$193,197,000	$184,463,000	($8,734,000)
4260-601-7503 Health Care Support Fund	$179,669,000	$91,399,000	($88,270,000)
4260-601-8107 Whole Person Care Pilot Fund	$240,000,000	$240,000,000	$0
4260-601-8108 Global Payment Program Fund	$1,135,544,000	$1,109,452,000	($26,092,000)
4260-602-0309 Perinatal Insurance Fund	$17,725,000	$13,412,000	($4,313,000)
4260-605-0001 SNF Quality & Accountability *	$92,165,000	$92,165,000	$0
4260-605-3167 SNF Quality & Accountability	$84,209,000	$86,335,000	$2,126,000
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	($92,165,000)	($92,165,000)	$0
4260-606-0834 SB 1100 DSH	$269,515,000	$250,018,000	($19,497,000)
4260-610-0995 Reimbursements	$2,743,772,000	$3,207,653,000	$463,881,000
4260-611-3158/0890 Hospital Quality Assurance	$13,063,047,000	$7,794,843,000	($5,268,204,000)
4260-611-3201 LIHP MCE Out-of-Network ER Svcs.	$116,250,000	$0	($116,250,000)
TOTAL MEDI-CAL Benefits	**$95,375,819,000**	**$84,764,787,000**	**($10,611,032,000)**
COUNTY ADMINISTRATION:			
4260-101-0001/0890(1)	$4,187,605,000	$3,992,097,000	($195,508,000)
4260-106-0890(1) Money Follow Person Fed. Grant	$696,000	$627,000	($69,000)
4260-107-0890 Prevention of Chronic Disease (MICPD)	$80,000	$80,000	$0
4260-113-0001/0890 Healthy Families	$61,491,000	$60,983,000	($508,000)
4260-117-0001/0890 HIPPA	$7,105,000	$6,881,000	($224,000)
4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct.	$5,966,000	$7,016,000	$1,050,000
4260-601-0942 Home Health Program Account	$0	$0	$0
4260-602-0313 Major Risk Medical Ins Fund	$1,422,000	$1,422,000	$0
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$0	$0	$0
4260-605-3167 SNF Quality & Accountability Admin.	$3,894,000	$3,930,000	$36,000
4260-610-0995 Reimbursements	$674,000	$664,000	($10,000)
TOTAL COUNTY ADMIN.	**$4,268,933,000**	**$4,073,700,000**	**($195,233,000)**
FISCAL INTERMEDIARY:			
4260-101-0001/0890(2)	$397,013,000	$383,223,000	($13,790,000)
4260-113-0001/0890 Healthy Families	$5,518,000	$5,518,000	$0
4260-117-0001/0890 HIPAA	$14,760,000	$14,585,000	($175,000)
4260-610-0995 Reimbursements	$0	$0	$0
TOTAL FISCAL INTERMEDIARY	**$417,291,000**	**$403,326,000**	**($13,965,000)**
GRAND TOTAL - ALL FUNDS	**$100,062,043,000**	**$89,241,813,000**	**($10,820,230,000)**

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

Medi-Cal Funding Summary

May 2017 Estimate Compared to November 2016 Estimate

Fiscal Year 2016 - 2017

STATE FUNDS

	Nov 2016 Estimate	May 2017 Estimate	Difference Incr./(Decr.)
MEDI-CAL Benefits:			
4260-101-0001(3) *	$17,997,899,000	$17,449,320,000	($548,579,000)
4260-101-0080 CLPP Funds	$725,000	$725,000	$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$112,172,000	$112,172,000	$0
4260-101-0233 Prop 99 Physician Srvc. Acct	$28,463,000	$28,463,000	$0
4260-101-0236 Prop 99 Unallocated Account	$57,925,000	$57,925,000	$0
4260-101-0313 Major Risk Medical Ins Fund	$3,404,000	$3,404,000	$0
4260-101-3168 Emergency Air Transportation Fund	$8,691,000	$8,116,000	($575,000)
4260-101-3305 Healthcare Treatment Fund	$0	$0	$0
4260-101-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$0	$0	$0
4260-102-0001 Capital Debt *	$60,259,000	$39,473,000	($20,786,000)
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	$182,175,000	$182,115,000	($60,000)
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($118,400,000)	($118,400,000)	$0
4260-113-0001 Healthy Families *	$309,639,000	$270,794,000	($38,845,000)
4260-601-0942142 Local Trauma Centers	$69,369,000	$70,291,000	$922,000
4260-601-0942 Home Health Program Account	$0	$0	$0
4260-601-3156 MCO Tax Fund	$302,009,000	$312,766,000	$10,757,000
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$1,313,419,000	$1,312,457,000	($962,000)
4260-601-3213 LTC QA Fund	$466,897,000	$481,448,000	$14,551,000
4260-601-3293 MCO Tax Fund 2016	$1,712,447,000	$1,712,448,000	$1,000
4260-601-8107 Whole Person Care Pilot Fund	$240,000,000	$240,000,000	$0
4260-601-8108 Global Payment Program Fund	$1,135,544,000	$1,109,452,000	($26,092,000)
4260-602-0309 Perinatal Insurance Fund	$17,725,000	$13,412,000	($4,313,000)
4260-605-0001 SNF Quality & Accountability *	$92,165,000	$92,165,000	$0
4260-605-3167 SNF Quality & Accountability	$84,209,000	$86,335,000	$2,126,000
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	($92,165,000)	($92,165,000)	$0
4260-606-0834 SB 1100 DSH	$269,515,000	$250,018,000	($19,497,000)
4260-610-0995 Reimbursements	$2,743,772,000	$3,207,653,000	$463,881,000
4260-611-3158 Hospital Quality Assurance Revenue	$5,027,396,000	$3,584,351,000	($1,443,045,000)
4260-611-3201 LIHP MCE Out-of-Network ER Svcs.	$116,250,000	$0	($116,250,000)
TOTAL MEDI-CAL Benefits	**$32,261,804,000**	**$30,535,038,000**	**($1,726,766,000)**
Total Benefits General Fund *	**$18,580,262,000**	**$17,972,052,000**	**($608,210,000)**
COUNTY ADMINISTRATION:			
4260-101-0001(1) *	$852,206,000	$845,767,000	($6,439,000)
4260-113-0001 Healthy Families *	$5,737,000	$5,706,000	($31,000)
4260-117-0001 HIPAA *	$1,294,000	$1,238,000	($56,000)
4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct.	$5,966,000	$7,016,000	$1,050,000
4260-601-0942 Home Health Program Account	$0	$0	$0
4260-602-0313 Major Risk Medical Ins Fund	$1,422,000	$1,422,000	$0
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$0	$0	$0
4260-605-3167 SNF Quality & Accountability Admin.	$3,894,000	$3,930,000	$36,000
4260-610-0995 Reimbursements	$674,000	$664,000	($10,000)
TOTAL COUNTY ADMIN.	**$871,193,000**	**$865,743,000**	**($5,450,000)**
Total Co. Admin. General Fund *	**$859,237,000**	**$852,711,000**	**($6,526,000)**
FISCAL INTERMEDIARY:			
4260-101-0001(2) *	$117,030,000	$112,026,000	($5,004,000)
4260-113-0001 Healthy Families *	$662,000	$662,000	$0
4260-117-0001 HIPAA *	$2,832,000	$2,789,000	($43,000)
4260-610-0995 Reimbursements	$0	$0	$0
TOTAL FISCAL INTERMEDIARY	**$120,524,000**	**$115,477,000**	**($5,047,000)**
Total FI General Fund *	**$120,524,000**	**$115,477,000**	**($5,047,000)**
GRAND TOTAL - STATE FUNDS	**$33,253,521,000**	**$31,516,258,000**	**($1,737,263,000)**
Grand Total - General Fund*	**$19,560,023,000**	**$18,940,240,000**	**($619,783,000)**

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

Medi-Cal Funding Summary

May 2017 Estimate Compared to November 2016 Estimate

Fiscal Year 2016 - 2017

FEDERAL FUNDS

	Nov 2016 Estimate	May 2017 Estimate	Difference Incr./(Decr.)
MEDI-CAL Benefits:			
4260-101-0890(3)	$52,133,221,000	$47,433,050,000	($4,700,171,000)
4260-102-0890 Capital Debt	$60,259,000	$39,473,000	($20,786,000)
4260-106-0890 Money Follows Person Federal Grant	$23,876,000	$18,933,000	($4,943,000)
4260-113-0890 Health Families	$2,488,142,000	$2,251,939,000	($236,203,000)
4260-601-7502 Demonstration DSH Fund	$193,197,000	$184,463,000	($8,734,000)
4260-601-7503 Health Care Support Fund	$179,669,000	$91,399,000	($88,270,000)
4260-611-0890 Hospital Quality Assurance	$8,035,651,000	$4,210,492,000	($3,825,159,000)
TOTAL MEDI-CAL Benefits	**$63,114,015,000**	**$54,229,749,000**	**($8,884,266,000)**
COUNTY ADMINISTRATION:			
4260-101-0890(1)	$3,335,399,000	$3,146,330,000	($189,069,000)
4260-106-0890(1) Money Follows Person Fed. Grant	$696,000	$627,000	($69,000)
4260-107-0890 Prevention of Chronic Disease (MIPCD)	$80,000	$80,000	$0
4260-113-0890 Healthy Families	$55,754,000	$55,277,000	($477,000)
4260-117-0890 HIPAA	$5,811,000	$5,643,000	($168,000)
TOTAL COUNTY ADMIN.	**$3,397,740,000**	**$3,207,957,000**	**($189,783,000)**
FISCAL INTERMEDIARY:			
4260-101-0890(2)	$279,983,000	$271,197,000	($8,786,000)
4260-113-0890 Healthy Families	$4,856,000	$4,856,000	$0
4260-117-0890 HIPAA	$11,928,000	$11,796,000	($132,000)
TOTAL FISCAL INTERMEDIARY	**$296,767,000**	**$287,849,000**	**($8,918,000)**
GRAND TOTAL - FEDERAL FUNDS	**$66,808,522,000**	**$57,725,555,000**	**($9,082,967,000)**

Medi-Cal Funding Summary

May 2017 Estimate Compared to Appropriation

Fiscal Year 2016 - 2017

TOTAL FUNDS

MEDI-CAL Benefits:	**Total Appropriation**	**May 2017 Estimate**	**Difference Incr./(Decr.)**
4260-101-0001/0890(3)	$63,268,665,000	$64,882,370,000	$1,613,705,000
4260-101-0080 CLPP Funds	$725,000	$725,000	$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$112,172,000	$112,172,000	$0
4260-101-0233 Prop 99 Physician Srvc. Acct	$28,463,000	$28,463,000	$0
4260-101-0236 Prop 99 Unallocated Account	$57,925,000	$57,925,000	$0
4260-101-0313 Major Risk Medical Ins Fund	$2,016,000	$3,404,000	$1,388,000
4260-101-3168 Emergency Air Transportation Fund	$8,982,000	$8,116,000	($866,000)
4260-102-0001/0890 Capital Debt	$82,282,000	$78,946,000	($3,336,000)
4260-104-0001 NDPH Hosp Supp *	$1,900,000	$1,900,000	$0
4260-601-3096 NDPH Suppl	$2,356,000	$1,900,000	($456,000)
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	$130,197,000	$182,115,000	$51,918,000
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	$22,517,000	$18,933,000	($3,584,000)
4260-113-0001/0890 Healthy Families	$3,511,008,000	$2,522,733,000	($988,275,000)
4260-601-0942142 Local Trauma Centers	$56,278,000	$70,291,000	$14,013,000
4260-601-0942 Home Health Program Account	$137,000	$0	($137,000)
4260-601-3156 MCO Tax Fund	$271,214,000	$312,766,000	$41,552,000
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$800,000,000	$1,312,457,000	$512,457,000
4260-601-3213 LTC QA Fund	$491,075,000	$481,448,000	($9,627,000)
4260-601-3293 MCO Tax Fund 2016	$1,737,918,000	$1,712,448,000	($25,470,000)
4260-601-7502 Demonstration DSH Fund	$0	$184,463,000	$184,463,000
4260-601-7503 Health Care Support Fund	$63,050,000	$91,399,000	$28,349,000
4260-601-8107 Whole Person Care Pilot Fund	$0	$240,000,000	$240,000,000
4260-601-8108 Global Payment Program Fund	$0	$1,109,452,000	$1,109,452,000
4260-602-0309 Perinatal Insurance Fund	$12,759,000	$13,412,000	$653,000
4260-605-0001 SNF Quality & Accountability *	$48,928,000	$92,165,000	$43,237,000
4260-605-3167 SNF Quality & Accountability	$44,069,000	$86,335,000	$42,266,000
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	($48,928,000)	($92,165,000)	($43,237,000)
4260-606-0834 SB 1100 DSH	$1,377,911,000	$250,018,000	($1,127,893,000)
4260-610-0995 Reimbursements	$5,892,571,000	$3,207,653,000	($2,684,918,000)
4260-611-3158/0890 Hospital Quality Assurance	$7,675,580,000	$7,794,843,000	$119,263,000
4260-611-3201 LIHP MCE Out-of-Network ER Svcs.	$116,249,000	$0	($116,249,000)
TOTAL MEDI-CAL Benefits	**$85,766,119,000**	**$84,764,787,000**	**($1,001,332,000)**
COUNTY ADMINISTRATION:			
4260-101-0001/0890(1)	$4,087,253,000	$3,992,097,000	($95,156,000)
4260-106-0890(1) Money Follow Person Fed. Grant	$708,000	$627,000	($81,000)
4260-107-0890 Prevention of Chronic Disease (MICPD)	$80,000	$80,000	$0
4260-113-0001/0890 Healthy Families	$64,558,000	$60,983,000	($3,575,000)
4260-117-0001/0890 HIPPA	$7,037,000	$6,881,000	($156,000)
4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct.	$3,153,000	$7,016,000	$3,863,000
4260-601-0942 Home Health Program Account	$0	$0	$0
4260-602-0313 Major Risk Medical Ins Fund	$2,049,000	$1,422,000	($627,000)
4260-605-3167 SNF Quality & Accountability Admin.	$3,560,000	$3,930,000	$370,000
4260-610-0995 Reimbursements	$660,000	$664,000	$4,000
TOTAL COUNTY ADMIN.	**$4,169,058,000**	**$4,073,700,000**	**($95,358,000)**
FISCAL INTERMEDIARY:			
4260-101-0001/0890(2)	$346,468,000	$383,223,000	$36,755,000
4260-113-0001/0890 Healthy Families	$5,475,000	$5,518,000	$43,000
4260-117-0001/0890 HIPAA	$15,190,000	$14,585,000	($605,000)
4260-610-0995 Reimbursements	$0	$0	$0
TOTAL FISCAL INTERMEDIARY	**$367,133,000**	**$403,326,000**	**$36,193,000**
GRAND TOTAL - ALL FUNDS	**$90,302,310,000**	**$89,241,813,000**	**($1,060,497,000)**

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

Medi-Cal Funding Summary

May 2017 Estimate Compared to Appropriation

Fiscal Year 2016 - 2017

STATE FUNDS

MEDI-CAL Benefits:	**State Funds Appropriation**	**May 2017 Estimate**	**Difference Incr./(Decr.)**
4260-101-0001(3) *	$16,097,892,000	$17,449,320,000	$1,351,428,000
4260-101-0080 CLPP Funds	$725,000	$725,000	$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$112,172,000	$112,172,000	$0
4260-101-0233 Prop 99 Physician Srvc. Acct	$28,463,000	$28,463,000	$0
4260-101-0236 Prop 99 Unallocated Account	$57,925,000	$57,925,000	$0
4260-101-0313 Major Risk Medical Ins Fund	$2,016,000	$3,404,000	$1,388,000
4260-101-3168 Emergency Air Transportation Fund	$8,982,000	$8,116,000	($866,000)
4260-102-0001 Capital Debt *	$41,141,000	$39,473,000	($1,668,000)
4260-104-0001 NDPH Hosp Supp *	$1,900,000	$1,900,000	$0
4260-601-3096 NDPH Suppl	$2,356,000	$1,900,000	($456,000)
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	$130,197,000	$182,115,000	$51,918,000
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($118,400,000)	($118,400,000)	$0
4260-113-0001 Healthy Families *	$478,392,000	$270,794,000	($207,598,000)
4260-601-0942142 Local Trauma Centers	$56,278,000	$70,291,000	$14,013,000
4260-601-0942 Home Health Program Account	$137,000	$0	($137,000)
4260-601-3156 MCO Tax Fund	$271,214,000	$312,766,000	$41,552,000
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$800,000,000	$1,312,457,000	$512,457,000
4260-601-3213 LTC QA Fund	$491,075,000	$481,448,000	($9,627,000)
4260-601-3293 MCO Tax Fund 2016	$1,737,918,000	$1,712,448,000	($25,470,000)
4260-601-8107 Whole Person Care Pilot Fund	$0	$240,000,000	$240,000,000
4260-601-8108 Global Payment Program Fund	$0	$1,109,452,000	$1,109,452,000
4260-602-0309 Perinatal Insurance Fund	$12,759,000	$13,412,000	$653,000
4260-605-0001 SNF Quality & Accountability *	$48,928,000	$92,165,000	$43,237,000
4260-605-3167 SNF Quality & Accountability	$44,069,000	$86,335,000	$42,266,000
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	($48,928,000)	($92,165,000)	($43,237,000)
4260-606-0834 SB 1100 DSH	$1,377,911,000	$250,018,000	($1,127,893,000)
4260-610-0995 Reimbursements	$5,892,571,000	$3,207,653,000	($2,684,918,000)
4260-611-3158 Hospital Quality Assurance Revenue	$3,792,518,000	$3,584,351,000	($208,167,000)
4260-611-3201 LIHP MCE Out-of-Network ER Svcs.	$116,249,000	$0	($116,249,000)
TOTAL MEDI-CAL Benefits	**$31,552,960,000**	**$30,535,038,000**	**($1,017,922,000)**
Total Benefits General Fund *	**$16,786,653,000**	**$17,972,052,000**	**$1,185,399,000**
COUNTY ADMINISTRATION:			
4260-101-0001(1) *	$853,803,000	$845,767,000	($8,036,000)
4260-113-0001 Healthy Families *	$6,353,000	$5,706,000	($647,000)
4260-117-0001 HIPAA *	$1,287,000	$1,238,000	($49,000)
4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct.	$3,153,000	$7,016,000	$3,863,000
4260-601-0942 Home Health Program Account	$0	$0	$0
4260-602-0313 Major Risk Medical Ins Fund	$2,049,000	$1,422,000	($627,000)
4260-605-3167 SNF Quality & Accountability Admin.	$3,560,000	$3,930,000	$370,000
4260-610-0995 Reimbursements	$660,000	$664,000	$4,000
TOTAL COUNTY ADMIN.	**$870,865,000**	**$865,743,000**	**($5,122,000)**
Total Co. Admin. General Fund *	**$861,443,000**	**$852,711,000**	**($8,732,000)**
FISCAL INTERMEDIARY:			
4260-101-0001(2) *	$103,087,000	$112,026,000	$8,939,000
4260-113-0001 Healthy Families *	$657,000	$662,000	$5,000
4260-117-0001 HIPAA *	$3,118,000	$2,789,000	($329,000)
4260-610-0995 Reimbursements	$0	$0	$0
TOTAL FISCAL INTERMEDIARY	**$106,862,000**	**$115,477,000**	**$8,615,000**
Total FI General Fund *	**$106,862,000**	**$115,477,000**	**$8,615,000**
GRAND TOTAL - STATE FUNDS	**$32,530,687,000**	**$31,516,258,000**	**($1,014,429,000)**
Grand Total - General Fund *	**$17,754,958,000**	**$18,940,240,000**	**$1,185,282,000**

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

Medi-Cal Funding Summary

May 2017 Estimate Compared to Appropriation

Fiscal Year 2016 - 2017

FEDERAL FUNDS

	Federal Funds Appropriation	May 2017 Estimate	Difference Incr./(Decr.)
MEDI-CAL Benefits:			
4260-101-0890(3)	$47,170,775,000	$47,433,050,000	$262,275,000
4260-102-0890 Capital Debt	$41,141,000	$39,473,000	($1,668,000)
4260-106-0890 Money Follows Person Federal Grant	$22,517,000	$18,933,000	($3,584,000)
4260-113-0890 Health Families	$3,032,616,000	$2,251,939,000	($780,677,000)
4260-601-7502 Demonstration DSH Fund	$0	$184,463,000	$184,463,000
4260-601-7503 Health Care Support Fund	$63,050,000	$91,399,000	$28,349,000
4260-611-0890 Hospital Quality Assurance	$3,883,062,000	$4,210,492,000	$327,430,000
TOTAL MEDI-CAL Benefits	**$54,213,161,000**	**$54,229,749,000**	**$16,588,000**
COUNTY ADMINISTRATION:			
4260-101-0890(1)	$3,233,450,000	$3,146,330,000	($87,120,000)
4260-106-0890(1) Money Follows Person Fed. Grant	$708,000	$627,000	($81,000)
4260-107-0890 Prevention of Chronic Disease (MIPCD)	$80,000	$80,000	$0
4260-113-0890 Healthy Families	$58,205,000	$55,277,000	($2,928,000)
4260-117-0890 HIPAA	$5,750,000	$5,643,000	($107,000)
TOTAL COUNTY ADMIN.	**$3,298,193,000**	**$3,207,957,000**	**($90,236,000)**
FISCAL INTERMEDIARY:			
4260-101-0890(2)	$243,381,000	$271,197,000	$27,816,000
4260-113-0890 Healthy Families	$4,818,000	$4,856,000	$38,000
4260-117-0890 HIPAA	$12,072,000	$11,796,000	($276,000)
TOTAL FISCAL INTERMEDIARY	**$260,271,000**	**$287,849,000**	**$27,578,000**
GRAND TOTAL - FEDERAL FUNDS	**$57,771,625,000**	**$57,725,555,000**	**($46,070,000)**

Medi-Cal Funding Summary

May 2017 Estimate Comparison of FY 2016-17 to FY 2017-18

TOTAL FUNDS

	FY 2016-17 Estimate	FY 2017-18 Estimate	Difference Incr./(Decr.)
MEDI-CAL Benefits:			
4260-101-0001/0890(3)	$64,882,370,000	$67,566,482,000	$2,684,112,000
4260-101-0080 CLPP Funds	$725,000	$725,000	$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$112,172,000	$111,400,000	($772,000)
4260-101-0233 Prop 99 Physician Srvc. Acct	$28,463,000	$40,220,000	$11,757,000
4260-101-0236 Prop 99 Unallocated Account	$57,925,000	$56,904,000	($1,021,000)
4260-101-0313 Major Risk Medical Ins Fund	$3,404,000	$0	($3,404,000)
4260-101-3156 MCO Tax Fund MRMIB	$0	$99,407,000	$99,407,000
4260-101-3168 Emergency Air Transportation Fund	$8,116,000	$7,890,000	($226,000)
4260-101-3305 Healthcare Treatment Fund	$0	$1,257,166,000	$1,257,166,000
4260-101-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$0	$46,633,000	$46,633,000
4260-102-0001/0890 Capital Debt	$78,946,000	$165,619,000	$86,673,000
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	$182,115,000	$127,550,000	($54,565,000)
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	$18,933,000	$19,496,000	$563,000
4260-113-0001/0890 Healthy Families	$2,522,733,000	$3,020,483,000	$497,750,000
4260-601-0942142 Local Trauma Centers	$70,291,000	$44,845,000	($25,446,000)
4260-601-0942 Home Health Program Account	$0	$0	$0
4260-601-3156 MCO Tax Fund	$312,766,000	$328,610,000	$15,844,000
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$1,312,457,000	$800,000,000	($512,457,000)
4260-601-3213 LTC QA Fund	$481,448,000	$482,975,000	$1,527,000
4260-601-3293 MCO Tax Fund 2016	$1,712,448,000	$2,392,507,000	$680,059,000
4260-601-7502 Demonstration DSH Fund	$184,463,000	$148,011,000	($36,452,000)
4260-601-7503 Health Care Support Fund	$91,399,000	$324,393,000	$232,994,000
4260-601-8107 Whole Person Care Pilot Fund	$240,000,000	$360,000,000	$120,000,000
4260-601-8108 Global Payment Program Fund	$1,109,452,000	$1,152,567,000	$43,115,000
4260-602-0309 Perinatal Insurance Fund	$13,412,000	$10,997,000	($2,415,000)
4260-605-0001 SNF Quality & Accountability *	$92,165,000	$48,928,000	($43,237,000)
4260-605-3167 SNF Quality & Accountability	$86,335,000	$43,122,000	($43,213,000)
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	($92,165,000)	($48,928,000)	$43,237,000
4260-606-0834 SB 1100 DSH	$250,018,000	$177,411,000	($72,607,000)
4260-610-0995 Reimbursements	$3,207,653,000	$4,885,881,000	$1,678,228,000
4260-611-3158/0890 Hospital Quality Assurance	$7,794,843,000	$16,840,000,000	$9,045,157,000
4260-611-3201 LIHP MCE Out-of-Network ER Svcs.	$0	$116,250,000	$116,250,000
TOTAL MEDI-CAL Benefits	**$84,764,787,000**	**$100,629,444,000**	**$15,864,657,000**
COUNTY ADMINISTRATION:			
4260-101-0001/0890(1)	$3,992,097,000	$4,518,300,000	$526,203,000
4260-106-0890(1) Money Follow Person Fed. Grant	$627,000	$688,000	$61,000
4260-107-0890 Prevention of Chronic Disease (MICPD)	$80,000	$0	($80,000)
4260-113-0001/0890 Healthy Families	$60,983,000	$32,587,000	($28,396,000)
4260-117-0001/0890 HIPPA	$6,881,000	$10,581,000	$3,700,000
4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct.	$7,016,000	$5,856,000	($1,160,000)
4260-601-0942 Home Health Program Account	$0	$317,000	$317,000
4260-602-0313 Major Risk Medical Ins Fund	$1,422,000	$0	($1,422,000)
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$0	$1,419,000	$1,419,000
4260-605-3167 SNF Quality & Accountability Admin.	$3,930,000	$3,907,000	($23,000)
4260-610-0995 Reimbursements	$664,000	$692,000	$28,000
TOTAL COUNTY ADMIN.	**$4,073,700,000**	**$4,574,347,000**	**$500,647,000**
FISCAL INTERMEDIARY:			
4260-101-0001/0890(2)	$383,223,000	$403,121,000	$19,898,000
4260-113-0001/0890 Healthy Families	$5,518,000	$5,816,000	$298,000
4260-117-0001/0890 HIPAA	$14,585,000	$14,293,000	($292,000)
4260-610-0995 Reimbursements	$0	$0	$0
TOTAL FISCAL INTERMEDIARY	**$403,326,000**	**$423,230,000**	**$19,904,000**
GRAND TOTAL - ALL FUNDS	**$89,241,813,000**	**$105,627,021,000**	**$16,385,208,000**

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

Medi-Cal Funding Summary

May 2017 Estimate Comparison of FY 2016-17 to FY 2017-18

STATE FUNDS

	FY 2016-17 Estimate	FY 2017-18 Estimate	Difference Incr./(Decr.)
MEDI-CAL Benefits:			
4260-101-0001(3) *	$17,449,320,000	$16,507,594,000	($941,726,000)
4260-101-0080 CLPP Funds	$725,000	$725,000	$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$112,172,000	$111,400,000	($772,000)
4260-101-0233 Prop 99 Physician Srvc. Acct	$28,463,000	$40,220,000	$11,757,000
4260-101-0236 Prop 99 Unallocated Account	$57,925,000	$56,904,000	($1,021,000)
4260-101-0313 Major Risk Medical Ins Fund	$3,404,000	$0	($3,404,000)
4260-101-3156 MCO Tax Fund MRMIB	$0	$99,407,000	$99,407,000
4260-101-3168 Emergency Air Transportation Fund	$8,116,000	$7,890,000	($226,000)
4260-101-3305 Healthcare Treatment Fund	$0	$1,257,166,000	$1,257,166,000
4260-101-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$0	$46,633,000	$46,633,000
4260-102-0001 Capital Debt *	$39,473,000	$82,809,000	$43,336,000
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	$182,115,000	$127,550,000	($54,565,000)
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($118,400,000)	($118,400,000)	$0
4260-113-0001 Healthy Families *	$270,794,000	$718,959,000	$448,165,000
4260-601-0942142 Local Trauma Centers	$70,291,000	$44,845,000	($25,446,000)
4260-601-0942 Home Health Program Account	$0	$0	$0
4260-601-3156 MCO Tax Fund	$312,766,000	$328,610,000	$15,844,000
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$1,312,457,000	$800,000,000	($512,457,000)
4260-601-3213 LTC QA Fund	$481,448,000	$482,975,000	$1,527,000
4260-601-3293 MCO Tax Fund 2016	$1,712,448,000	$2,392,507,000	$680,059,000
4260-601-8107 Whole Person Care Pilot Fund	$240,000,000	$360,000,000	$120,000,000
4260-601-8108 Global Payment Program Fund	$1,109,452,000	$1,152,567,000	$43,115,000
4260-602-0309 Perinatal Insurance Fund	$13,412,000	$10,997,000	($2,415,000)
4260-605-0001 SNF Quality & Accountability *	$92,165,000	$48,928,000	($43,237,000)
4260-605-3167 SNF Quality & Accountability	$86,335,000	$43,122,000	($43,213,000)
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	($92,165,000)	($48,928,000)	$43,237,000
4260-606-0834 SB 1100 DSH	$250,018,000	$177,411,000	($72,607,000)
4260-610-0995 Reimbursements	$3,207,653,000	$4,885,881,000	$1,678,228,000
4260-611-3158 Hospital Quality Assurance Revenue	$3,584,351,000	$6,382,189,000	$2,797,838,000
4260-611-3201 LIHP MCE Out-of-Network ER Svcs.	$0	$116,250,000	$116,250,000
TOTAL MEDI-CAL Benefits	**$30,535,038,000**	**$36,236,511,000**	**$5,701,473,000**
Total Benefits General Fund *	**$17,972,052,000**	**$17,478,590,000**	**($493,462,000)**
COUNTY ADMINISTRATION:			
4260-101-0001(1) *	$845,767,000	$946,049,000	$100,282,000
4260-113-0001 Healthy Families *	$5,706,000	$12,804,000	$7,098,000
4260-117-0001 HIPAA *	$1,238,000	$1,708,000	$470,000
4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct.	$7,016,000	$5,856,000	($1,160,000)
4260-601-0942 Home Health Program Account	$0	$317,000	$317,000
4260-602-0313 Major Risk Medical Ins Fund	$1,422,000	$0	($1,422,000)
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$0	$1,419,000	$1,419,000
4260-605-3167 SNF Quality & Accountability Admin.	$3,930,000	$3,907,000	($23,000)
4260-610-0995 Reimbursements	$664,000	$692,000	$28,000
TOTAL COUNTY ADMIN.	**$865,743,000**	**$972,752,000**	**$107,009,000**
Total Co. Admin. General Fund *	**$852,711,000**	**$960,561,000**	**$107,850,000**
FISCAL INTERMEDIARY:			
4260-101-0001(2) *	$112,026,000	$150,157,000	$38,131,000
4260-113-0001 Healthy Families *	$662,000	$1,701,000	$1,039,000
4260-117-0001 HIPAA *	$2,789,000	$2,681,000	($108,000)
4260-610-0995 Reimbursements	$0	$0	$0
TOTAL FISCAL INTERMEDIARY	**$115,477,000**	**$154,539,000**	**$39,062,000**
Total FI General Fund *	**$115,477,000**	**$154,539,000**	**$39,062,000**
GRAND TOTAL - STATE FUNDS	**$31,516,258,000**	**$37,363,802,000**	**$5,847,544,000**
Grand Total General Fund *	**$18,940,240,000**	**$18,593,690,000**	**($346,550,000)**

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

Medi-Cal Funding Summary

May 2017 Estimate Comparison of FY 2016-17 to FY 2017-18

FEDERAL FUNDS

	FY 2016-17 Estimate	FY 2017-18 Estimate	Difference Incr./(Decr.)
MEDI-CAL Benefits:			
4260-101-0890(3)	$47,433,050,000	$51,058,888,000	$3,625,838,000
4260-102-0890 Capital Debt	$39,473,000	$82,810,000	$43,337,000
4260-106-0890 Money Follows Person Federal Grant	$18,933,000	$19,496,000	$563,000
4260-113-0890 Health Families	$2,251,939,000	$2,301,524,000	$49,585,000
4260-601-7502 Demonstration DSH Fund	$184,463,000	$148,011,000	($36,452,000)
4260-601-7503 Health Care Support Fund	$91,399,000	$324,393,000	$232,994,000
4260-611-0890 Hospital Quality Assurance	$4,210,492,000	$10,457,811,000	$6,247,319,000
TOTAL MEDI-CAL Benefits	**$54,229,749,000**	**$64,392,933,000**	**$10,163,184,000**
COUNTY ADMINISTRATION:			
4260-101-0890(1)	$3,146,330,000	$3,572,251,000	$425,921,000
4260-106-0890(1) Money Follows Person Fed. Grant	$627,000	$688,000	$61,000
4260-107-0890 Prevention of Chronic Disease (MIPCD)	$80,000	$0	($80,000)
4260-113-0890 Healthy Families	$55,277,000	$19,783,000	($35,494,000)
4260-117-0890 HIPAA	$5,643,000	$8,873,000	$3,230,000
TOTAL COUNTY ADMIN.	**$3,207,957,000**	**$3,601,595,000**	**$393,638,000**
FISCAL INTERMEDIARY:			
4260-101-0890(2)	$271,197,000	$252,964,000	($18,233,000)
4260-113-0890 Healthy Families	$4,856,000	$4,115,000	($741,000)
4260-117-0890 HIPAA	$11,796,000	$11,612,000	($184,000)
TOTAL FISCAL INTERMEDIARY	**$287,849,000**	**$268,691,000**	**($19,158,000)**
GRAND TOTAL - FEDERAL FUNDS	**$57,725,555,000**	**$68,263,219,000**	**$10,537,664,000**

Medi-Cal Funding Summary
May 2017 Estimate Compared to November 2016 Estimate
Fiscal Year 2017 - 2018

TOTAL FUNDS

	Nov 2016 Estimate	May 2017 Estimate	Difference Incr./(Decr.)
MEDI-CAL Benefits:			
4260-101-0001/0890(3)	$69,370,053,000	$67,566,482,000	($1,803,571,000)
4260-101-0080 CLPP Funds	$725,000	$725,000	$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$112,075,000	$111,400,000	($675,000)
4260-101-0233 Prop 99 Physician Srvc. Acct	$36,802,000	$40,220,000	$3,418,000
4260-101-0236 Prop 99 Unallocated Account	$57,377,000	$56,904,000	($473,000)
4260-101-0313 Major Risk Medical Ins Fund	$0	$0	$0
4260-101-3156 MCO Tax Fund MRMIB	$0	$99,407,000	$99,407,000
4260-101-3168 Emergency Air Transportation Fund	$7,038,000	$7,890,000	$852,000
4260-101-3305 Healthcare Treatment Fund	$1,237,393,000	$1,257,166,000	$19,773,000
4260-101-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$65,700,000	$46,633,000	($19,067,000)
4260-102-0001/0890 Capital Debt	$118,808,000	$165,619,000	$46,811,000
4260-104-0001 NDPH Hosp Supp *	$1,773,000	$1,900,000	$127,000
4260-601-3096 NDPH Suppl	$1,900,000	$1,900,000	$0
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	($1,773,000)	($1,900,000)	($127,000)
4260-105-0001 Private Hosp Supp Fund *	$100,150,000	$118,400,000	$18,250,000
4260-601-3097 Private Hosp Suppl	$127,550,000	$127,550,000	$0
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($100,150,000)	($118,400,000)	($18,250,000)
4260-106-0890 Money Follows Person Federal Grant	$19,141,000	$19,496,000	$355,000
4260-113-0001/0890 Healthy Families	$3,855,114,000	$3,020,483,000	($834,631,000)
4260-601-0942142 Local Trauma Centers	$43,000,000	$44,845,000	$1,845,000
4260-601-0942 Home Health Program Account	$1,536,000	$0	($1,536,000)
4260-601-3156 MCO Tax Fund	$0	$328,610,000	$328,610,000
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$800,000,000	$800,000,000	$0
4260-601-3213 LTC QA Fund	$484,587,000	$482,975,000	($1,612,000)
4260-601-3293 MCO Tax Fund 2016	$2,392,507,000	$2,392,507,000	$0
4260-601-7502 Demonstration DSH Fund	$148,013,000	$148,011,000	($2,000)
4260-601-7503 Health Care Support Fund	$69,500,000	$324,393,000	$254,893,000
4260-601-8107 Whole Person Care Pilot Fund	$360,000,000	$360,000,000	$0
4260-601-8108 Global Payment Program Fund	$1,126,476,000	$1,152,567,000	$26,091,000
4260-602-0309 Perinatal Insurance Fund	$12,765,000	$10,997,000	($1,768,000)
4260-605-0001 SNF Quality & Accountability *	$48,928,000	$48,928,000	$0
4260-605-3167 SNF Quality & Accountability	$40,996,000	$43,122,000	$2,126,000
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	($48,928,000)	($48,928,000)	$0
4260-606-0834 SB 1100 DSH	$182,654,000	$177,411,000	($5,243,000)
4260-610-0995 Reimbursements	$2,536,172,000	$4,885,881,000	$2,349,709,000
4260-611-3158/0890 Hospital Quality Assurance	$14,580,343,000	$16,840,000,000	$2,259,657,000
4260-611-3201 LIHP MCE Out-of-Network ER Svcs.	$0	$116,250,000	$116,250,000
TOTAL MEDI-CAL Benefits	**$97,788,225,000**	**$100,629,444,000**	**$2,841,219,000**
COUNTY ADMINISTRATION:			
4260-101-0001/0890(1)	$4,285,897,000	$4,518,300,000	$232,403,000
4260-106-0890(1) Money Follow Person Fed. Grant	$688,000	$688,000	$0
4260-107-0890 Prevention of Chronic Disease (MICPD)	$0	$0	$0
4260-113-0001/0890 Healthy Families	$63,686,000	$32,587,000	($31,099,000)
4260-117-0001/0890 HIPPA	$10,583,000	$10,581,000	($2,000)
4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct.	$5,888,000	$5,856,000	($32,000)
4260-601-0942 Home Health Program Account	$0	$317,000	$317,000
4260-602-0313 Major Risk Medical Ins Fund	$0	$0	$0
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$1,419,000	$1,419,000	$0
4260-605-3167 SNF Quality & Accountability Admin.	$3,871,000	$3,907,000	$36,000
4260-610-0995 Reimbursements	$641,000	$692,000	$51,000
TOTAL COUNTY ADMIN.	**$4,372,673,000**	**$4,574,347,000**	**$201,674,000**
FISCAL INTERMEDIARY:			
4260-101-0001/0890(2)	$403,876,000	$403,121,000	($755,000)
4260-113-0001/0890 Healthy Families	$5,816,000	$5,816,000	$0
4260-117-0001/0890 HIPAA	$14,438,000	$14,293,000	($145,000)
4260-610-0995 Reimbursements	$0	$0	$0
TOTAL FISCAL INTERMEDIARY	**$424,130,000**	**$423,230,000**	**($900,000)**
GRAND TOTAL - ALL FUNDS	**$102,585,028,000**	**$105,627,021,000**	**$3,041,993,000**

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

Medi-Cal Funding Summary
May 2017 Estimate Compared to November 2016 Estimate
Fiscal Year 2017 - 2018

STATE FUNDS

	Nov 2016 Estimate	May 2017 Estimate	Difference Incr./(Decr.)
MEDI-CAL Benefits:			
4260-101-0001(3) *	$16,981,825,000	$16,507,594,000	($474,231,000)
4260-101-0080 CLPP Funds	$725,000	$725,000	$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$112,075,000	$111,400,000	($675,000)
4260-101-0233 Prop 99 Physician Srvc. Acct	$36,802,000	$40,220,000	$3,418,000
4260-101-0236 Prop 99 Unallocated Account	$57,377,000	$56,904,000	($473,000)
4260-101-0313 Major Risk Medical Ins Fund	$0	$0	$0
4260-101-3156 MCO Tax Fund MRMIB	$0	$99,407,000	$99,407,000
4260-101-3168 Emergency Air Transportation Fund	$7,038,000	$7,890,000	$852,000
4260-101-3305 Healthcare Treatment Fund	$1,237,393,000	$1,257,166,000	$19,773,000
4260-101-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$65,700,000	$46,633,000	($19,067,000)
4260-102-0001 Capital Debt *	$59,404,000	$82,809,000	$23,405,000
4260-104-0001 NDPH Hosp Supp *	$1,773,000	$1,900,000	$127,000
4260-601-3096 NDPH Suppl	$1,900,000	$1,900,000	$0
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	($1,773,000)	($1,900,000)	($127,000)
4260-105-0001 Private Hosp Supp Fund *	$100,150,000	$118,400,000	$18,250,000
4260-601-3097 Private Hosp Suppl	$127,550,000	$127,550,000	$0
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($100,150,000)	($118,400,000)	($18,250,000)
4260-113-0001 Healthy Families *	$926,209,000	$718,959,000	($207,250,000)
4260-601-0942142 Local Trauma Centers	$43,000,000	$44,845,000	$1,845,000
4260-601-0942 Home Health Program Account	$1,536,000	$0	($1,536,000)
4260-601-3156 MCO Tax Fund	$0	$328,610,000	$328,610,000
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$800,000,000	$800,000,000	$0
4260-601-3213 LTC QA Fund	$484,587,000	$482,975,000	($1,612,000)
4260-601-3293 MCO Tax Fund 2016	$2,392,507,000	$2,392,507,000	$0
4260-601-8107 Whole Person Care Pilot Fund	$360,000,000	$360,000,000	$0
4260-601-8108 Global Payment Program Fund	$1,126,476,000	$1,152,567,000	$26,091,000
4260-602-0309 Perinatal Insurance Fund	$12,765,000	$10,997,000	($1,768,000)
4260-605-0001 SNF Quality & Accountability *	$48,928,000	$48,928,000	$0
4260-605-3167 SNF Quality & Accountability	$40,996,000	$43,122,000	$2,126,000
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	($48,928,000)	($48,928,000)	$0
4260-606-0834 SB 1100 DSH	$182,654,000	$177,411,000	($5,243,000)
4260-610-0995 Reimbursements	$2,536,172,000	$4,885,881,000	$2,349,709,000
4260-611-3158 Hospital Quality Assurance Revenue	$7,216,668,000	$6,382,189,000	($834,479,000)
4260-611-3201 LIHP MCE Out-of-Network ER Svcs.	$0	$116,250,000	$116,250,000
TOTAL MEDI-CAL Benefits	**$34,811,359,000**	**$36,236,511,000**	**$1,425,152,000**
Total Benefits General Fund *	**$18,118,289,000**	**$17,478,590,000**	**($639,699,000)**
COUNTY ADMINISTRATION:			
4260-101-0001(1) *	$851,159,000	$946,049,000	$94,890,000
4260-113-0001 Healthy Families *	$5,965,000	$12,804,000	$6,839,000
4260-117-0001 HIPAA *	$1,647,000	$1,708,000	$61,000
4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct.	$5,888,000	$5,856,000	($32,000)
4260-601-0942 Home Health Program Account	$0	$317,000	$317,000
4260-602-0313 Major Risk Medical Ins Fund	$0	$0	$0
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$1,419,000	$1,419,000	$0
4260-605-3167 SNF Quality & Accountability Admin.	$3,871,000	$3,907,000	$36,000
4260-610-0995 Reimbursements	$641,000	$692,000	$51,000
TOTAL COUNTY ADMIN.	**$870,590,000**	**$972,752,000**	**$102,162,000**
Total Co. Admin. General Fund *	**$858,771,000**	**$960,561,000**	**$101,790,000**
FISCAL INTERMEDIARY:			
4260-101-0001(2) *	$149,567,000	$150,157,000	$590,000
4260-113-0001 Healthy Families *	$698,000	$1,701,000	$1,003,000
4260-117-0001 HIPAA *	$2,717,000	$2,681,000	($36,000)
4260-610-0995 Reimbursements	$0	$0	$0
TOTAL FISCAL INTERMEDIARY	**$152,982,000**	**$154,539,000**	**$1,557,000**
Total FI General Fund *	**$152,982,000**	**$154,539,000**	**$1,557,000**
GRAND TOTAL - STATE FUNDS	**$35,834,931,000**	**$37,363,802,000**	**$1,528,871,000**
Grand Total General Fund*	**$19,130,042,000**	**$18,593,690,000**	**($536,352,000)**

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

Medi-Cal Funding Summary
May 2017 Estimate Compared to November 2016 Estimate
Fiscal Year 2017 - 2018

FEDERAL FUNDS

	Nov 2016 Estimate	May 2017 Estimate	Difference Incr./(Decr.)
MEDI-CAL Benefits:			
4260-101-0890(3)	$52,388,228,000	$51,058,888,000	($1,329,340,000)
4260-102-0890 Capital Debt	$59,404,000	$82,810,000	$23,406,000
4260-106-0890 Money Follows Person Federal Grant	$19,141,000	$19,496,000	$355,000
4260-113-0890 Health Families	$2,928,905,000	$2,301,524,000	($627,381,000)
4260-601-7502 Demonstration DSH Fund	$148,013,000	$148,011,000	($2,000)
4260-601-7503 Health Care Support Fund	$69,500,000	$324,393,000	$254,893,000
4260-611-0890 Hospital Quality Assurance	$7,363,675,000	$10,457,811,000	$3,094,136,000
TOTAL MEDI-CAL Benefits	**$62,976,866,000**	**$64,392,933,000**	**$1,416,067,000**
COUNTY ADMINISTRATION:			
4260-101-0890(1)	$3,434,738,000	$3,572,251,000	$137,513,000
4260-106-0890(1) Money Follows Person Fed. Grant	$688,000	$688,000	$0
4260-107-0890 Prevention of Chronic Disease (MIPCD)	$0	$0	$0
4260-113-0890 Healthy Families	$57,721,000	$19,783,000	($37,938,000)
4260-117-0890 HIPAA	$8,936,000	$8,873,000	($63,000)
TOTAL COUNTY ADMIN.	**$3,502,083,000**	**$3,601,595,000**	**$99,512,000**
FISCAL INTERMEDIARY:			
4260-101-0890(2)	$254,309,000	$252,964,000	($1,345,000)
4260-113-0890 Healthy Families	$5,118,000	$4,115,000	($1,003,000)
4260-117-0890 HIPAA	$11,721,000	$11,612,000	($109,000)
TOTAL FISCAL INTERMEDIARY	**$271,148,000**	**$268,691,000**	**($2,457,000)**
GRAND TOTAL - FEDERAL FUNDS	**$66,750,097,000**	**$68,263,219,000**	**$1,513,122,000**

Medi-Cal Funding Summary

May 2017 Estimate Compared to Appropriation

Fiscal Year 2017 - 2018

TOTAL FUNDS

MEDI-CAL Benefits:	**Total Appropriation**	**May 2017 Estimate**	**Difference Incr./(Decr.)**
4260-101-0001/0890(3)	$63,268,665,000	$67,566,482,000	$4,297,817,000
4260-101-0080 CLPP Funds	$725,000	$725,000	$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$112,172,000	$111,400,000	($772,000)
4260-101-0233 Prop 99 Physician Srvc. Acct	$28,463,000	$40,220,000	$11,757,000
4260-101-0236 Prop 99 Unallocated Account	$57,925,000	$56,904,000	($1,021,000)
4260-101-0313 Major Risk Medical Ins Fund	$2,016,000	$0	($2,016,000)
4260-101-3156 MCO Tax Fund MRMIB	$0	$99,407,000	$99,407,000
4260-101-3168 Emergency Air Transportation Fund	$8,982,000	$7,890,000	($1,092,000)
4260-101-3305 Healthcare Treatment Fund	$0	$1,257,166,000	$1,257,166,000
4260-101-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$0	$46,633,000	$46,633,000
4260-102-0001/0890 Capital Debt	$82,282,000	$165,619,000	$83,337,000
4260-104-0001 NDPH Hosp Supp *	$1,900,000	$1,900,000	$0
4260-601-3096 NDPH Suppl	$2,356,000	$1,900,000	($456,000)
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	$130,197,000	$127,550,000	($2,647,000)
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	$22,517,000	$19,496,000	($3,021,000)
4260-113-0001/0890 Healthy Families	$3,511,008,000	$3,020,483,000	($490,525,000)
4260-601-0942142 Local Trauma Centers	$56,278,000	$44,845,000	($11,433,000)
4260-601-0942 Home Health Program Account	$137,000	$0	($137,000)
4260-601-3156 MCO Tax Fund	$271,214,000	$328,610,000	$57,396,000
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$800,000,000	$800,000,000	$0
4260-601-3213 LTC QA Fund	$491,075,000	$482,975,000	($8,100,000)
4260-601-3293 MCO Tax Fund 2016	$1,737,918,000	$2,392,507,000	$654,589,000
4260-601-7502 Demonstration DSH Fund	$0	$148,011,000	$148,011,000
4260-601-7503 Health Care Support Fund	$63,050,000	$324,393,000	$261,343,000
4260-601-8107 Whole Person Care Pilot Fund	$0	$360,000,000	$360,000,000
4260-601-8108 Global Payment Program Fund	$0	$1,152,567,000	$1,152,567,000
4260-602-0309 Perinatal Insurance Fund	$12,759,000	$10,997,000	($1,762,000)
4260-605-0001 SNF Quality & Accountability *	$48,928,000	$48,928,000	$0
4260-605-3167 SNF Quality & Accountability	$44,069,000	$43,122,000	($947,000)
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	($48,928,000)	($48,928,000)	$0
4260-606-0834 SB 1100 DSH	$1,377,911,000	$177,411,000	($1,200,500,000)
4260-610-0995 Reimbursements	$5,892,571,000	$4,885,881,000	($1,006,690,000)
4260-611-3158/0890 Hospital Quality Assurance	$7,675,580,000	$16,840,000,000	$9,164,420,000
4260-611-3201 LIHP MCE Out-of-Network ER Svcs.	$116,249,000	$116,250,000	$1,000
TOTAL MEDI-CAL Benefits	**$85,766,119,000**	**$100,629,444,000**	**$14,863,325,000**
COUNTY ADMINISTRATION:			
4260-101-0001/0890(1)	$4,087,253,000	$4,518,300,000	$431,047,000
4260-106-0890(1) Money Follow Person Fed. Grant	$708,000	$688,000	($20,000)
4260-107-0890 Prevention of Chronic Disease (MICPD)	$80,000	$0	($80,000)
4260-113-0001/0890 Healthy Families	$64,558,000	$32,587,000	($31,971,000)
4260-117-0001/0890 HIPPA	$7,037,000	$10,581,000	$3,544,000
4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct.	$3,153,000	$5,856,000	$2,703,000
4260-601-0942 Home Health Program Account	$0	$317,000	$317,000
4260-602-0313 Major Risk Medical Ins Fund	$2,049,000	$0	($2,049,000)
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$0	$1,419,000	$1,419,000
4260-605-3167 SNF Quality & Accountability Admin.	$3,560,000	$3,907,000	$347,000
4260-610-0995 Reimbursements	$660,000	$692,000	$32,000
TOTAL COUNTY ADMIN.	**$4,169,058,000**	**$4,574,347,000**	**$405,289,000**
FISCAL INTERMEDIARY:			
4260-101-0001/0890(2)	$346,468,000	$403,121,000	$56,653,000
4260-113-0001/0890 Healthy Families	$5,475,000	$5,816,000	$341,000
4260-117-0001/0890 HIPAA	$15,190,000	$14,293,000	($897,000)
4260-610-0995 Reimbursements	$0	$0	$0
TOTAL FISCAL INTERMEDIARY	**$367,133,000**	**$423,230,000**	**$56,097,000**
GRAND TOTAL - ALL FUNDS	**$90,302,310,000**	**$105,627,021,000**	**$15,324,711,000**

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

Medi-Cal Funding Summary

May 2017 Estimate Compared to Appropriation

Fiscal Year 2017 - 2018

STATE FUNDS

MEDI-CAL Benefits:	**State Funds Appropriation**	**May 2017 Estimate**	**Difference Incr./(Decr.)**
4260-101-0001(3) *	$16,097,892,000	$16,507,594,000	$409,702,000
4260-101-0080 CLPP Funds	$725,000	$725,000	$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$112,172,000	$111,400,000	($772,000)
4260-101-0233 Prop 99 Physician Srvc. Acct	$28,463,000	$40,220,000	$11,757,000
4260-101-0236 Prop 99 Unallocated Account	$57,925,000	$56,904,000	($1,021,000)
4260-101-0313 Major Risk Medical Ins Fund	$2,016,000	$0	($2,016,000)
4260-101-3156 MCO Tax Fund MRMIB	$0	$99,407,000	$99,407,000
4260-101-3168 Emergency Air Transportation Fund	$8,982,000	$7,890,000	($1,092,000)
4260-101-3305 Healthcare Treatment Fund	$0	$1,257,166,000	$1,257,166,000
4260-101-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$0	$46,633,000	$46,633,000
4260-102-0001 Capital Debt *	$41,141,000	$82,809,000	$41,668,000
4260-104-0001 NDPH Hosp Supp *	$1,900,000	$1,900,000	$0
4260-601-3096 NDPH Suppl	$2,356,000	$1,900,000	($456,000)
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	$130,197,000	$127,550,000	($2,647,000)
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($118,400,000)	($118,400,000)	$0
4260-113-0001 Healthy Families *	$478,392,000	$718,959,000	$240,567,000
4260-601-0942142 Local Trauma Centers	$56,278,000	$44,845,000	($11,433,000)
4260-601-0942 Home Health Program Account	$137,000	$0	($137,000)
4260-601-3156 MCO Tax Fund	$271,214,000	$328,610,000	$57,396,000
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$800,000,000	$800,000,000	$0
4260-601-3213 LTC QA Fund	$491,075,000	$482,975,000	($8,100,000)
4260-601-3293 MCO Tax Fund 2016	$1,737,918,000	$2,392,507,000	$654,589,000
4260-601-8107 Whole Person Care Pilot Fund	$0	$360,000,000	$360,000,000
4260-601-8108 Global Payment Program Fund	$0	$1,152,567,000	$1,152,567,000
4260-602-0309 Perinatal Insurance Fund	$12,759,000	$10,997,000	($1,762,000)
4260-605-0001 SNF Quality & Accountability *	$48,928,000	$48,928,000	$0
4260-605-3167 SNF Quality & Accountability	$44,069,000	$43,122,000	($947,000)
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	($48,928,000)	($48,928,000)	$0
4260-606-0834 SB 1100 DSH	$1,377,911,000	$177,411,000	($1,200,500,000)
4260-610-0995 Reimbursements	$5,892,571,000	$4,885,881,000	($1,006,690,000)
4260-611-3158 Hospital Quality Assurance Revenue	$3,792,518,000	$6,382,189,000	$2,589,671,000
4260-611-3201 LIHP MCE Out-of-Network ER Svcs.	$116,249,000	$116,250,000	$1,000
TOTAL MEDI-CAL Benefits	**$31,552,960,000**	**$36,236,511,000**	**$4,683,551,000**
Total Benefits General Fund *	**$16,786,653,000**	**$17,478,590,000**	**$691,937,000**
COUNTY ADMINISTRATION:			
4260-101-0001(1) *	$853,803,000	$946,049,000	$92,246,000
4260-113-0001 Healthy Families *	$6,353,000	$12,804,000	$6,451,000
4260-117-0001 HIPAA *	$1,287,000	$1,708,000	$421,000
4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct.	$3,153,000	$5,856,000	$2,703,000
4260-601-0942 Home Health Program Account	$0	$317,000	$317,000
4260-602-0313 Major Risk Medical Ins Fund	$2,049,000	$0	($2,049,000)
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$0	$1,419,000	$1,419,000
4260-605-3167 SNF Quality & Accountability Admin.	$3,560,000	$3,907,000	$347,000
4260-610-0995 Reimbursements	$660,000	$692,000	$32,000
TOTAL COUNTY ADMIN.	**$870,865,000**	**$972,752,000**	**$101,887,000**
Total Co. Admin. General Fund *	**$861,443,000**	**$960,561,000**	**$99,118,000**
FISCAL INTERMEDIARY:			
4260-101-0001(2) *	$103,087,000	$150,157,000	$47,070,000
4260-113-0001 Healthy Families *	$657,000	$1,701,000	$1,044,000
4260-117-0001 HIPAA *	$3,118,000	$2,681,000	($437,000)
4260-610-0995 Reimbursements	$0	$0	$0
TOTAL FISCAL INTERMEDIARY	**$106,862,000**	**$154,539,000**	**$47,677,000**
Total FI General Fund *	**$106,862,000**	**$154,539,000**	**$47,677,000**
GRAND TOTAL - STATE FUNDS	**$32,530,687,000**	**$37,363,802,000**	**$4,833,115,000**
Grand Total - General Fund *	**$17,754,958,000**	**$18,593,690,000**	**$838,732,000**

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

Medi-Cal Funding Summary

May 2017 Estimate Compared to Appropriation

Fiscal Year 2017 - 2018

FEDERAL FUNDS

	Federal Funds Appropriation	May 2017 Estimate	Difference Incr./(Decr.)
MEDI-CAL Benefits:			
4260-101-0890(3)	$47,170,775,000	$51,058,888,000	$3,888,113,000
4260-102-0890 Capital Debt	$41,141,000	$82,810,000	$41,669,000
4260-106-0890 Money Follows Person Federal Grant	$22,517,000	$19,496,000	($3,021,000)
4260-113-0890 Health Families	$3,032,616,000	$2,301,524,000	($731,092,000)
4260-601-7502 Demonstration DSH Fund	$0	$148,011,000	$148,011,000
4260-601-7503 Health Care Support Fund	$63,050,000	$324,393,000	$261,343,000
4260-611-0890 Hospital Quality Assurance	$3,883,062,000	$10,457,811,000	$6,574,749,000
TOTAL MEDI-CAL Benefits	**$54,213,161,000**	**$64,392,933,000**	**$10,179,772,000**
COUNTY ADMINISTRATION:			
4260-101-0890(1)	$3,233,450,000	$3,572,251,000	$338,801,000
4260-106-0890(1) Money Follows Person Fed. Grant	$708,000	$688,000	($20,000)
4260-107-0890 Prevention of Chronic Disease (MIPCD)	$80,000	$0	($80,000)
4260-113-0890 Healthy Families	$58,205,000	$19,783,000	($38,422,000)
4260-117-0890 HIPAA	$5,750,000	$8,873,000	$3,123,000
TOTAL COUNTY ADMIN.	**$3,298,193,000**	**$3,601,595,000**	**$303,402,000**
FISCAL INTERMEDIARY:			
4260-101-0890(2)	$243,381,000	$252,964,000	$9,583,000
4260-113-0890 Healthy Families	$4,818,000	$4,115,000	($703,000)
4260-117-0890 HIPAA	$12,072,000	$11,612,000	($460,000)
TOTAL FISCAL INTERMEDIARY	**$260,271,000**	**$268,691,000**	**$8,420,000**
GRAND TOTAL - FEDERAL FUNDS	**$57,771,625,000**	**$68,263,219,000**	**$10,491,594,000**

MEDI-CAL PROGRAM ESTIMATE SUMMARY
FISCAL YEAR 2016-17

	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
I. BASE ESTIMATES				
A. C/Y FFS BASE	$16,880,779,650	$8,440,389,820	$8,440,389,820	$0
B. C/Y BASE POLICY CHANGES	$44,518,923,990	$31,449,894,330	$12,955,770,660	$113,259,000
C. BASE ADJUSTMENTS	($132,632,000)	($167,081,200)	$34,449,200	$0
D. ADJUSTED BASE	**$61,267,071,630**	**$39,723,202,950**	**$21,430,609,680**	**$113,259,000**
II. REGULAR POLICY CHANGES				
A. ELIGIBILITY	$95,106,390	($920,389,060)	$1,015,495,450	$0
B. AFFORDABLE CARE ACT	$2,373,223,000	$2,336,511,390	$36,711,610	$0
C. BENEFITS	$1,246,972,160	$986,650,840	$240,432,330	$19,889,000
D. PHARMACY	($2,486,992,790)	($2,191,844,440)	($295,148,340)	$0
E. DRUG MEDI-CAL	$24,502,000	$20,305,990	$4,196,000	$0
F. MENTAL HEALTH	($48,008,000)	($55,460,000)	$7,252,000	$200,000
G. WAIVER--MH/UCD & BTR	$5,590,123,000	$2,660,837,500	$267,377,000	$2,661,908,500
H. MANAGED CARE	$5,881,445,000	$2,883,761,640	($134,657,640)	$3,132,341,000
I. PROVIDER RATES	$463,675,400	$562,664,530	($588,553,130)	$489,564,000
J. SUPPLEMENTAL PMNTS.	$9,599,457,000	$5,708,601,000	$539,846,500	$3,351,009,500
K. OTHER	$758,209,950	$2,514,905,740	($4,551,509,780)	$2,794,814,000
L. TOTAL CHANGES	**$23,497,713,120**	**$14,506,545,130**	**($3,458,558,000)**	**$12,449,726,000**
III. TOTAL MEDI-CAL ESTIMATE	**$84,764,784,750**	**$54,229,748,080**	**$17,972,051,680**	**$12,562,985,000**

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2016-17

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	ELIGIBILITY				
3	MEDI-CAL STATE INMATE PROGRAMS	$77,936,000	$77,936,000	$0	$0
5	BREAST AND CERVICAL CANCER TREATMENT	$67,000,000	$30,900,000	$36,100,000	$0
6	MEDI-CAL COUNTY INMATE PROGRAMS	$27,385,000	$18,039,500	$9,345,500	$0
9	STATE-ONLY BCCTP COVERAGE EXTENSION	$522,290	$0	$522,290	$0
10	NON-OTLICP CHIP	$0	($53,229,010)	$53,229,010	$0
11	NON-EMERGENCY FUNDING ADJUSTMENT	$0	($985,633,000)	$985,633,000	$0
12	SCHIP FUNDING FOR PRENATAL CARE	$0	$63,757,760	($63,757,760)	$0
13	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN	$0	($5,313,000)	$5,313,000	$0
14	PARIS-VETERANS	($2,575,900)	($1,287,950)	($1,287,950)	$0
15	MINIMUM WAGE INCREASE - CASELOAD SAVINGS	($7,714,000)	($6,206,000)	($1,508,000)	$0
16	OTLICP PREMIUMS	($67,447,000)	($59,353,360)	($8,093,640)	$0
	ELIGIBILITY SUBTOTAL	**$95,106,390**	**($920,389,060)**	**$1,015,495,450**	**$0**
	AFFORDABLE CARE ACT				
17	COMMUNITY FIRST CHOICE OPTION	$2,045,900,000	$2,045,900,000	$0	$0
19	HEALTH INSURER FEE	$220,166,000	$145,417,190	$74,748,810	$0
20	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	$101,925,000	$101,925,000	$0	$0
22	PAYMENTS TO PRIMARY CARE PHYSICIANS	$5,232,000	$5,232,000	$0	$0
23	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	($1,181,000)	$1,181,000	$0
24	STATE-ONLY FORMER FOSTER CARE PROGRAM	$0	($398,000)	$398,000	$0
25	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	$0	$39,616,200	($39,616,200)	$0
26	ACA MAGI SAVINGS	$0	$0	$0	$0
	AFFORDABLE CARE ACT SUBTOTAL	**$2,373,223,000**	**$2,336,511,390**	**$36,711,610**	**$0**
	BENEFITS				
1	FAMILY PACT PROGRAM	$316,502,000	$240,374,200	$76,127,800	$0
29	BEHAVIORAL HEALTH TREATMENT	$235,807,000	$131,220,900	$104,586,100	$0
30	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$379,487,000	$379,487,000	$0	$0
31	BEHAVIORAL HEALTH TREATMENT - DDS TRANSITION	$86,168,000	$48,528,260	$37,639,740	$0
32	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$123,498,000	$123,420,000	$78,000	$0
33	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	$39,778,000	$19,889,000	$0	$19,889,000
34	CCS DEMONSTRATION PROJECT	$32,792,000	$17,885,760	$14,906,240	$0
35	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$19,545,000	$17,011,000	$2,534,000	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2016-17

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	BENEFITS				
36	IMPLEMENT AAP BRIGHT FUTURES PERIODICITY FOR EPSDT	$2,868,210	$1,495,150	$1,373,050	$0
38	YOUTH REGIONAL TREATMENT CENTERS	$4,259,000	$4,197,000	$62,000	$0
39	PEDIATRIC PALLIATIVE CARE WAIVER	$1,727,480	$449,400	$1,278,080	$0
40	DENTAL CHILDREN'S OUTREACH AGES 0-3	$3,180,000	$1,590,000	$1,590,000	$0
41	CCT FUND TRANSFER TO CDSS AND CDDS	$1,825,000	$1,825,000	$0	$0
42	DENTAL TRANSFORMATION INITIATIVE UTILIZATION	$4,538,000	$2,269,000	$2,269,000	$0
43	END OF LIFE SERVICES	$23,910	$0	$23,910	$0
44	DENTAL BENEFICIARY OUTREACH AND EDUCATION PROGRAM	$53,000	$26,500	$26,500	$0
45	MEDICAL MANAGEMENT AND TREATMENT FOR ALD	$75,850	$41,660	$34,190	$0
46	ALLIED DENTAL PROFESSIONALS ENROLLMENT	$252,000	$126,000	$126,000	$0
48	SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER	$153,000	$153,000	$0	$0
49	QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS	$97,000	$97,000	$0	$0
51	PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINGS	($341,650)	($187,550)	($154,100)	$0
52	SRP PRIOR AUTH. & PREVENTIVE DENTAL SERVICES	($3,168,000)	($1,584,000)	($1,584,000)	$0
53	WOMEN'S HEALTH SERVICES	($5,897,260)	($4,567,250)	($1,330,010)	$0
208	ANNUAL CONTRACEPTIVE COVERAGE	$3,749,630	$2,903,810	$845,820	$0
	BENEFITS SUBTOTAL	**$1,246,972,160**	**$986,650,830**	**$240,432,330**	**$19,889,000**
	PHARMACY				
55	NEW HIGH COST TREATMENTS FOR SPECIFIC CONDITIONS	$11,671,210	$6,282,050	$5,389,170	$0
56	NON FFP DRUGS	$0	($39,000)	$39,000	$0
57	BCCTP DRUG REBATES	($12,486,000)	($8,538,350)	($3,947,650)	$0
58	FAMILY PACT DRUG REBATES	($20,748,000)	($18,163,000)	($2,585,000)	$0
59	MEDICAL SUPPLY REBATES	($24,916,000)	($12,458,000)	($12,458,000)	$0
60	LITIGATION SETTLEMENTS	($29,867,000)	$0	($29,867,000)	$0
61	STATE SUPPLEMENTAL DRUG REBATES	($208,826,000)	($181,235,340)	($27,590,660)	$0
62	FEDERAL DRUG REBATE PROGRAM	($2,201,821,000)	($1,490,416,600)	($711,404,400)	$0
204	DRUG REBATES - RETROACTIVE ACA ADJUSTMENTS	$0	($487,276,200)	$487,276,200	$0
	PHARMACY SUBTOTAL	**($2,486,992,790)**	**($2,191,844,440)**	**($295,148,340)**	**$0**
	DRUG MEDI-CAL				
64	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	$21,503,000	$17,341,000	$4,162,000	$0
67	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	$2,999,000	$2,965,000	$34,000	$0
	DRUG MEDI-CAL SUBTOTAL	**$24,502,000**	**$20,306,000**	**$4,196,000**	**$0**

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2016-17

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	MENTAL HEALTH				
73	MHP COSTS FOR CONTINUUM OF CARE REFORM	$7,539,000	$3,012,000	$4,527,000	$0
74	PATHWAYS TO WELL-BEING	$5,650,000	$5,650,000	$0	$0
75	LATE CLAIMS FOR SMHS	$24,000	$24,000	$0	$0
76	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	($315,000)	($585,000)	$70,000	$200,000
78	CHART REVIEW	($1,869,000)	($1,869,000)	$0	$0
79	INTERIM AND FINAL COST SETTLEMENTS - SMHS	($59,037,000)	($61,692,000)	$2,655,000	$0
	MENTAL HEALTH SUBTOTAL	**($48,008,000)**	**($55,460,000)**	**$7,252,000**	**$200,000**
	WAIVER--MH/UCD & BTR				
80	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL	$2,622,000,000	$1,311,000,000	$0	$1,311,000,000
81	GLOBAL PAYMENT PROGRAM	$2,218,904,000	$1,109,452,000	$0	$1,109,452,000
82	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS	$480,000,000	$240,000,000	$0	$240,000,000
83	BTR - LIHP - MCE	$125,692,000	$125,692,000	$0	$0
85	BTR - LOW INCOME HEALTH PROGRAM - HCCI	$44,037,000	$44,037,000	$0	$0
86	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	$46,216,000	$23,108,000	$23,108,000	$0
87	MH/UCD—HEALTH CARE COVERAGE INITIATIVE	$1,343,000	$1,343,000	$0	$0
88	MH/UCD—STABILIZATION FUNDING	$33,686,000	$0	$33,686,000	$0
89	MH/UCD—SAFETY NET CARE POOL	$7,844,000	$7,844,000	$0	$0
90	MH/UCD & BTR—CCS AND GHPP	$6,025,000	$6,025,000	$0	$0
91	BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE POOL	$2,913,000	$1,456,500	$0	$1,456,500
92	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	$1,463,000	$1,463,000	$0	$0
93	BTR—DESIGNATED STATE HEALTH PROGRAMS	$0	($50,518,000)	$50,518,000	$0
94	MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP	$0	$6,205,000	($6,205,000)	$0
95	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM	$0	$75,000,000	($75,000,000)	$0
222	CMS DEFERRED CLAIMS	$0	($14,926,000)	$14,926,000	$0
223	CMS DEFERRALS & NEGATIVE BALANCE REPAYMENT	$0	($226,344,000)	$226,344,000	$0
	WAIVER--MH/UCD & BTR SUBTOTAL	**$5,590,123,000**	**$2,660,837,500**	**$267,377,000**	**$2,661,908,500**
	MANAGED CARE				
98	CCI-MANAGED CARE PAYMENTS	$4,584,508,980	$2,292,254,490	$2,292,254,490	$0
100	MANAGED CARE PUBLIC HOSPITAL IGTS	$247,118,000	$123,559,000	$0	$123,559,000
101	MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.RATES	$1,849,578,000	$1,327,896,360	$521,681,640	$0
103	MANAGED CARE RATE RANGE IGTS	$870,681,000	$485,023,000	$0	$385,658,000
105	HQAF RATE RANGE INCREASES	$125,000,000	$62,500,000	$0	$62,500,000

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2016-17

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	MANAGED CARE				
111	PALLIATIVE CARE SERVICES IMPLEMENTATION	$10,000	$5,000	$5,000	$0
114	MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ.	$0	$0	($521,682,000)	$521,682,000
115	MCO ENROLLMENT TAX MANAGED CARE PLANS	$0	$0	($1,190,766,000)	$1,190,766,000
116	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT	$0	$0	($128,145,000)	$128,145,000
117	MCO TAX MANAGED CARE PLANS	$0	$0	($184,621,000)	$184,621,000
118	MANAGED CARE IGT ADMIN. & PROCESSING FEE	$0	$0	($69,204,000)	$69,204,000
119	GENERAL FUND REIMBURSEMENTS FROM DPHS	$0	$0	($48,535,000)	$48,535,000
120	CENCAL HEALTH PLAN-ADDITION OF CHDP	($581,980)	($290,990)	($290,990)	$0
121	FORMER AGNEWS' BENEFICIARIES RECOUPMENT	($6,477,000)	($3,238,500)	($3,238,500)	$0
122	MCO TAX MGD. CARE PLANS - INCR. CAP. RATES	$25,332,000	$12,666,000	$12,666,000	$0
123	MANAGED CARE DRUG REBATES	($2,146,160,000)	($1,539,613,320)	($606,546,680)	$0
124	RETRO MC RATE ADJUSTMENTS	$331,083,000	$122,324,100	($208,912,100)	$417,671,000
220	CCI-QUALITY WITHHOLD REPAYMENTS	$1,353,000	$676,500	$676,500	$0
	MANAGED CARE SUBTOTAL	**$5,881,445,000**	**$2,883,761,640**	**($134,657,640)**	**$3,132,341,000**
	PROVIDER RATES				
125	MEDICARE PART B ADJUSTMENT	$11,711,500	$5,855,750	$5,855,750	$0
126	DENTAL RETROACTIVE RATE CHANGES	$131,542,000	$89,125,620	$42,416,380	$0
127	FQHC/RHC/CBRC RECONCILIATION PROCESS	$155,446,580	$97,688,320	$57,758,260	$0
128	AB 1629 ANNUAL RATE ADJUSTMENTS	$87,883,770	$43,941,890	$43,941,890	$0
130	DPH INTERIM & FINAL RECONS	$81,174,000	$81,174,000	$0	$0
132	LTC RATE ADJUSTMENT	$11,636,710	$5,818,350	$5,818,350	$0
133	ANNUAL MEI INCREASE FOR FQHCS/RHCS	$0	$0	$0	$0
134	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	$11,188,000	$5,594,000	($2,522,000)	$8,116,000
135	HOSPICE RATE INCREASES	$623,680	$311,840	$311,840	$0
136	DISCONTINUE PHARMACY RATE REDUCTIONS	$4,532,130	$2,266,070	$2,266,070	$0
137	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	$650,460	$325,230	$325,230	$0
139	ALAMEDA HOSP & SAN LEANDRO HOSP INTERIM RATE	$32,060	$56,660	($24,600)	$0
141	DP/NF-B RETROACTIVE RECOUPMENT FORGIVENESS	$0	($104,415,000)	$104,415,000	$0
142	DPH INTERIM RATE	$0	$350,932,550	($350,932,550)	$0
143	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	$0	$0	($481,448,000)	$481,448,000
144	LABORATORY RATE METHODOLOGY CHANGE	($2,312,560)	($1,156,280)	($1,156,280)	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2016-17

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	PROVIDER RATES				
145	REDUCTION TO RADIOLOGY RATES	($16,013,000)	($8,006,500)	($8,006,500)	$0
146	10% PROVIDER PAYMENT REDUCTION	($17,153,940)	($8,576,970)	($8,576,970)	$0
216	BORDER OUT-OF-STATE DIAGNOSIS RELATED GROUP	$2,734,000	$1,729,000	$1,005,000	$0
	PROVIDER RATES SUBTOTAL	**$463,675,400**	**$562,664,530**	**($588,553,130)**	**$489,564,000**
	SUPPLEMENTAL PMNTS.				
129	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	$82,670,000	$41,335,000	$47,165,000	($5,830,000)
147	EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS	$7,022,721,000	$4,147,992,000	$0	$2,874,729,000
148	PRIVATE HOSPITAL DSH REPLACEMENT	$618,284,000	$309,142,000	$309,142,000	$0
149	DSH PAYMENT	$531,697,000	$358,080,000	$14,744,000	$158,873,000
150	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	$364,229,000	$182,114,500	$118,400,000	$63,714,500
151	NDPH IGT SUPPLEMENTAL PAYMENTS	$182,290,000	$91,145,000	$0	$91,145,000
152	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	$192,175,000	$96,088,000	$0	$96,087,000
153	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$141,358,000	$141,358,000	$0	$0
154	CAPITAL PROJECT DEBT REIMBURSEMENT	$100,295,000	$60,822,500	$39,472,500	$0
155	FFP FOR LOCAL TRAUMA CENTERS	$140,582,000	$70,291,000	$0	$70,291,000
156	DPH PHYSICIAN & NON-PHYS. COST	$59,450,000	$59,450,000	$0	$0
158	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	$89,940,000	$89,940,000	$0	$0
159	GEMT SUPPLEMENTAL PAYMENT PROGRAM	$43,716,000	$43,716,000	$0	$0
160	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	$10,037,000	$5,018,500	$5,018,500	$0
161	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	$8,009,000	$4,004,500	$4,004,500	$0
162	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	$4,204,000	$4,204,000	$0	$0
163	IGT PAYMENTS FOR HOSPITAL SERVICES	$4,000,000	$2,000,000	$0	$2,000,000
164	NDPH SUPPLEMENTAL PAYMENT	$3,800,000	$1,900,000	$1,900,000	$0
	SUPPLEMENTAL PMNTS. SUBTOTAL	**$9,599,457,000**	**$5,708,601,000**	**$539,846,500**	**$3,351,009,500**
	OTHER				
77	IMD ANCILLARY SERVICES	$0	($26,632,000)	$26,632,000	$0
166	INFANT DEVELOPMENT PROGRAM	$31,899,000	$31,899,000	$0	$0
172	CCI IHSS RECONCILIATION	$339,270,000	$339,270,000	$0	$0
174	ARRA HITECH - PROVIDER PAYMENTS	$198,460,000	$198,460,000	$0	$0
176	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	$77,067,000	$77,067,000	$0	$0
180	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	$12,711,000	$6,894,000	$5,817,000	$0
181	OVERTIME FOR WPCS PROVIDERS	$11,190,820	$5,595,410	$5,595,410	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2016-17

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER				
182	MEDI-CAL ESTATE RECOVERIES	$12,587,000	$6,293,500	$6,293,500	$0
183	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	$5,406,130	$2,703,060	$2,703,060	$0
184	WPCS WORKERS' COMPENSATION	$7,511,000	$3,755,500	$3,755,500	$0
185	INDIAN HEALTH SERVICES	$0	$0	$0	$0
189	CDDS DENTAL SERVICES	$984,000	$0	$0	$984,000
191	MANAGED CARE ADMIN FINES AND PENALTIES REVENUE	$0	$0	($3,404,000)	$3,404,000
192	COUNTY SHARE OF OTLICP-CCS COSTS	$0	$0	($7,793,000)	$7,793,000
193	FUNDING ADJUST.—ACA OPT. EXPANSION	$0	$1,736,550,000	($1,736,550,000)	$0
194	FUNDING ADJUST.—OTLICP	$74,000	$171,739,760	($171,665,760)	$0
195	FFP REPAYMENT FOR CDDS COSTS	$0	($36,262,000)	$0	$36,262,000
196	CLPP FUND	$0	$0	($725,000)	$725,000
197	CCI-TRANSFER OF IHSS COSTS TO DHCS	$0	$0	($1,871,911,000)	$1,871,911,000
198	EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	$0	($675,175,000)	$675,175,000
199	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	$0	($198,560,000)	$198,560,000
202	NONCONTRACT HOSP INPATIENT COST SETTLEMENTS	($6,096,000)	($3,048,000)	($3,048,000)	$0
205	AUDIT SETTLEMENTS	$548,000	$0	$548,000	$0
210	CCI-FFS SAVINGS FOR ADDITIONAL ENROLLMENT	($18,757,990)	($9,379,000)	($9,379,000)	$0
227	NOD - SETTLEMENT PAYMENT TO DMC PLANS	$19,999,000	$9,999,500	$9,999,500	$0
228	FY 2015-16 ACCRUAL ADJUSTMENT	$65,357,000	$0	$65,357,000	$0
	OTHER SUBTOTAL	**$758,209,950**	**$2,514,905,740**	**($4,551,509,780)**	**$2,794,814,000**
	GRAND TOTAL	**$23,497,713,130**	**$14,506,545,130**	**($3,458,558,000)**	**$12,449,726,000**

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

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
FISCAL YEAR 2016-17

SERVICE CATEGORY	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
PROFESSIONAL	$6,180,760,530	$3,707,075,150	$1,743,731,030	$729,954,350
PHYSICIANS	$864,670,200	$508,456,230	$330,996,310	$25,217,650
OTHER MEDICAL	$3,624,580,110	$2,148,263,810	$1,380,919,540	$95,396,750
CO. & COMM. OUTPATIENT	$1,691,510,220	$1,050,355,110	$31,815,180	$609,339,940
PHARMACY	$933,638,370	($78,610,180)	$978,762,050	$33,486,500
HOSPITAL INPATIENT	$12,555,413,960	$7,740,789,500	$1,917,668,090	$2,896,956,360
COUNTY INPATIENT	$1,232,381,510	$1,027,363,110	$55,254,400	$149,764,000
COMMUNITY INPATIENT	$11,323,032,440	$6,713,426,390	$1,862,413,690	$2,747,192,360
LONG TERM CARE	$3,371,845,350	$1,665,231,590	$1,590,057,400	$116,556,350
NURSING FACILITIES	$2,974,897,220	$1,465,769,090	$1,409,953,970	$99,174,160
ICF-DD	$396,948,130	$199,462,500	$180,103,440	$17,382,190
OTHER SERVICES	$1,141,909,910	$665,672,770	$431,898,570	$44,338,570
MEDICAL TRANSPORTATION	$124,112,130	$88,411,780	$26,959,390	$8,740,950
OTHER SERVICES	$797,442,870	$466,922,880	$296,500,590	$34,019,400
HOME HEALTH	$220,354,910	$110,338,110	$108,438,590	$1,578,220
TOTAL FEE-FOR-SERVICE	**$24,183,568,110**	**$13,700,158,830**	**$6,662,117,140**	**$3,821,292,140**
MANAGED CARE	$43,008,429,720	$28,554,665,350	$7,260,475,490	$7,193,288,870
TWO PLAN MODEL	$25,913,850,860	$17,067,363,720	$4,375,722,700	$4,470,764,440
COUNTY ORGANIZED HEALTH SYSTEMS	$10,292,847,810	$6,942,384,340	$1,609,685,100	$1,740,778,380
GEOGRAPHIC MANAGED CARE	$4,704,797,620	$3,187,384,630	$782,768,800	$734,644,180
PHP & OTHER MANAG. CARE	$749,954,410	$412,247,820	$261,813,050	$75,893,550
REGIONAL MODEL	$1,346,979,020	$945,284,850	$230,485,850	$171,208,330
DENTAL	$1,155,736,240	$773,562,120	$357,463,210	$24,710,920
MENTAL HEALTH	$2,295,747,000	$2,171,611,850	($32,266,820)	$156,401,970
AUDITS/ LAWSUITS	($3,962,000)	($228,116,000)	$224,154,000	$0
EPSDT SCREENS	$38,281,210	$19,755,790	$17,800,420	$725,000
MEDICARE PAYMENTS	$4,996,479,000	$1,431,565,500	$3,564,913,500	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$207,330,000	$171,068,000	$0	$36,262,000
MISC. SERVICES	$8,986,989,470	$7,598,629,440	$58,055,930	$1,330,304,100
RECOVERIES	($309,233,000)	($160,871,500)	($148,361,500)	$0
DRUG MEDI-CAL	$205,419,000	$197,718,700	$7,700,300	$0
GRAND TOTAL MEDI-CAL	**$84,764,784,750**	**$54,229,748,080**	**$17,972,051,680**	**$12,562,985,000**

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
MAY 2017 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2016-17

SERVICE CATEGORY	2016-17 APPROPRIATION	MAY 2017 EST. FOR 2016-17	DOLLAR DIFFERENCE	% CHANGE
PROFESSIONAL	$6,359,903,380	$6,180,760,530	($179,142,850)	-2.82%
PHYSICIANS	$913,097,040	$864,670,200	($48,426,840)	-5.30%
OTHER MEDICAL	$3,667,493,030	$3,624,580,110	($42,912,920)	-1.17%
CO. & COMM. OUTPATIENT	$1,779,313,320	$1,691,510,220	($87,803,090)	-4.93%
PHARMACY	$1,422,397,240	$933,638,370	($488,758,880)	-34.36%
HOSPITAL INPATIENT	$12,390,766,510	$12,555,413,960	$164,647,450	1.33%
COUNTY INPATIENT	$2,892,704,090	$1,232,381,510	($1,660,322,570)	-57.40%
COMMUNITY INPATIENT	$9,498,062,420	$11,323,032,440	$1,824,970,020	19.21%
LONG TERM CARE	$3,032,374,150	$3,371,845,350	$339,471,200	11.19%
NURSING FACILITIES	$2,674,442,300	$2,974,897,220	$300,454,920	11.23%
ICF-DD	$357,931,850	$396,948,130	$39,016,280	10.90%
OTHER SERVICES	$951,719,630	$1,141,909,910	$190,190,290	19.98%
MEDICAL TRANSPORTATION	$119,263,680	$124,112,130	$4,848,450	4.07%
OTHER SERVICES	$627,433,150	$797,442,870	$170,009,720	27.10%
HOME HEALTH	$205,022,790	$220,354,910	$15,332,120	7.48%
TOTAL FEE-FOR-SERVICE	**$24,157,160,910**	**$24,183,568,110**	**$26,407,200**	**0.11%**
MANAGED CARE	$44,477,241,010	$43,008,429,720	($1,468,811,290)	-3.30%
TWO PLAN MODEL	$26,721,682,180	$25,913,850,860	($807,831,320)	-3.02%
COUNTY ORGANIZED HEALTH SYSTEMS	$10,836,533,950	$10,292,847,810	($543,686,140)	-5.02%
GEOGRAPHIC MANAGED CARE	$4,833,858,420	$4,704,797,620	($129,060,800)	-2.67%
PHP & OTHER MANAG. CARE	$768,858,190	$749,954,410	($18,903,780)	-2.46%
REGIONAL MODEL	$1,316,308,270	$1,346,979,020	$30,670,750	2.33%
DENTAL	$1,201,347,430	$1,155,736,240	($45,611,190)	-3.80%
MENTAL HEALTH	$3,011,514,200	$2,295,747,000	($715,767,200)	-23.77%
AUDITS/ LAWSUITS	$14,684,000	($3,962,000)	($18,646,000)	-126.98%
EPSDT SCREENS	$55,189,800	$38,281,210	($16,908,590)	-30.64%
MEDICARE PAYMENTS	$4,959,576,000	$4,996,479,000	$36,903,000	0.74%
STATE HOSP./DEVELOPMENTAL CNTRS.	$207,330,000	$207,330,000	$0	0.00%
MISC. SERVICES	$7,796,886,110	$8,986,989,470	$1,190,103,370	15.26%
RECOVERIES	($298,270,000)	($309,233,000)	($10,963,000)	3.68%
DRUG MEDI-CAL	$183,458,000	$205,419,000	$21,961,000	11.97%
GRAND TOTAL MEDI-CAL	**$85,766,117,460**	**$84,764,784,750**	**($1,001,332,710)**	**-1.17%**
GENERAL FUNDS	**$16,786,652,010**	**$17,972,051,680**	**$1,185,399,670**	**7.06%**
OTHER STATE FUNDS	**$14,766,305,700**	**$12,562,985,000**	**($2,203,320,700)**	**-14.92%**

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
MAY 2017 ESTIMATE COMPARED TO NOVEMBER 2016 ESTIMATE
FISCAL YEAR 2016-17

SERVICE CATEGORY	NOV. 2016 EST. FOR 2016-17	MAY 2017 EST. FOR 2016-17	DOLLAR DIFFERENCE	% CHANGE
PROFESSIONAL	$6,353,155,140	$6,180,760,530	($172,394,610)	-2.71%
PHYSICIANS	$963,665,690	$864,670,200	($98,995,490)	-10.27%
OTHER MEDICAL	$3,573,541,450	$3,624,580,110	$51,038,660	1.43%
CO. & COMM. OUTPATIENT	$1,815,948,000	$1,691,510,220	($124,437,780)	-6.85%
PHARMACY	$1,432,865,980	$933,638,370	($499,227,610)	-34.84%
HOSPITAL INPATIENT	$13,183,777,250	$12,555,413,960	($628,363,290)	-4.77%
COUNTY INPATIENT	$3,277,633,060	$1,232,381,510	($2,045,251,550)	-62.40%
COMMUNITY INPATIENT	$9,906,144,190	$11,323,032,440	$1,416,888,250	14.30%
LONG TERM CARE	$3,330,198,910	$3,371,845,350	$41,646,440	1.25%
NURSING FACILITIES	$2,929,795,290	$2,974,897,220	$45,101,930	1.54%
ICF-DD	$400,403,620	$396,948,130	($3,455,500)	-0.86%
OTHER SERVICES	$1,102,752,170	$1,141,909,910	$39,157,740	3.55%
MEDICAL TRANSPORTATION	$162,127,880	$124,112,130	($38,015,750)	-23.45%
OTHER SERVICES	$709,337,920	$797,442,870	$88,104,950	12.42%
HOME HEALTH	$231,286,370	$220,354,910	($10,931,460)	-4.73%
TOTAL FEE-FOR-SERVICE	**$25,402,749,460**	**$24,183,568,110**	**($1,219,181,340)**	**-4.80%**
MANAGED CARE	$50,874,563,160	$43,008,429,720	($7,866,133,440)	-15.46%
TWO PLAN MODEL	$31,641,268,470	$25,913,850,860	($5,727,417,610)	-18.10%
COUNTY ORGANIZED HEALTH SYSTEMS	$11,532,908,830	$10,292,847,810	($1,240,061,020)	-10.75%
GEOGRAPHIC MANAGED CARE	$5,272,215,390	$4,704,797,620	($567,417,770)	-10.76%
PHP & OTHER MANAG. CARE	$875,350,920	$749,954,410	($125,396,510)	-14.33%
REGIONAL MODEL	$1,552,819,550	$1,346,979,020	($205,840,520)	-13.26%
DENTAL	$1,217,825,190	$1,155,736,240	($62,088,950)	-5.10%
MENTAL HEALTH	$2,424,448,780	$2,295,747,000	($128,701,780)	-5.31%
AUDITS/ LAWSUITS	($22,879,000)	($3,962,000)	$18,916,990	-82.68%
EPSDT SCREENS	$50,116,300	$38,281,210	($11,835,090)	-23.62%
MEDICARE PAYMENTS	$5,029,011,000	$4,996,479,000	($32,532,000)	-0.65%
STATE HOSP./DEVELOPMENTAL CNTRS.	$207,330,000	$207,330,000	$0	0.00%
MISC. SERVICES	$10,350,545,810	$8,986,989,470	($1,363,556,340)	-13.17%
RECOVERIES	($337,377,000)	($309,233,000)	$28,143,990	-8.34%
DRUG MEDI-CAL	$179,484,000	$205,419,000	$25,935,000	14.45%
GRAND TOTAL MEDI-CAL	**$95,375,817,700**	**$84,764,784,750**	**($10,611,032,950)**	**-11.13%**
GENERAL FUNDS	**$18,580,261,630**	**$17,972,051,680**	**($608,209,960)**	**-3.27%**
OTHER STATE FUNDS	**$13,681,541,520**	**$12,562,985,000**	**($1,118,556,520)**	**-8.18%**

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2017 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2016 ESTIMATE
FISCAL YEAR 2016-17

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	2016-17 APPROPRIATION TOTAL FUNDS	2016-17 APPROPRIATION GENERAL FUNDS	NOV. 2016 EST. FOR 2016-17 TOTAL FUNDS	NOV. 2016 EST. FOR 2016-17 GENERAL FUNDS	MAY 2017 EST. FOR 2016-17 TOTAL FUNDS	MAY 2017 EST. FOR 2016-17 GENERAL FUNDS	DIFF. MAY TO APPROPRIATION TOTAL FUNDS	DIFF. MAY TO APPROPRIATION GENERAL FUNDS	DIFFERENCE MAY TO NOVEMBER TOTAL FUNDS	DIFFERENCE MAY TO NOVEMBER GENERAL FUNDS
		ELIGIBILITY										
3	3	MEDI-CAL STATE INMATE PROGRAMS	$272,397,000	$0	$207,758,000	$0	$77,936,000	$0	($194,461,000)	$0	($129,822,000)	$0
5	5	BREAST AND CERVICAL CANCER TREATMENT	$85,914,000	$42,681,200	$71,126,000	$37,702,350	$67,000,000	$36,100,000	($18,914,000)	($6,581,200)	($4,126,000)	($1,602,350)
6	6	MEDI-CAL COUNTY INMATE PROGRAMS	$63,016,000	$0	$48,243,000	$0	$27,385,000	$9,345,500	($35,631,000)	$9,345,500	($20,858,000)	$9,345,500
9	9	STATE-ONLY BCCTP COVERAGE EXTENSION	$0	$0	$532,000	$532,000	$551,000	$551,000	$551,000	$551,000	$19,000	$19,000
10	10	NON-OTLICP CHIP	$0	($365,023,930)	$0	($165,854,970)	$0	$53,229,010	$0	$418,252,940	$0	$219,083,980
11	11	NON-EMERGENCY FUNDING ADJUSTMENT	$0	$633,813,000	$0	$706,987,000	$0	$985,633,000	$0	$351,820,000	$0	$278,646,000
12	12	SCHIP FUNDING FOR PRENATAL CARE	$0	($118,174,320)	$0	($67,760,000)	$0	($63,757,760)	$0	$54,416,560	$0	$4,002,240
13	13	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN	$0	($14,801,360)	$0	($66,796,950)	$0	$5,313,000	$0	$20,114,360	$0	$72,109,950
14	14	PARIS-VETERANS	($10,910,940)	($5,455,470)	($11,041,260)	($5,520,630)	($11,520,120)	($5,760,060)	($609,170)	($304,590)	($478,850)	($239,430)
15	15	MINIMUM WAGE INCREASE - CASELOAD SAVINGS	($3,438,000)	($729,000)	($7,464,000)	($1,509,000)	($7,714,000)	($1,508,000)	($4,276,000)	($779,000)	($250,000)	$1,000
16	16	OTLICP PREMIUMS	($70,919,000)	($8,510,280)	($69,423,000)	($8,330,760)	($67,447,000)	($8,093,640)	$3,472,000	$416,640	$1,976,000	$237,120
2	--	UNDOCUMENTED CHILDREN FULL SCOPE EXPANSION	$243,880,000	$188,199,500	$292,296,000	$230,369,000	$0	$0	($243,880,000)	($188,199,500)	($292,296,000)	($230,369,000)
7	--	COUNTY HEALTH INITIATIVE MATCHING (CHIM)	$6,232,000	$747,840	$5,940,000	$712,800	$0	$0	($6,232,000)	($747,840)	($5,940,000)	($712,800)
--	--	PREGNANT WOMEN FULL SCOPE EXPANSION 60-138%	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
--	--	INCARCERATION VERIFICATION PROGRAM	($16,688,000)	($6,282,950)	$0	$0	$0	$0	$16,688,000	$6,282,950	$0	$0
		ELIGIBILITY SUBTOTAL	**$569,483,060**	**$346,464,230**	**$537,966,740**	**$660,530,840**	**$86,190,880**	**$1,011,052,050**	**($483,292,170)**	**$664,587,820**	**($451,775,850)**	**$350,521,210**
		AFFORDABLE CARE ACT										
17	17	COMMUNITY FIRST CHOICE OPTION	$1,884,200,000	$0	$2,048,500,000	$0	$2,045,900,000	$0	$161,700,000	$0	($2,600,000)	$0
19	19	HEALTH INSURER FEE	$246,342,000	$82,691,500	$305,344,000	$103,577,370	$220,166,000	$74,748,810	($26,176,000)	($7,942,690)	($85,178,000)	($28,828,560)
20	20	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	$34,640,000	$0	$174,288,000	$0	$101,925,000	$0	$67,285,000	$0	($72,363,000)	$0
22	22	PAYMENTS TO PRIMARY CARE PHYSICIANS	$10,000,000	$0	$10,000,000	$0	$8,000,000	$0	($2,000,000)	$0	($2,000,000)	$0
23	23	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	($6,363,000)	$0	($3,222,000)	$0	$1,181,000	$0	$7,544,000	$0	$4,403,000
24	24	STATE-ONLY FORMER FOSTER CARE PROGRAM	$0	$349,000	$0	$398,000	$0	$398,000	$0	$49,000	$0	$0
25	25	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	$0	($92,623,550)	$0	($93,622,450)	$0	($39,616,200)	$0	$53,007,350	$0	$54,006,250

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2017 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2016 ESTIMATE
FISCAL YEAR 2016-17

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	2016-17 APPROPRIATION TOTAL FUNDS	2016-17 APPROPRIATION GENERAL FUNDS	NOV. 2016 EST. FOR 2016-17 TOTAL FUNDS	NOV. 2016 EST. FOR 2016-17 GENERAL FUNDS	MAY 2017 EST. FOR 2016-17 TOTAL FUNDS	MAY 2017 EST. FOR 2016-17 GENERAL FUNDS	DIFF. MAY TO APPROPRIATION TOTAL FUNDS	DIFF. MAY TO APPROPRIATION GENERAL FUNDS	DIFFERENCE MAY TO NOVEMBER TOTAL FUNDS	DIFFERENCE MAY TO NOVEMBER GENERAL FUNDS
		AFFORDABLE CARE ACT										
26	26	ACA MAGI SAVINGS	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
18	--	ACA OPTIONAL EXPANSION	$1,309,663,000	$40,784,350	$1,483,021,000	$50,453,500	$0	$0	($1,309,663,000)	($40,784,350)	($1,483,021,000)	($50,453,500)
21	--	ACA MANDATORY EXPANSION	$140,760,000	$58,692,720	$139,725,000	$60,377,700	$0	$0	($140,760,000)	($58,692,720)	($139,725,000)	($60,377,700)
--	--	RECOVERY AUDIT CONTRACTOR SAVINGS	($688,000)	($344,000)	$0	$0	$0	$0	$688,000	$344,000	$0	$0
		AFFORDABLE CARE ACT SUBTOTAL	**$3,624,917,000**	**$83,187,020**	**$4,160,878,000**	**$117,962,120**	**$2,375,991,000**	**$36,711,610**	**($1,248,926,000)**	**($46,475,410)**	**($1,784,887,000)**	**($81,250,510)**
		BENEFITS										
1	1	FAMILY PACT PROGRAM	$414,876,000	$102,763,500	$340,181,000	$81,823,200	$316,502,000	$76,127,800	($98,374,000)	($26,635,700)	($23,679,000)	($5,695,400)
29	29	BEHAVIORAL HEALTH TREATMENT	$213,974,000	$92,334,200	$341,996,000	$149,628,410	$235,807,000	$104,586,100	$21,833,000	$12,251,900	($106,189,000)	($45,042,310)
30	30	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$286,516,000	$0	$446,024,000	$0	$379,487,000	$0	$92,971,000	$0	($66,537,000)	$0
31	31	BEHAVIORAL HEALTH TREATMENT - DDS TRANSITION	$203,683,000	$87,893,600	$239,925,000	$103,786,280	$86,168,000	$37,639,740	($117,515,000)	($50,253,860)	($153,757,000)	($66,146,540)
32	32	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$126,049,000	$0	$125,407,000	$78,000	$123,498,000	$78,000	($2,551,000)	$78,000	($1,909,000)	$0
33	33	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	$39,778,000	$0	$39,778,000	$0	$39,778,000	$0	$0	$0	$0	$0
34	34	CCS DEMONSTRATION PROJECT	$40,958,000	$18,599,140	$33,099,000	$15,077,600	$32,792,000	$14,906,240	($8,166,000)	($3,692,900)	($307,000)	($171,360)
35	35	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$36,080,000	$5,271,000	$23,314,000	$2,376,000	$19,545,000	$2,534,000	($16,535,000)	($2,737,000)	($3,769,000)	$158,000
36	36	IMPLEMENT AAP BRIGHT FUTURES PERIODICITY FOR EPSDT	$12,996,800	$6,146,320	$13,222,300	$6,345,490	$12,685,570	$6,072,780	($311,220)	($73,550)	($536,730)	($272,710)
38	38	YOUTH REGIONAL TREATMENT CENTERS	$5,298,000	$21,000	$3,909,000	($98,000)	$4,259,000	$62,000	($1,039,000)	$41,000	$350,000	$160,000
39	39	PEDIATRIC PALLIATIVE CARE WAIVER	$1,163,000	$549,960	$3,346,000	$2,438,080	$2,589,530	$1,915,870	$1,426,530	$1,365,910	($756,470)	($522,210)
40	40	DENTAL CHILDREN'S OUTREACH AGES 0-3	$6,871,000	$2,913,380	$3,180,000	$1,590,000	$3,180,000	$1,590,000	($3,691,000)	($1,323,380)	$0	$0
41	41	CCT FUND TRANSFER TO CDSS AND CDDS	$5,107,000	$0	$2,858,000	$0	$1,825,000	$0	($3,282,000)	$0	($1,033,000)	$0
42	42	DENTAL TRANSFORMATION INITIATIVE UTILIZATION	$1,512,000	$511,510	$2,766,000	$1,383,000	$4,538,000	$2,269,000	$3,026,000	$1,757,490	$1,772,000	$886,000
43	43	END OF LIFE SERVICES	$1,275,010	$1,275,010	$719,720	$719,720	$23,910	$23,910	($1,251,110)	($1,251,110)	($695,810)	($695,810)
44	44	DENTAL BENEFICIARY OUTREACH AND EDUCATION PROGRAM	$448,000	$224,000	$639,000	$319,500	$53,000	$26,500	($395,000)	($197,500)	($586,000)	($293,000)
45	45	MEDICAL MANAGEMENT AND TREATMENT FOR ALD	$313,590	$148,400	$335,460	$151,500	$335,460	$151,210	$21,870	$2,820	$0	($290)
46	46	ALLIED DENTAL PROFESSIONALS ENROLLMENT	$201,000	$100,500	$293,000	$146,500	$252,000	$126,000	$51,000	$25,500	($41,000)	($20,500)

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2017 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2016 ESTIMATE
FISCAL YEAR 2016-17

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	2016-17 APPROPRIATION		NOV. 2016 EST. FOR 2016-17		MAY 2017 EST. FOR 2016-17		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		BENEFITS										
48	48	SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER	$159,000	$0	$136,000	$0	$153,000	$0	($6,000)	$0	$17,000	$0
49	49	QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS	$154,000	$0	$80,000	$0	$97,000	$0	($57,000)	$0	$17,000	$0
51	51	PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINGS	($6,203,000)	($2,933,540)	($1,974,000)	($892,380)	($1,071,000)	($483,060)	$5,132,000	$2,450,480	$903,000	$409,320
52	52	SRP PRIOR AUTH. & PREVENTIVE DENTAL SERVICES	($843,000)	($421,500)	($2,742,000)	($1,371,000)	($3,168,000)	($1,584,000)	($2,325,000)	($1,162,500)	($426,000)	($213,000)
53	53	WOMEN'S HEALTH SERVICES	($6,367,000)	($1,431,700)	($6,461,000)	($1,455,500)	($5,897,260)	($1,330,010)	$469,740	$101,690	$563,740	$125,490
--	208	ANNUAL CONTRACEPTIVE COVERAGE	$0	$0	$0	$0	$3,749,630	$845,820	$3,749,630	$845,820	$3,749,630	$845,820
37	--	ACUPUNCTURE SERVICES RESTORATION	$12,174,000	$3,663,000	$4,438,170	$1,462,150	$0	$0	($12,174,000)	($3,663,000)	($4,438,170)	($1,462,150)
47	--	CHDP PROGRAM DENTAL REFERRAL	$234,000	$110,540	$193,000	$87,380	$0	$0	($234,000)	($110,540)	($193,000)	($87,380)
--	--	CALIFORNIA COMMUNITY TRANSITIONS SAVINGS	($27,106,000)	($13,553,000)	$0	$0	$0	$0	$27,106,000	$13,553,000	$0	$0
		BENEFITS SUBTOTAL	**$1,369,301,400**	**$304,185,330**	**$1,614,662,650**	**$363,595,930**	**$1,257,181,840**	**$245,557,900**	**($112,119,560)**	**($58,627,430)**	**($357,480,810)**	**($118,038,030)**
		PHARMACY										
55	55	NEW HIGH COST TREATMENTS FOR SPECIFIC CONDITIONS	$45,220,920	$21,969,380	$24,416,750	$11,544,740	$26,086,750	$12,045,520	($19,134,170)	($9,923,860)	$1,670,000	$500,780
56	56	NON FFP DRUGS	$0	$269,500	$0	$97,000	$0	$39,000	$0	($230,500)	$0	($58,000)
57	57	BCCTP DRUG REBATES	($13,349,000)	($4,672,150)	($11,356,000)	($3,554,250)	($12,486,000)	($3,947,650)	$863,000	$724,500	($1,130,000)	($393,400)
58	58	FAMILY PACT DRUG REBATES	($30,337,000)	($3,805,300)	($19,663,000)	($2,148,500)	($20,748,000)	($2,585,000)	$9,589,000	$1,220,300	($1,085,000)	($436,500)
59	59	MEDICAL SUPPLY REBATES	($26,514,000)	($10,863,950)	($26,880,000)	($13,440,000)	($24,916,000)	($12,458,000)	$1,598,000	($1,594,050)	$1,964,000	$982,000
60	60	LITIGATION SETTLEMENTS	$0	$0	($28,964,000)	($28,964,000)	($29,867,000)	($29,867,000)	($29,867,000)	($29,867,000)	($903,000)	($903,000)
61	61	STATE SUPPLEMENTAL DRUG REBATES	($148,506,000)	($58,566,150)	($183,631,000)	($68,549,020)	($208,826,000)	($27,590,660)	($60,320,000)	$30,975,490	($25,195,000)	$40,958,360
62	62	FEDERAL DRUG REBATE PROGRAM	($1,593,279,000)	($600,334,520)	($2,035,575,000)	($694,796,820)	($2,201,821,000)	($711,404,400)	($608,542,000)	($111,069,880)	($166,246,000)	($16,607,580)
204	204	DRUG REBATES - RETROACTIVE ACA ADJUSTMENTS	$0	$0	$0	$487,276,200	$0	$487,276,200	$0	$487,276,200	$0	$0
--	--	ADAP RYAN WHITE MEDS DATA MATCH	$2,400,000	$1,200,000	$0	$0	$0	$0	($2,400,000)	($1,200,000)	$0	$0
--	--	HEPATITIS C REVISED CLINICAL GUIDELINES	$2,400,000	$1,200,000	$0	$0	$0	$0	($2,400,000)	($1,200,000)	$0	$0
--	--	FEDERAL UPPER LIMITS UPDATED FOR PHARMACY DRUGS	($327,790,110)	($130,067,070)	$0	$0	$0	$0	$327,790,110	$130,067,070	$0	$0
--	--	AGED AND DISPUTED DRUG REBATES	($300,000,000)	($118,290,000)	$0	$0	$0	$0	$300,000,000	$118,290,000	$0	$0
		PHARMACY SUBTOTAL	**($2,389,754,190)**	**($901,960,260)**	**($2,281,652,250)**	**($312,534,650)**	**($2,472,577,250)**	**($288,491,990)**	**($82,823,060)**	**$613,468,270**	**($190,925,000)**	**$24,042,660**

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2017 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2016 ESTIMATE
FISCAL YEAR 2016-17

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	2016-17 APPROPRIATION TOTAL FUNDS	2016-17 APPROPRIATION GENERAL FUNDS	NOV. 2016 EST. FOR 2016-17 TOTAL FUNDS	NOV. 2016 EST. FOR 2016-17 GENERAL FUNDS	MAY 2017 EST. FOR 2016-17 TOTAL FUNDS	MAY 2017 EST. FOR 2016-17 GENERAL FUNDS	DIFF. MAY TO APPROPRIATION TOTAL FUNDS	DIFF. MAY TO APPROPRIATION GENERAL FUNDS	DIFFERENCE MAY TO NOVEMBER TOTAL FUNDS	DIFFERENCE MAY TO NOVEMBER GENERAL FUNDS
		DRUG MEDI-CAL										
64	64	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	$0	$0	$19,864,000	$3,115,610	$21,503,000	$4,162,000	$21,503,000	$4,162,000	$1,639,000	$1,046,390
67	67	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	$3,036,000	$0	$3,036,000	$0	$2,999,000	$34,000	($37,000)	$34,000	($37,000)	$34,000
--	--	RESIDENTIAL TREATMENT SERVICES EXPANSION	$39,059,000	$12,349,400	$0	$0	$0	$0	($39,059,000)	($12,349,400)	$0	$0
--	--	ANNUAL RATE ADJUSTMENT	$2,566,000	$35,100	$0	$0	$0	$0	($2,566,000)	($35,100)	$0	$0
		DRUG MEDI-CAL SUBTOTAL	**$44,661,000**	**$12,384,500**	**$22,900,000**	**$3,115,610**	**$24,502,000**	**$4,196,000**	**($20,159,000)**	**($8,188,500)**	**$1,602,000**	**$1,080,390**
		MENTAL HEALTH										
73	73	MHP COSTS FOR CONTINUUM OF CARE REFORM	$12,039,000	$6,777,000	$7,854,000	$4,684,500	$7,539,000	$4,527,000	($4,500,000)	($2,250,000)	($315,000)	($157,500)
74	74	PATHWAYS TO WELL-BEING	$36,023,000	$0	$10,312,000	$0	$5,650,000	$0	($30,373,000)	$0	($4,662,000)	$0
75	75	LATE CLAIMS FOR SMHS	$3,598,000	$2,646,000	$20,000	$2,000	$24,000	$0	($3,574,000)	($2,646,000)	$4,000	($2,000)
76	76	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	$0	$70,000	$0	$385,000	($315,000)	$70,000	($315,000)	$0	($315,000)	($315,000)
78	78	CHART REVIEW	($1,148,000)	$0	($1,817,000)	$0	($1,869,000)	$0	($721,000)	$0	($52,000)	$0
79	79	INTERIM AND FINAL COST SETTLEMENTS - SMHS	($63,306,000)	$741,000	($59,037,000)	$2,655,000	($59,037,000)	$2,655,000	$4,269,000	$1,914,000	$0	$0
72	--	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT	$407,835,000	$0	$108,899,000	$0	$0	$0	($407,835,000)	$0	($108,899,000)	$0
--	--	INVESTMENT IN MENTAL HEALTH WELLNESS	$25,500,000	$0	$0	$0	$0	$0	($25,500,000)	$0	$0	$0
--	--	ELIMINATION OF STATE MAXIMUM RATES	$78,309,000	$0	$0	$0	$0	$0	($78,309,000)	$0	$0	$0
--	--	TRANSITION OF HFP - SMH SERVICES	$53,804,000	$0	$0	$0	$0	$0	($53,804,000)	$0	$0	$0
		MENTAL HEALTH SUBTOTAL	**$552,654,000**	**$10,234,000**	**$66,231,000**	**$7,726,500**	**($48,008,000)**	**$7,252,000**	**($600,662,000)**	**($2,982,000)**	**($114,239,000)**	**($474,500)**
		WAIVER--MH/UCD & BTR										
80	80	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL	$1,600,000,000	$0	$2,624,000,000	$0	$2,622,000,000	$0	$1,022,000,000	$0	($2,000,000)	$0
81	81	GLOBAL PAYMENT PROGRAM	$1,917,088,000	$0	$2,271,088,000	$0	$2,218,904,000	$0	$301,816,000	$0	($52,184,000)	$0
82	82	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS	$600,000,000	$0	$480,000,000	$0	$480,000,000	$0	($120,000,000)	$0	$0	$0
83	83	BTR - LIHP - MCE	$141,648,000	$0	$296,381,000	$0	$125,692,000	$0	($15,956,000)	$0	($170,689,000)	$0
85	85	BTR - LOW INCOME HEALTH PROGRAM - HCCI	($12,363,000)	$0	$109,833,000	$0	$44,037,000	$0	$56,400,000	$0	($65,796,000)	$0
86	86	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	$105,271,000	$52,635,500	$62,499,000	$31,249,500	$46,216,000	$23,108,000	($59,055,000)	($29,527,500)	($16,283,000)	($8,141,500)

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FISCAL YEAR 2016-17

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			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		WAIVER--MH/UCD & BTR										
87	87	MH/UCD—HEALTH CARE COVERAGE INITIATIVE	$0	$0	$23,509,000	$0	$1,343,000	$0	$1,343,000	$0	($22,166,000)	$0
88	88	MH/UCD—STABILIZATION FUNDING	$11,298,000	$11,298,000	$11,298,000	$11,298,000	$33,686,000	$33,686,000	$22,388,000	$22,388,000	$22,388,000	$22,388,000
89	89	MH/UCD—SAFETY NET CARE POOL	$8,186,000	$0	$8,186,000	$0	$7,844,000	$0	($342,000)	$0	($342,000)	$0
90	90	MH/UCD & BTR—CCS AND GHPP	$0	$0	$6,061,000	$0	$6,025,000	$0	$6,025,000	$0	($36,000)	$0
91	91	BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE POOL	$0	$0	$2,838,000	$0	$2,913,000	$0	$2,913,000	$0	$75,000	$0
92	92	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	$1,764,000	$0	$1,573,000	$0	$1,463,000	$0	($301,000)	$0	($110,000)	$0
93	93	BTR—DESIGNATED STATE HEALTH PROGRAMS	$0	$48,958,000	$0	$50,518,000	$0	$50,518,000	$0	$1,560,000	$0	$0
94	94	MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP	$0	($1,921,000)	$0	($6,025,000)	$0	($6,205,000)	$0	($4,284,000)	$0	($180,000)
95	95	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM	$0	($112,500,000)	$0	($75,000,000)	$0	($75,000,000)	$0	$37,500,000	$0	$0
--	222	CMS DEFERRED CLAIMS	$0	$0	$0	$0	$0	$14,926,000	$0	$14,926,000	$0	$14,926,000
--	223	CMS DEFERRALS & NEGATIVE BALANCE REPAYMENT	$0	$0	$0	$0	$0	$226,344,000	$0	$226,344,000	$0	$226,344,000
84	--	LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND	$232,498,000	$0	$232,500,000	$0	$0	$0	($232,498,000)	$0	($232,500,000)	$0
		WAIVER--MH/UCD & BTR SUBTOTAL	**$4,605,390,000**	**($1,529,500)**	**$6,129,766,000**	**$12,040,500**	**$5,590,123,000**	**$267,377,000**	**$984,733,000**	**$268,906,500**	**($539,643,000)**	**$255,336,500**
		MANAGED CARE										
98	98	CCI-MANAGED CARE PAYMENTS	$10,187,921,000	$5,093,960,500	$9,609,417,000	$4,804,708,500	$10,042,736,000	$5,021,368,000	($145,185,000)	($72,592,500)	$433,319,000	$216,659,500
100	100	MANAGED CARE PUBLIC HOSPITAL IGTS	$1,082,601,000	$0	$2,247,119,000	$0	$247,118,000	$0	($835,483,000)	$0	($2,000,001,000)	$0
101	101	MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.RATES	$1,938,526,000	$678,484,310	$1,849,578,000	$646,517,660	$1,849,578,000	$521,681,640	($88,948,000)	($156,802,670)	$0	($124,836,020)
103	103	MANAGED CARE RATE RANGE IGTS	$883,801,000	$0	$917,104,000	$0	$870,681,000	$0	($13,120,000)	$0	($46,423,000)	$0
105	105	HQAF RATE RANGE INCREASES	$273,000,000	$0	$357,000,000	$0	$125,000,000	$0	($148,000,000)	$0	($232,000,000)	$0
111	111	PALLIATIVE CARE SERVICES IMPLEMENTATION	$915,000	$457,500	$482,000	$216,700	$10,000	$5,000	($905,000)	($452,500)	($472,000)	($211,700)
114	114	MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ.	$0	($678,484,000)	$0	($646,517,000)	$0	($521,682,000)	$0	$156,802,000	$0	$124,835,000
115	115	MCO ENROLLMENT TAX MANAGED CARE PLANS	$0	($1,059,434,000)	$0	($1,065,930,000)	$0	($1,190,766,000)	$0	($131,332,000)	$0	($124,836,000)
116	116	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT	$0	($106,889,000)	$0	($117,388,000)	$0	($128,145,000)	$0	($21,256,000)	$0	($10,757,000)
117	117	MCO TAX MANAGED CARE PLANS	$0	($164,325,000)	$0	($184,621,000)	$0	($184,621,000)	$0	($20,296,000)	$0	$0

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2017 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2016 ESTIMATE
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NOV. NO.	MAY NO.	POLICY CHANGE TITLE	2016-17 APPROPRIATION TOTAL FUNDS	2016-17 APPROPRIATION GENERAL FUNDS	NOV. 2016 EST. FOR 2016-17 TOTAL FUNDS	NOV. 2016 EST. FOR 2016-17 GENERAL FUNDS	MAY 2017 EST. FOR 2016-17 TOTAL FUNDS	MAY 2017 EST. FOR 2016-17 GENERAL FUNDS	DIFF. MAY TO APPROPRIATION TOTAL FUNDS	DIFF. MAY TO APPROPRIATION GENERAL FUNDS	DIFFERENCE MAY TO NOVEMBER TOTAL FUNDS	DIFFERENCE MAY TO NOVEMBER GENERAL FUNDS
		MANAGED CARE										
118	118	MANAGED CARE IGT ADMIN. & PROCESSING FEE	$0	($73,465,000)	$0	($69,459,000)	$0	($69,204,000)	$0	$4,261,000	$0	$255,000
119	119	GENERAL FUND REIMBURSEMENTS FROM DPHS	$0	($190,825,000)	$0	($73,535,000)	$0	($48,535,000)	$0	$142,290,000	$0	$25,000,000
120	120	CENCAL HEALTH PLAN-ADDITION OF CHDP	$624,000	$312,000	($2,895,000)	($1,447,500)	($2,574,000)	($1,287,000)	($3,198,000)	($1,599,000)	$321,000	$160,500
121	121	FORMER AGNEWS' BENEFICIARIES RECOUPMENT	$0	$0	($5,687,000)	($2,843,500)	($6,477,000)	($3,238,500)	($6,477,000)	($3,238,500)	($790,000)	($395,000)
122	122	MCO TAX MGD. CARE PLANS - INCR. CAP. RATES	$0	$0	($2,515,000)	($1,257,500)	$25,332,000	$12,666,000	$25,332,000	$12,666,000	$27,847,000	$13,923,500
123	123	MANAGED CARE DRUG REBATES	($694,758,000)	($281,296,690)	($1,053,196,000)	($323,454,880)	($2,146,160,000)	($606,546,680)	($1,451,402,000)	($325,249,990)	($1,092,964,000)	($283,091,800)
124	124	RETRO MC RATE ADJUSTMENTS	($3,139,097,000)	($287,180,200)	($2,450,083,000)	($61,263,590)	$331,083,000	($208,912,100)	$3,470,180,000	$78,268,100	$2,781,166,000	($147,648,510)
--	220	CCI-QUALITY WITHHOLD REPAYMENTS	$0	$0	$0	$0	$1,353,000	$676,500	$1,353,000	$676,500	$1,353,000	$676,500
109	--	NOTICES OF DISPUTE/ADMINISTRATIVE APPEALS	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$0	$0	($2,000,000)	($2,000,000)	($2,000,000)	($2,000,000)
--	--	RECONCILIATION WITH BUDGET ACT	$47,305,000	$0	$0	$0	$0	$0	($47,305,000)	$0	$0	$0
--	--	HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS	$1,372,000	$0	$0	$0	$0	$0	($1,372,000)	$0	$0	$0
--	--	CCI-SAVINGS AND DEFERRAL	($7,487,837,000)	($3,743,918,500)	$0	$0	$0	$0	$7,487,837,000	$3,743,918,500	$0	$0
--	--	CAPITATED RATE ADJUSTMENT FOR FY 2016-17	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
--	--	CCI-TRANSFER OF IHSS COSTS TO CDSS	$2,776,709,000	$0	$0	$0	$0	$0	($2,776,709,000)	$0	$0	$0
		MANAGED CARE SUBTOTAL	**$5,873,082,000**	**($810,603,080)**	**$11,468,324,000**	**$2,905,725,890**	**$11,337,680,000**	**$2,593,459,860**	**$5,464,598,000**	**$3,404,062,940**	**($130,644,000)**	**($312,266,030)**
		PROVIDER RATES										
125	125	MEDICARE PART B ADJUSTMENT	$48,229,000	$26,892,500	$128,751,000	$70,279,000	$23,423,000	$11,711,500	($24,806,000)	($15,181,000)	($105,328,000)	($58,567,500)
126	126	DENTAL RETROACTIVE RATE CHANGES	$75,601,000	$25,751,840	$184,244,000	$64,972,640	$131,542,000	$42,416,380	$55,941,000	$16,664,540	($52,702,000)	($22,556,260)
127	127	FQHC/RHC/CBRC RECONCILIATION PROCESS	$209,049,710	$80,971,190	$196,115,790	$74,353,890	$196,942,330	$73,176,560	($12,107,380)	($7,794,620)	$826,550	($1,177,320)
128	128	AB 1629 ANNUAL RATE ADJUSTMENTS	$410,561,270	$205,280,640	$134,047,590	$67,023,790	$93,156,430	$46,578,210	($317,404,850)	($158,702,420)	($40,891,160)	($20,445,580)
130	130	DPH INTERIM & FINAL RECONS	$21,588,000	$0	$64,241,000	$0	$81,174,000	$0	$59,586,000	$0	$16,933,000	$0
132	132	LTC RATE ADJUSTMENT	$137,723,790	$68,861,890	$30,653,180	$15,326,590	$13,434,200	$6,717,100	($124,289,590)	($62,144,790)	($17,218,980)	($8,609,490)
133	133	ANNUAL MEI INCREASE FOR FQHCS/RHCS	$28,624,230	$11,087,340	$36,946,190	$13,965,970	$38,778,220	$14,408,150	$10,153,990	$3,320,800	$1,832,030	$442,170
134	134	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	$14,500,000	($1,732,000)	$14,500,000	($1,441,000)	$11,188,000	($2,522,000)	($3,312,000)	($790,000)	($3,312,000)	($1,081,000)

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		PROVIDER RATES										
135	135	HOSPICE RATE INCREASES	$11,675,610	$5,837,800	$8,204,070	$4,102,030	$2,102,750	$1,051,370	($9,572,860)	($4,786,430)	($6,101,320)	($3,050,660)
136	136	DISCONTINUE PHARMACY RATE REDUCTIONS	$0	$0	$5,045,250	$2,522,620	$4,532,130	$2,266,070	$4,532,130	$2,266,070	($513,120)	($256,560)
137	137	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	$3,096,840	$1,548,420	$3,167,240	$1,583,620	$650,460	$325,230	($2,446,380)	($1,223,190)	($2,516,780)	($1,258,390)
139	139	ALAMEDA HOSP & SAN LEANDRO HOSP INTERIM RATE	$0	$0	$785,160	($581,700)	$32,060	($24,600)	$32,060	($24,600)	($753,090)	$557,100
141	141	DP/NF-B RETROACTIVE RECOUPMENT FORGIVENESS	$0	$106,279,000	$0	$104,415,000	$0	$104,415,000	$0	($1,864,000)	$0	$0
142	142	DPH INTERIM RATE	$0	($351,104,600)	$0	($368,239,500)	$0	($350,932,550)	$0	$172,050	$0	$17,306,950
143	143	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	$0	($491,075,000)	$0	($466,897,000)	$0	($481,448,000)	$0	$9,627,000	$0	($14,551,000)
144	144	LABORATORY RATE METHODOLOGY CHANGE	($41,362,430)	($20,681,220)	($24,043,510)	($12,021,760)	($2,312,560)	($1,156,280)	$39,049,880	$19,524,940	$21,730,950	$10,865,480
145	145	REDUCTION TO RADIOLOGY RATES	($53,365,000)	($26,682,500)	($48,510,510)	($24,255,250)	($16,013,000)	($8,006,500)	$37,352,000	$18,676,000	$32,497,510	$16,248,750
146	146	10% PROVIDER PAYMENT REDUCTION	($204,274,000)	($102,137,000)	($194,759,000)	($97,379,500)	($197,626,000)	($98,813,000)	$6,648,000	$3,324,000	($2,867,000)	($1,433,500)
--	216	BORDER OUT-OF-STATE DIAGNOSIS RELATED GROUP	$0	$0	$0	$0	$2,734,000	$1,005,000	$2,734,000	$1,005,000	$2,734,000	$1,005,000
131	--	DPH INTERIM RATE GROWTH	$28,805,380	$14,402,690	$32,378,020	$16,189,010	$0	$0	($28,805,380)	($14,402,690)	($32,378,020)	($16,189,010)
138	--	GDSP PRENATAL SCREENING FEE INCREASE	$1,871,620	$802,340	$1,914,170	$957,090	$0	$0	($1,871,620)	($802,340)	($1,914,170)	($957,090)
		PROVIDER RATES SUBTOTAL	**$692,325,020**	**($445,696,660)**	**$573,679,640**	**($535,124,450)**	**$383,738,040**	**($638,832,350)**	**($308,586,980)**	**($193,135,690)**	**($189,941,600)**	**($103,707,900)**
		SUPPLEMENTAL PMNTS.										
129	129	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	$88,137,000	$48,928,000	$78,418,000	$47,165,000	$82,670,000	$47,165,000	($5,467,000)	($1,763,000)	$4,252,000	$0
147	147	EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS	$6,643,733,000	$0	$11,995,235,000	$0	$7,022,721,000	$0	$378,988,000	$0	($4,972,514,000)	$0
148	148	PRIVATE HOSPITAL DSH REPLACEMENT	$560,664,000	$280,332,000	$614,260,000	$307,130,000	$618,284,000	$309,142,000	$57,620,000	$28,810,000	$4,024,000	$2,012,000
149	149	DSH PAYMENT	$767,903,000	$16,708,000	$531,201,000	$18,084,000	$531,697,000	$14,744,000	($236,206,000)	($1,964,000)	$496,000	($3,340,000)
150	150	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	$260,393,000	$118,400,000	$382,600,000	$118,400,000	$364,229,000	$118,400,000	$103,836,000	$0	($18,371,000)	$0
151	151	NDPH IGT SUPPLEMENTAL PAYMENTS	$100,498,000	($5,436,000)	$284,783,000	($5,436,000)	$182,290,000	$0	$81,792,000	$5,436,000	($102,493,000)	$5,436,000
152	152	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	$141,495,000	$8,851,390	$202,464,660	$15,005,370	$192,175,000	$0	$50,680,000	($8,851,390)	($10,289,660)	($15,005,370)
153	153	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$254,275,000	$0	$208,536,000	$0	$141,358,000	$0	($112,917,000)	$0	($67,178,000)	$0

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		SUPPLEMENTAL PMNTS.										
154	154	CAPITAL PROJECT DEBT REIMBURSEMENT	$102,317,000	$41,140,500	$141,859,000	$60,258,500	$100,295,000	$39,472,500	($2,022,000)	($1,668,000)	($41,564,000)	($20,786,000)
155	155	FFP FOR LOCAL TRAUMA CENTERS	$112,556,000	$0	$138,737,000	$0	$140,582,000	$0	$28,026,000	$0	$1,845,000	$0
156	156	DPH PHYSICIAN & NON-PHYS. COST	$100,693,000	$0	$132,512,000	$0	$59,450,000	$0	($41,243,000)	$0	($73,062,000)	$0
158	158	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	$72,005,000	$0	$89,940,000	$0	$89,940,000	$0	$17,935,000	$0	$0	$0
159	159	GEMT SUPPLEMENTAL PAYMENT PROGRAM	$26,880,000	$0	$69,800,000	$0	$43,716,000	$0	$16,836,000	$0	($26,084,000)	$0
160	160	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	$10,000,000	$5,000,000	$10,037,000	$5,018,500	$10,037,000	$5,018,500	$37,000	$18,500	$0	$0
161	161	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	$8,000,000	$4,000,000	$8,009,000	$4,004,500	$8,009,000	$4,004,500	$9,000	$4,500	$0	$0
162	162	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	$3,662,000	$0	$4,336,000	$0	$4,204,000	$0	$542,000	$0	($132,000)	$0
163	163	IGT PAYMENTS FOR HOSPITAL SERVICES	$4,000,000	$0	$4,000,000	$0	$4,000,000	$0	$0	$0	$0	$0
164	164	NDPH SUPPLEMENTAL PAYMENT	$4,712,000	$1,900,000	$3,928,000	$1,900,000	$3,800,000	$1,900,000	($912,000)	$0	($128,000)	$0
157	--	HOSPITAL QAF - HOSPITAL PAYMENTS	$83,672,000	$0	$100,398,000	$0	$0	$0	($83,672,000)	$0	($100,398,000)	$0
--	--	FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS	$194,489,000	$0	$0	$0	$0	$0	($194,489,000)	$0	$0	$0
		SUPPLEMENTAL PMNTS. SUBTOTAL	**$9,540,084,000**	**$519,823,890**	**$15,001,053,660**	**$571,529,870**	**$9,599,457,000**	**$539,846,500**	**$59,373,000**	**$20,022,610**	**($5,401,596,660)**	**($31,683,370)**
		OTHER										
77	77	IMD ANCILLARY SERVICES	$0	$0	$0	$6,410,000	$0	$26,632,000	$0	$26,632,000	$0	$20,222,000
166	166	INFANT DEVELOPMENT PROGRAM	$0	$0	$33,464,000	$0	$31,899,000	$0	$31,899,000	$0	($1,565,000)	$0
172	172	CCI IHSS RECONCILIATION	$62,300,000	$0	$339,270,000	$0	$339,270,000	$0	$276,970,000	$0	$0	$0
174	174	ARRA HITECH - PROVIDER PAYMENTS	$186,216,000	$0	$162,852,000	$0	$198,460,000	$0	$12,244,000	$0	$35,608,000	$0
176	176	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	$117,245,000	$0	$131,233,000	$0	$77,067,000	$0	($40,178,000)	$0	($54,166,000)	$0
180	180	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	$19,146,000	$5,442,000	$18,408,000	$6,906,000	$12,711,000	$5,817,000	($6,435,000)	$375,000	($5,697,000)	($1,089,000)
181	181	OVERTIME FOR WPCS PROVIDERS	$6,632,920	$3,316,460	$12,240,020	$6,120,010	$11,190,820	$5,595,410	$4,557,890	$2,278,950	($1,049,200)	($524,600)
182	182	MEDI-CAL ESTATE RECOVERIES	$11,423,000	$5,711,500	$11,222,000	$5,611,000	$12,587,000	$6,293,500	$1,164,000	$582,000	$1,365,000	$682,500
183	183	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	$8,150,000	$4,075,000	$7,861,000	$3,930,500	$5,406,130	$2,703,060	($2,743,870)	($1,371,940)	($2,454,870)	($1,227,440)
184	184	WPCS WORKERS' COMPENSATION	$4,764,000	$2,382,000	$7,265,000	$3,632,500	$7,511,000	$3,755,500	$2,747,000	$1,373,500	$246,000	$123,000
185	185	INDIAN HEALTH SERVICES	$26,153,000	($14,345,150)	$3,208,000	($20,795,000)	$3,208,000	($20,795,000)	($22,945,000)	($6,449,850)	$0	$0

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		OTHER										
189	189	CDDS DENTAL SERVICES	$984,000	$0	$984,000	$0	$984,000	$0	$0	$0	$0	$0
191	191	MANAGED CARE ADMIN FINES AND PENALTIES REVENUE	$0	($2,016,000)	$0	($3,404,000)	$0	($3,404,000)	$0	($1,388,000)	$0	$0
192	192	COUNTY SHARE OF OTLICP-CCS COSTS	$0	($5,860,000)	$0	($6,468,000)	$0	($7,793,000)	$0	($1,933,000)	$0	($1,325,000)
193	193	FUNDING ADJUST.—ACA OPT. EXPANSION	$0	($1,725,221,850)	$0	($1,740,989,800)	$0	($1,736,550,000)	$0	($11,328,150)	$0	$4,439,800
194	194	FUNDING ADJUST.—OTLICP	$0	($140,873,890)	$0	($162,513,490)	$74,000	($171,665,760)	$74,000	($30,791,870)	$74,000	($9,152,270)
195	195	FFP REPAYMENT FOR CDDS COSTS	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
196	196	CLPP FUND	$0	($725,000)	$0	($725,000)	$0	($725,000)	$0	$0	$0	$0
197	197	CCI-TRANSFER OF IHSS COSTS TO DHCS	$0	($1,341,405,000)	$0	($1,681,460,000)	$0	($1,871,911,000)	$0	($530,506,000)	$0	($190,451,000)
198	198	EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	($675,175,000)	$0	($675,175,000)	$0	($675,175,000)	$0	$0	$0	$0
199	199	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	($198,560,000)	$0	($198,560,000)	$0	($198,560,000)	$0	$0	$0	$0
202	202	NONCONTRACT HOSP INPATIENT COST SETTLEMENTS	$50,929,000	$25,464,500	($18,035,000)	($9,017,500)	($6,096,000)	($3,048,000)	($57,025,000)	($28,512,500)	$11,939,000	$5,969,500
205	205	AUDIT SETTLEMENTS	$10,771,000	$10,771,000	$548,000	$548,000	$548,000	$548,000	($10,223,000)	($10,223,000)	$0	$0
210	210	CCI-FFS SAVINGS FOR ADDITIONAL ENROLLMENT	$0	$0	($112,056,000)	($56,028,000)	($94,594,000)	($47,297,000)	($94,594,000)	($47,297,000)	$17,462,000	$8,731,000
--	227	NOD - SETTLEMENT PAYMENT TO DMC PLANS	$0	$0	$0	$0	$19,999,000	$9,999,500	$19,999,000	$9,999,500	$19,999,000	$9,999,500
--	228	FY 2015-16 ACCRUAL ADJUSTMENT	$0	$0	$0	$0	$65,357,000	$65,357,000	$65,357,000	$65,357,000	$65,357,000	$65,357,000
201	--	MEDICARE BUY-IN QUALITY REVIEW PROJECT RECOVERIES	($15,000,000)	($7,500,000)	($15,000,000)	($7,500,000)	$0	$0	$15,000,000	$7,500,000	$15,000,000	$7,500,000
--	--	HOMEMAKER SERVICES - AIDS MEDI-CAL WAIVER	$449,000	$224,500	$0	$0	$0	$0	($449,000)	($224,500)	$0	$0
		OTHER SUBTOTAL	**$490,162,920**	**($4,054,294,930)**	**$583,464,020**	**($4,529,477,780)**	**$685,581,940**	**($4,610,222,790)**	**$195,419,020**	**($555,927,860)**	**$102,117,930**	**($80,745,010)**
		GRAND TOTAL	**$24,972,306,220**	**($4,937,805,470)**	**$37,877,273,450**	**($734,909,610)**	**$28,819,860,450**	**($832,094,210)**	**$3,847,554,240**	**$4,105,711,260**	**($9,057,412,990)**	**($97,184,590)**

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

FISCAL YEAR 2016-17 COST PER ELIGIBLE BASED ON MAY 2017 ESTIMATE

SERVICE CATEGORY	PA-OAS	NEWLY	PA-ATD	PA-AFDC	LT-OAS	H-PE
PHYSICIANS	$12,899,180	$138,213,250	$97,883,020	$43,481,680	$3,108,390	$41,725,910
OTHER MEDICAL	$61,495,050	$936,663,180	$361,146,650	$270,107,030	$5,572,950	$41,536,810
CO. & COMM. OUTPATIENT	$6,336,340	$119,044,080	$117,083,730	$29,496,180	$841,830	$44,421,120
PHARMACY	$3,292,440	$291,177,800	$348,719,910	$33,572,230	$1,585,080	$21,171,510
COUNTY INPATIENT	$4,844,850	$460,657,570	$44,042,190	$24,253,090	$2,782,250	$70,727,100
COMMUNITY INPATIENT	$66,788,950	$1,100,254,150	$660,718,640	$269,779,160	$19,930,970	$221,310,200
NURSING FACILITIES	$219,365,780	$118,606,020	$518,300,240	$3,909,560	$1,281,008,350	$1,221,030
ICF-DD	$974,970	$3,811,620	$174,238,610	$440,030	$38,504,440	$0
MEDICAL TRANSPORTATION	$5,170,960	$13,385,370	$16,680,050	$2,767,770	$2,745,870	$2,428,940
OTHER SERVICES	$69,150,980	$21,299,620	$315,988,050	$35,177,990	$63,898,540	$1,282,720
HOME HEALTH	$1,278,760	$1,341,780	$127,544,900	$5,342,540	$40,420	$185,430
FFS SUBTOTAL	**$451,598,280**	**$3,204,454,450**	**$2,782,346,000**	**$718,327,260**	**$1,420,019,080**	**$446,010,770**
DENTAL	$29,026,620	$252,707,830	$77,404,310	$97,195,320	$9,636,670	$0
MENTAL HEALTH	$7,682,810	$171,665,840	$872,754,210	$624,381,560	$963,890	$0
TWO PLAN MODEL	$1,832,684,790	$8,832,066,040	$5,716,498,400	$1,261,349,770	$0	$0
COUNTY ORGANIZED HEALTH SYSTEMS	$299,609,630	$3,586,418,570	$1,469,939,340	$312,057,120	$785,324,200	$0
GEOGRAPHIC MANAGED CARE	$195,992,930	$1,725,553,370	$1,078,302,490	$205,629,670	$0	$0
PHP & OTHER MANAG. CARE	$211,913,390	$37,320,180	$128,455,770	$18,706,360	$7,481,790	$0
EPSDT SCREENS	$0	$0	$0	$6,930,830	$0	$0
MEDICARE PAYMENTS	$1,601,909,930	$54,599,160	$1,514,945,280	$2,682,060	$154,590,530	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$11,784,480	$0	$26,986,150	$35,491,310	$1,157,090	$0
MISC. SERVICES	$445,058,700	$315,530	$4,250,662,920	$4,996,490	$0	$0
DRUG MEDI-CAL	$6,345,190	$57,569,050	$14,728,150	$19,229,780	$620,310	$0
REGIONAL MODEL	$8,857,400	$580,247,050	$262,085,320	$59,295,760	$0	$0
NON-FFS SUBTOTAL	**$4,650,865,870**	**$15,298,462,620**	**$15,412,762,350**	**$2,647,946,030**	**$959,774,490**	**$0**
TOTAL DOLLARS (1)	**$5,102,464,150**	**$18,502,917,070**	**$18,195,108,350**	**$3,366,273,290**	**$2,379,793,570**	**$446,010,770**
ELIGIBLES * **	**435,900**	**3,773,100**	**998,200**	**1,312,800**	**42,700**	**30,400**
ANNUAL $/ELIGIBLE	**$11,706**	**$4,904**	**$18,228**	**$2,564**	**$55,733**	**$14,671**
AVG. MO. $/ELIGIBLE	**$975**	**$409**	**$1,519**	**$214**	**$4,644**	**$1,223**

(1) Does not include Audits & Lawsuits and Recoveries.
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Refer to page following for listing of excluded policy changes.

FISCAL YEAR 2016-17 COST PER ELIGIBLE BASED ON MAY 2017 ESTIMATE

SERVICE CATEGORY	LT-ATD	POV 250	MN-OAS	MN-ATD	MN-AFDC	MI-C
PHYSICIANS	$2,618,560	$18,798,820	$24,327,860	$13,072,510	$158,220,160	$20,856,770
OTHER MEDICAL	$3,491,020	$169,178,050	$110,129,050	$70,155,040	$773,774,560	$85,586,750
CO. & COMM. OUTPATIENT	$741,940	$26,279,810	$17,725,610	$13,071,970	$114,942,710	$12,313,770
PHARMACY	$2,970,280	$30,317,490	$9,110,630	$22,629,720	$81,577,440	$19,604,140
COUNTY INPATIENT	$4,990,100	$3,909,980	$53,294,510	$27,643,420	$132,822,890	$7,832,500
COMMUNITY INPATIENT	$19,891,290	$100,580,260	$151,873,010	$75,530,850	$835,612,160	$74,848,420
NURSING FACILITIES	$284,129,050	$1,966,070	$244,779,960	$50,767,170	$17,234,070	$3,781,230
ICF-DD	$165,300,520	$167,580	$1,176,470	$8,228,700	$993,440	$1,770,500
MEDICAL TRANSPORTATION	$914,990	$603,400	$7,785,660	$6,395,960	$6,082,720	$1,030,530
OTHER SERVICES	$9,946,570	$13,182,140	$66,701,740	$56,174,600	$89,936,520	$12,961,250
HOME HEALTH	$4,070	$9,393,500	$894,770	$47,303,170	$8,843,480	$10,973,190
FFS SUBTOTAL	**$494,998,390**	**$374,377,090**	**$687,799,280**	**$390,973,110**	**$2,220,040,140**	**$251,559,040**
DENTAL	$9,636,670	$68,036,720	$29,026,620	$9,675,540	$281,866,430	$19,439,060
MENTAL HEALTH	$3,118,480	$16,571,010	$8,334,860	$89,927,210	$411,198,980	$64,323,250
TWO PLAN MODEL	$0	$768,706,780	$1,525,135,640	$534,956,000	$2,743,820,240	$37,166,190
COUNTY ORGANIZED HEALTH SYSTEMS	$236,821,300	$418,739,710	$394,512,890	$317,732,930	$1,088,470,180	$32,957,580
GEOGRAPHIC MANAGED CARE	$0	$172,264,470	$160,017,590	$110,216,940	$474,519,390	$4,747,540
PHP & OTHER MANAG. CARE	$273,400	$9,675,600	$187,289,860	$21,471,910	$39,156,160	$2,764,160
EPSDT SCREENS	$0	$4,964,870	$0	$0	$19,493,740	$1,064,580
MEDICARE PAYMENTS	$39,588,680	$0	$1,050,472,060	$486,364,490	$91,326,820	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$324,420	$0	$12,033,200	$4,376,940	$99,804,430	$5,463,740
MISC. SERVICES	$0	($56,902,850)	$459,799,100	$693,673,150	$14,233,370	$802,970
DRUG MEDI-CAL	$178,270	$14,284,650	$6,555,340	$2,449,380	$55,686,370	$3,095,800
REGIONAL MODEL	$0	$47,382,540	$29,137,610	$22,610,290	$157,346,330	$780,600
NON-FFS SUBTOTAL	**$289,941,220**	**$1,463,723,520**	**$3,862,314,770**	**$2,293,454,760**	**$5,476,922,440**	**$172,605,450**
TOTAL DOLLARS (1)	**$784,939,620**	**$1,838,100,600**	**$4,550,114,050**	**$2,684,427,870**	**$7,696,962,590**	**$424,164,480**
ELIGIBLES * **	**12,000**	**940,500**	**454,200**	**168,100**	**3,691,700**	**201,600**
ANNUAL $/ELIGIBLE	**$65,412**	**$1,954**	**$10,018**	**$15,969**	**$2,085**	**$2,104**
AVG. MO. $/ELIGIBLE	**$5,451**	**$163**	**$835**	**$1,331**	**$174**	**$175**

(1) Does not include Audits & Lawsuits and Recoveries.
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Refer to page following for listing of excluded policy changes.

FISCAL YEAR 2016-17 COST PER ELIGIBLE BASED ON MAY 2017 ESTIMATE

SERVICE CATEGORY	MI-A	REFUGEE	OBRA	POV 185	POV 133	POV 100
PHYSICIANS	$299,380	$228,920	$1,251,930	$127,158,950	$13,222,510	$5,441,620
OTHER MEDICAL	$350,480	$1,035,580	$1,553,920	$248,401,410	$156,139,650	$65,832,150
CO. & COMM. OUTPATIENT	$147,930	$106,300	$888,240	$27,115,340	$12,082,780	$6,550,240
PHARMACY	$448,070	$131,690	$486,210	$9,538,030	$7,101,560	$9,951,430
COUNTY INPATIENT	$15,770	$47,430	$1,366,550	$66,196,050	$2,880,420	$1,919,870
COMMUNITY INPATIENT	$433,170	$402,850	$13,000,430	$789,639,120	$74,708,280	$31,211,190
NURSING FACILITIES	$22,599,090	$2,400	$3,534,520	$1,901,860	$3,602,550	$22,840
ICF-DD	$1,007,520	$0	$333,410	$0	$0	$100
MEDICAL TRANSPORTATION	$65,060	$5,340	$138,440	$2,102,710	$564,490	$167,890
OTHER SERVICES	$376,680	$8,200	$115,810	$13,951,750	$16,403,020	$9,402,790
HOME HEALTH	$30	$0	$740	$2,911,240	$3,108,850	$935,730
FFS SUBTOTAL	**$25,743,170**	**$1,968,720**	**$22,670,190**	**$1,288,916,460**	**$289,814,110**	**$131,435,850**
DENTAL	$9,719,530	$9,719,530	$10,009,950	$30,029,850	$50,049,740	$30,029,850
MENTAL HEALTH	$28,350	$99,310	$199,370	$996,840	$5,480,680	$18,335,360
TWO PLAN MODEL	$53,200	$1,282,470	$0	$173,251,790	$652,710	$316,045,470
COUNTY ORGANIZED HEALTH SYSTEMS	$90,740	$191,780	$126,800	$84,480,880	$291,181,360	$148,556,650
GEOGRAPHIC MANAGED CARE	$6,480	$374,170	$0	$30,097,060	$114,675,370	$59,986,060
PHP & OTHER MANAG. CARE	$1,382,080	$0	$0	$4,146,690	$6,911,140	$4,146,690
EPSDT SCREENS	$0	$0	$0	$0	$3,928,570	$1,898,620
MEDICARE PAYMENTS	$0	$0	$0	$0	$0	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$43,260	$0	$59,480	$83,810	$0	$9,721,720
MISC. SERVICES	$100	$0	$0	$65,900	$2,267,600	$1,245,490
DRUG MEDI-CAL	$8,700	$26,090	$0	$5,713,280	$10,687,400	$5,242,250
REGIONAL MODEL	$0	$17,410	$0	$10,149,270	$37,837,680	$16,949,330
NON-FFS SUBTOTAL	**$11,332,430**	**$11,710,760**	**$10,395,600**	**$339,015,350**	**$523,672,250**	**$612,157,500**
TOTAL DOLLARS (1)	**$37,075,600**	**$13,679,480**	**$33,065,780**	**$1,627,931,810**	**$813,486,360**	**$743,593,340**
ELIGIBLES * **	**1,600**	**2,200**	**3,100**	**375,400**	**744,200**	**359,600**
ANNUAL $/ELIGIBLE	**$23,172**	**$6,218**	**$10,666**	**$4,337**	**$1,093**	**$2,068**
AVG. MO. $/ELIGIBLE	**$1,931**	**$518**	**$889**	**$361**	**$91**	**$172**

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FISCAL YEAR 2016-17 COST PER ELIGIBLE BASED ON MAY 2017 ESTIMATE

SERVICE CATEGORY	TOTAL
PHYSICIANS	**$722,809,430**
OTHER MEDICAL	**$3,362,149,350**
CO. & COMM. OUTPATIENT	**$549,189,920**
PHARMACY	**$893,385,660**
COUNTY INPATIENT	**$910,226,560**
COMMUNITY INPATIENT	**$4,506,513,090**
NURSING FACILITIES	**$2,776,731,770**
ICF-DD	**$396,947,890**
MEDICAL TRANSPORTATION	**$69,036,130**
OTHER SERVICES	**$795,958,970**
HOME HEALTH	**$220,102,610**
FFS SUBTOTAL	**$15,203,051,370**
DENTAL	**$1,023,210,240**
MENTAL HEALTH	**$2,296,062,000**
TWO PLAN MODEL	**$23,743,669,480**
COUNTY ORGANIZED HEALTH SYSTEMS	**$9,467,211,670**
GEOGRAPHIC MANAGED CARE	**$4,332,383,550**
PHP & OTHER MANAG. CARE	**$681,095,180**
EPSDT SCREENS	**$38,281,210**
MEDICARE PAYMENTS	**$4,996,479,000**
STATE HOSP./DEVELOPMENTAL CNTRS.	**$207,330,000**
MISC. SERVICES	**$5,816,218,470**
DRUG MEDI-CAL	**$202,420,000**
REGIONAL MODEL	**$1,232,696,590**
NON-FFS SUBTOTAL	**$54,037,057,410**
TOTAL DOLLARS (1)	**$69,240,108,780**
ELIGIBLES * **	**13,547,300**
ANNUAL $/ELIGIBLE	**$5,111**
AVG. MO. $/ELIGIBLE	**$426**

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Refer to page following for listing of excluded policy changes.

FISCAL YEAR 2016-17 COST PER ELIGIBLE BASED ON MAY 2017 ESTIMATE

EXCLUDED POLICY CHANGES: 79

1	FAMILY PACT PROGRAM
4	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL
5	BREAST AND CERVICAL CANCER TREATMENT
7	COUNTY HEALTH INITIATIVE MATCHING (CHIM)
8	MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL
10	NON-OTLICP CHIP
13	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN
23	1% FMAP INCREASE FOR PREVENTIVE SERVICES
26	ACA MAGI SAVINGS
28	ACA DSH REDUCTION
58	FAMILY PACT DRUG REBATES
67	DRUG MEDI-CAL PROGRAM COST SETTLEMENT
72	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT
76	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT
80	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL
81	GLOBAL PAYMENT PROGRAM
82	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS
83	BTR - LIHP - MCE
84	LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND
85	BTR - LOW INCOME HEALTH PROGRAM - HCCI
87	MH/UCD—HEALTH CARE COVERAGE INITIATIVE
88	MH/UCD—STABILIZATION FUNDING
89	MH/UCD—SAFETY NET CARE POOL
90	MH/UCD & BTR—CCS AND GHPP
91	BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE POOL
92	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG
93	BTR—DESIGNATED STATE HEALTH PROGRAMS
94	MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP
95	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM
110	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)
111	PALLIATIVE CARE SERVICES IMPLEMENTATION
114	MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ.
115	MCO ENROLLMENT TAX MANAGED CARE PLANS
116	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT

FISCAL YEAR 2016-17 COST PER ELIGIBLE BASED ON MAY 2017 ESTIMATE

EXCLUDED POLICY CHANGES: 79

117	MCO TAX MANAGED CARE PLANS
118	MANAGED CARE IGT ADMIN. & PROCESSING FEE
119	GENERAL FUND REIMBURSEMENTS FROM DPHS
126	DENTAL RETROACTIVE RATE CHANGES
129	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS
134	EMERGENCY MEDICAL AIR TRANSPORTATION ACT
141	DP/NF-B RETROACTIVE RECOUPMENT FORGIVENESS
143	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES
147	EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS
148	PRIVATE HOSPITAL DSH REPLACEMENT
149	DSH PAYMENT
150	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
151	NDPH IGT SUPPLEMENTAL PAYMENTS
153	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS
154	CAPITAL PROJECT DEBT REIMBURSEMENT
155	FFP FOR LOCAL TRAUMA CENTERS
156	DPH PHYSICIAN & NON-PHYS. COST
157	HOSPITAL QAF - HOSPITAL PAYMENTS
158	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS
159	GEMT SUPPLEMENTAL PAYMENT PROGRAM
160	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH
161	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH
162	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS
163	IGT PAYMENTS FOR HOSPITAL SERVICES
164	NDPH SUPPLEMENTAL PAYMENT
165	FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS
174	ARRA HITECH - PROVIDER PAYMENTS
178	MEDI-CAL TCM PROGRAM
189	CDDS DENTAL SERVICES
191	MANAGED CARE ADMIN FINES AND PENALTIES REVENUE
196	CLPP FUND
197	CCI-TRANSFER OF IHSS COSTS TO DHCS
198	EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE
199	CIGARETTE AND TOBACCO SURTAX FUNDS

FISCAL YEAR 2016-17 COST PER ELIGIBLE BASED ON MAY 2017 ESTIMATE

EXCLUDED POLICY CHANGES: 79

205	AUDIT SETTLEMENTS
212	HEALTH CARE SVCS. PLANS FINES AND PENALTIES FUND
214	DP-NF CAPITAL PROJECT DEBT REPAYMENT
215	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS
216	BORDER OUT-OF-STATE DIAGNOSIS RELATED GROUP
217	TRANSITIONAL SMHS CLAIMS
221	MEC OPTIONAL EXPANSION ADJUSTMENT
222	CMS DEFERRED CLAIMS
223	CMS DEFERRALS & NEGATIVE BALANCE REPAYMENT
227	NOD - SETTLEMENT PAYMENT TO DMC PLANS
228	FY 2015-16 ACCRUAL ADJUSTMENT

MEDI-CAL PROGRAM ESTIMATE SUMMARY
FISCAL YEAR 2017-18

	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
I. BASE ESTIMATES				
A. B/Y FFS BASE	$17,394,954,530	$8,697,477,260	$8,697,477,260	$0
B. B/Y BASE POLICY CHANGES	$46,844,215,010	$32,331,076,100	$13,344,689,920	$1,168,449,000
C. BASE ADJUSTMENTS	($136,943,000)	($171,223,650)	$34,280,650	$0
D. ADJUSTED BASE	**$64,102,226,540**	**$40,857,329,710**	**$22,076,447,830**	**$1,168,449,000**
II. REGULAR POLICY CHANGES				
A. ELIGIBILITY	($240,463,180)	($854,887,920)	$498,699,740	$115,725,000
B. AFFORDABLE CARE ACT	$2,809,003,000	$2,345,495,250	$507,229,750	($43,722,000)
C. BENEFITS	$1,162,982,940	$891,500,600	$243,434,350	$28,048,000
D. PHARMACY	($2,315,852,570)	($1,552,069,600)	($775,952,770)	$12,169,800
E. DRUG MEDI-CAL	$594,737,000	$469,835,360	$27,612,640	$97,289,000
F. MENTAL HEALTH	$314,763,000	$279,717,500	$34,845,500	$200,000
G. WAIVER--MH/UCD & BTR	$5,586,007,000	$3,051,803,500	$63,730,500	$2,470,473,000
H. MANAGED CARE	$7,835,145,430	$2,711,743,830	($550,830,400)	$5,674,232,000
I. PROVIDER RATES	$412,897,640	$702,639,450	($784,767,880)	$495,026,070
J. SUPPLEMENTAL PMNTS.	$20,084,389,000	$13,255,692,500	$622,032,000	$6,206,664,500
K. OTHER	$283,607,870	$2,234,132,300	($4,483,890,440)	$2,533,366,000
L. TOTAL CHANGES	**$36,527,217,130**	**$23,535,602,770**	**($4,597,857,020)**	**$17,589,471,370**
III. TOTAL MEDI-CAL ESTIMATE	**$100,629,443,660**	**$64,392,932,480**	**$17,478,590,810**	**$18,757,920,370**

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2017-18

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	ELIGIBILITY				
3	MEDI-CAL STATE INMATE PROGRAMS	$117,057,000	$117,057,000	$0	$0
5	BREAST AND CERVICAL CANCER TREATMENT	$69,000,000	$32,200,000	$36,800,000	$0
6	MEDI-CAL COUNTY INMATE PROGRAMS	$301,867,000	$264,389,450	$37,477,550	$0
9	STATE-ONLY BCCTP COVERAGE EXTENSION	$1,643,590	$0	$1,643,590	$0
10	NON-OTLICP CHIP	$0	$479,752,490	($479,752,490)	$0
11	NON-EMERGENCY FUNDING ADJUSTMENT	$0	($899,150,000)	$822,150,000	$77,000,000
12	SCHIP FUNDING FOR PRENATAL CARE	$0	$68,261,600	($68,261,600)	$0
14	PARIS-VETERANS	($3,792,780)	($1,896,390)	($1,896,390)	$0
15	MINIMUM WAGE INCREASE - CASELOAD SAVINGS	($144,192,000)	($114,325,980)	($29,866,020)	$0
16	OTLICP PREMIUMS	($66,749,000)	($58,739,120)	($8,009,880)	$0
219	MEDI-CAL COUNTY INMATE REIMBURSEMENT	$0	$0	($37,456,000)	$37,456,000
221	MEC OPTIONAL EXPANSION ADJUSTMENT	($515,297,000)	($742,436,970)	$225,870,970	$1,269,000
	ELIGIBILITY SUBTOTAL	**($240,463,180)**	**($854,887,920)**	**$498,699,730**	**$115,725,000**
	AFFORDABLE CARE ACT				
17	COMMUNITY FIRST CHOICE OPTION	$2,535,500,000	$2,535,500,000	$0	$0
19	HEALTH INSURER FEE	$502,274,000	$332,631,940	$169,642,060	$0
20	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	$19,463,000	$19,463,000	$0	$0
22	PAYMENTS TO PRIMARY CARE PHYSICIANS	$2,000,000	$2,000,000	$0	$0
23	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	$2,026,000	($2,026,000)	$0
25	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	$0	$36,365,640	($36,365,640)	$0
26	ACA MAGI SAVINGS	$0	$0	$0	$0
28	ACA DSH REDUCTION	($137,873,000)	($73,170,000)	($16,177,000)	($48,526,000)
209	TITLE XXI FEDERAL MATCH REDUCTION	($112,361,000)	($509,321,330)	$392,156,330	$4,804,000
	AFFORDABLE CARE ACT SUBTOTAL	**$2,809,003,000**	**$2,345,495,250**	**$507,229,750**	**($43,722,000)**
	BENEFITS				
1	FAMILY PACT PROGRAM	$310,264,000	$235,636,200	$74,627,800	$0
29	BEHAVIORAL HEALTH TREATMENT	$213,817,000	$120,418,260	$93,398,740	$0
30	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$245,649,000	$245,649,000	$0	$0
31	BEHAVIORAL HEALTH TREATMENT - DDS TRANSITION	$101,325,000	$57,064,740	$44,260,260	$0
32	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$131,106,000	$131,106,000	$0	$0
33	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	$39,778,000	$19,889,000	$0	$19,889,000
34	CCS DEMONSTRATION PROJECT	$36,847,000	$20,074,220	$16,772,780	$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				
35	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$19,680,000	$17,038,000	$2,642,000	$0
36	IMPLEMENT AAP BRIGHT FUTURES PERIODICITY FOR EPSDT	$4,626,730	$2,411,840	$2,214,890	$0
38	YOUTH REGIONAL TREATMENT CENTERS	$5,825,000	$5,796,000	$29,000	$0
39	PEDIATRIC PALLIATIVE CARE WAIVER	$3,530,790	$1,881,690	$1,649,100	$0
40	DENTAL CHILDREN'S OUTREACH AGES 0-3	$5,724,000	$2,862,000	$2,862,000	$0
41	CCT FUND TRANSFER TO CDSS AND CDDS	$2,458,000	$2,458,000	$0	$0
42	DENTAL TRANSFORMATION INITIATIVE UTILIZATION	$6,490,000	$3,245,000	$3,245,000	$0
43	END OF LIFE SERVICES	$659,980	$0	$659,980	$0
44	DENTAL BENEFICIARY OUTREACH AND EDUCATION PROGRAM	$725,000	$362,500	$362,500	$0
45	MEDICAL MANAGEMENT AND TREATMENT FOR ALD	$124,340	$68,190	$56,160	$0
46	ALLIED DENTAL PROFESSIONALS ENROLLMENT	$763,000	$381,500	$381,500	$0
48	SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER	$56,000	$56,000	$0	$0
51	PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINGS	($2,867,130)	($1,571,490)	($1,295,640)	$0
52	SRP PRIOR AUTH. & PREVENTIVE DENTAL SERVICES	($3,201,000)	($1,600,500)	($1,600,500)	$0
53	WOMEN'S HEALTH SERVICES	($7,932,000)	($6,144,500)	($1,787,500)	$0
208	ANNUAL CONTRACEPTIVE COVERAGE	$36,371,230	$28,167,950	$44,280	$8,159,000
229	BEHAVIORAL HEALTH TREATMENT - BIS DDS TRANSITION	$11,163,000	$6,251,000	$4,912,000	$0
	BENEFITS SUBTOTAL	**$1,162,982,940**	**$891,500,600**	**$243,434,350**	**$28,048,000**
	PHARMACY				
55	NEW HIGH COST TREATMENTS FOR SPECIFIC CONDITIONS	$69,438,430	$37,712,660	$19,555,970	$12,169,800
56	NON FFP DRUGS	$0	($69,500)	$69,500	$0
57	BCCTP DRUG REBATES	($11,263,000)	($7,717,850)	($3,545,150)	$0
58	FAMILY PACT DRUG REBATES	($17,183,000)	($15,050,600)	($2,132,400)	$0
59	MEDICAL SUPPLY REBATES	($24,916,000)	($12,458,000)	($12,458,000)	$0
61	STATE SUPPLEMENTAL DRUG REBATES	($192,285,000)	($126,861,210)	($65,423,790)	$0
62	FEDERAL DRUG REBATE PROGRAM	($2,139,644,000)	($1,427,625,100)	($712,018,900)	$0
	PHARMACY SUBTOTAL	**($2,315,852,570)**	**($1,552,069,600)**	**($775,952,770)**	**$12,169,800**
	DRUG MEDI-CAL				
64	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	$580,548,000	$456,183,260	$27,075,740	$97,289,000
69	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	$14,189,000	$13,652,100	$536,900	$0
	DRUG MEDI-CAL SUBTOTAL	**$594,737,000**	**$469,835,360**	**$27,612,640**	**$97,289,000**

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
	MENTAL HEALTH				
72	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT	$253,505,000	$253,505,000	$0	$0
73	MHP COSTS FOR CONTINUUM OF CARE REFORM	$23,308,000	$10,884,500	$12,423,500	$0
74	PATHWAYS TO WELL-BEING	$17,201,000	$17,201,000	$0	$0
75	LATE CLAIMS FOR SMHS	$4,000	$0	$4,000	$0
76	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	$0	$0	($200,000)	$200,000
78	CHART REVIEW	($1,485,000)	($1,485,000)	$0	$0
79	INTERIM AND FINAL COST SETTLEMENTS - SMHS	$20,758,000	($388,000)	$21,146,000	$0
217	TRANSITIONAL SMHS CLAIMS	$1,472,000	$0	$1,472,000	$0
	MENTAL HEALTH SUBTOTAL	**$314,763,000**	**$279,717,500**	**$34,845,500**	**$200,000**
	WAIVER--MH/UCD & BTR				
80	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL	$1,600,000,000	$800,000,000	$0	$800,000,000
81	GLOBAL PAYMENT PROGRAM	$2,388,446,000	$1,194,223,000	$0	$1,194,223,000
82	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS	$720,000,000	$360,000,000	$0	$360,000,000
83	BTR - LIHP - MCE	$198,363,000	$198,363,000	$0	$0
84	LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND	$232,500,000	$116,250,000	$0	$116,250,000
85	BTR - LOW INCOME HEALTH PROGRAM - HCCI	$231,547,000	$231,547,000	$0	$0
86	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	$141,905,000	$70,952,500	$70,952,500	$0
87	MH/UCD—HEALTH CARE COVERAGE INITIATIVE	$23,509,000	$23,509,000	$0	$0
88	MH/UCD—STABILIZATION FUNDING	$55,400,000	$0	$55,400,000	$0
89	MH/UCD—SAFETY NET CARE POOL	($6,723,000)	($6,723,000)	$0	$0
92	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	$1,060,000	$1,060,000	$0	$0
95	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM	$0	$75,000,000	($75,000,000)	$0
222	CMS DEFERRED CLAIMS	$0	($12,378,000)	$12,378,000	$0
	WAIVER--MH/UCD & BTR SUBTOTAL	**$5,586,007,000**	**$3,051,803,500**	**$63,730,500**	**$2,470,473,000**
	MANAGED CARE				
98	CCI-MANAGED CARE PAYMENTS	$4,524,106,210	$2,262,053,100	$2,262,053,100	$0
100	MANAGED CARE PUBLIC HOSPITAL IGTS	$2,880,095,000	$2,408,350,000	$61,648,000	$410,097,000
101	MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.RATES	$2,131,736,000	$1,519,512,990	$612,223,010	$0
103	MANAGED CARE RATE RANGE IGTS	$3,143,888,000	$1,771,220,000	$0	$1,372,668,000
105	HQAF RATE RANGE INCREASES	$232,000,000	$116,000,000	$0	$116,000,000
111	PALLIATIVE CARE SERVICES IMPLEMENTATION	$2,977,000	$1,642,470	$1,334,530	$0
112	CAPITATED RATE ADJUSTMENT FOR FY 2017-18	$0	$0	$0	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2017-18

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	($612,223,000)	$612,223,000
115	MCO ENROLLMENT TAX MANAGED CARE PLANS	$0	$0	($1,780,284,000)	$1,780,284,000
116	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT	$0	$0	($13,631,000)	$13,631,000
117	MCO TAX MANAGED CARE PLANS	$0	$0	($414,386,000)	$414,386,000
118	MANAGED CARE IGT ADMIN. & PROCESSING FEE	$0	$0	($275,965,000)	$275,965,000
119	GENERAL FUND REIMBURSEMENTS FROM DPHS	$0	$0	($253,242,000)	$253,242,000
120	CENCAL HEALTH PLAN-ADDITION OF CHDP	($940,780)	($470,390)	($470,390)	$0
122	MCO TAX MGD. CARE PLANS - INCR. CAP. RATES	$21,304,000	$10,840,000	$10,464,000	$0
123	MANAGED CARE DRUG REBATES	($1,066,751,000)	($720,799,810)	($345,951,190)	$0
124	RETRO MC RATE ADJUSTMENTS	($4,048,269,000)	($4,665,379,000)	$191,374,000	$425,736,000
220	CCI-QUALITY WITHHOLD REPAYMENTS	$9,000,000	$4,500,000	$4,500,000	$0
225	MEDI-CAL NONMEDICAL TRANSPORTATION	$6,000,000	$4,274,470	$1,725,530	$0
	MANAGED CARE SUBTOTAL	**$7,835,145,430**	**$2,711,743,840**	**($550,830,400)**	**$5,674,232,000**
	PROVIDER RATES				
125	MEDICARE PART B ADJUSTMENT	($160,682,000)	($72,124,500)	($88,557,500)	$0
126	DENTAL RETROACTIVE RATE CHANGES	$23,693,000	$14,597,730	$9,095,270	$0
127	FQHC/RHC/CBRC RECONCILIATION PROCESS	$171,669,480	$106,491,030	$65,178,450	$0
128	AB 1629 ANNUAL RATE ADJUSTMENTS	$144,999,930	$72,499,960	$72,499,960	$0
130	DPH INTERIM & FINAL RECONS	$137,004,000	$137,004,000	$0	$0
131	DPH INTERIM RATE GROWTH	$37,920,420	$18,960,210	$18,960,210	$0
132	LTC RATE ADJUSTMENT	$29,408,930	$14,704,460	$14,704,460	$0
133	ANNUAL MEI INCREASE FOR FQHCS/RHCS	$21,631,560	$13,418,600	$8,212,960	$0
134	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	$11,000,000	$5,500,000	($2,390,000)	$7,890,000
135	HOSPICE RATE INCREASES	$19,921,040	$9,960,520	$5,799,450	$4,161,070
136	DISCONTINUE PHARMACY RATE REDUCTIONS	$22,531,850	$11,265,920	$11,265,920	$0
137	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	$19,464,620	$9,732,310	$9,732,310	$0
138	GDSP PRENATAL SCREENING FEE INCREASE	$4,088,310	$2,044,150	$2,044,150	$0
139	ALAMEDA HOSP & SAN LEANDRO HOSP INTERIM RATE	$1,551,580	$2,798,840	($1,247,260)	$0
140	ALTERNATIVE BIRTHING CENTER REIMBURSEMENT	$44,390	$22,190	$22,190	$0
142	DPH INTERIM RATE	$0	$391,438,740	($391,438,740)	$0
143	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	$0	$0	($482,975,000)	$482,975,000

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2017-18

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	PROVIDER RATES				
144	LABORATORY RATE METHODOLOGY CHANGE	($23,980,830)	($11,990,410)	($11,990,410)	$0
145	REDUCTION TO RADIOLOGY RATES	($22,711,270)	($11,355,630)	($11,355,630)	$0
146	10% PROVIDER PAYMENT REDUCTION	($24,657,350)	($12,328,670)	($12,328,670)	$0
	PROVIDER RATES SUBTOTAL	**$412,897,640**	**$702,639,450**	**($784,767,880)**	**$495,026,070**
	SUPPLEMENTAL PMNTS.				
129	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	$86,243,000	$43,121,500	$48,928,000	($5,806,500)
147	EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS	$15,569,513,000	$10,329,673,000	$0	$5,239,840,000
148	PRIVATE HOSPITAL DSH REPLACEMENT	$573,382,000	$286,691,000	$286,691,000	$0
149	DSH PAYMENT	$444,414,000	$300,446,000	$17,000,000	$126,968,000
150	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	$300,261,000	$172,711,000	$118,400,000	$9,150,000
151	NDPH IGT SUPPLEMENTAL PAYMENTS	$184,924,000	$130,052,000	($2,441,000)	$57,313,000
152	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	$125,117,000	$74,120,000	$2,520,000	$48,477,000
153	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$415,351,000	$415,351,000	$0	$0
154	CAPITAL PROJECT DEBT REIMBURSEMENT	$186,120,000	$103,310,000	$82,810,000	$0
155	FFP FOR LOCAL TRAUMA CENTERS	$106,601,000	$61,756,000	$0	$44,845,000
156	DPH PHYSICIAN & NON-PHYS. COST	$154,861,000	$154,861,000	$0	$0
157	HOSPITAL QAF - HOSPITAL PAYMENTS	$100,398,000	$10,270,000	$0	$90,128,000
158	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	$73,762,000	$73,762,000	$0	$0
159	GEMT SUPPLEMENTAL PAYMENT PROGRAM	$76,800,000	$76,800,000	$0	$0
160	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	$10,000,000	$5,000,000	$5,000,000	$0
161	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	$8,000,000	$4,000,000	$4,000,000	$0
162	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	$4,631,000	$4,631,000	$0	$0
163	IGT PAYMENTS FOR HOSPITAL SERVICES	$5,613,000	$3,613,000	$0	$2,000,000
164	NDPH SUPPLEMENTAL PAYMENT	$4,950,000	$3,050,000	$1,900,000	$0
165	FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS	$465,948,000	$465,948,000	$0	$0
214	DP-NF CAPITAL PROJECT DEBT REPAYMENT	$0	($57,224,000)	$57,224,000	$0
215	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	$1,187,500,000	$593,750,000	$0	$593,750,000
	SUPPLEMENTAL PMNTS. SUBTOTAL	**$20,084,389,000**	**$13,255,692,500**	**$622,032,000**	**$6,206,664,500**
	OTHER				
77	IMD ANCILLARY SERVICES	$0	($29,565,000)	$29,565,000	$0
166	INFANT DEVELOPMENT PROGRAM	$26,305,000	$26,305,000	$0	$0
174	ARRA HITECH - PROVIDER PAYMENTS	$175,130,000	$175,130,000	$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				
176	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	$110,533,000	$110,533,000	$0	$0
180	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	$19,921,000	$11,582,000	$8,339,000	$0
181	OVERTIME FOR WPCS PROVIDERS	$12,284,000	$6,142,000	$6,142,000	$0
182	MEDI-CAL ESTATE RECOVERIES	$64,707,000	$32,353,500	$32,353,500	$0
183	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	$15,297,260	$7,648,630	$7,648,630	$0
184	WPCS WORKERS' COMPENSATION	$3,019,000	$1,509,500	$1,509,500	$0
185	INDIAN HEALTH SERVICES	$6,239,000	$27,034,000	($20,795,000)	$0
189	CDDS DENTAL SERVICES	$984,000	$0	$0	$984,000
190	NURSING FACILITY/ACUTE HOSPITAL WAIVER RENEWAL	$6,749,700	$3,374,850	$3,374,850	$0
192	COUNTY SHARE OF OTLICP-CCS COSTS	$0	$0	($8,217,000)	$8,217,000
193	FUNDING ADJUST.—ACA OPT. EXPANSION	$0	$1,764,846,210	($1,764,846,210)	$0
194	FUNDING ADJUST.—OTLICP	$154,000	$176,980,160	($176,826,160)	$0
196	CLPP FUND	$0	$0	($725,000)	$725,000
197	CCI-TRANSFER OF IHSS COSTS TO DHCS	$0	$0	($1,247,758,000)	$1,247,758,000
198	EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	$0	($1,020,525,000)	$1,020,525,000
199	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	$0	($208,524,000)	$208,524,000
200	MEDI-CAL RECOVERIES FIFTY PERCENT RULE	($12,160,000)	$0	($12,160,000)	$0
201	MEDICARE BUY-IN QUALITY REVIEW PROJECT RECOVERIES	$0	$0	$0	$0
205	AUDIT SETTLEMENTS	$13,928,000	$0	$13,928,000	$0
206	INTEGRATION OF THE SF CLSB INTO THE ALW	($746,330)	($373,170)	($373,170)	$0
210	CCI-FFS SAVINGS FOR ADDITIONAL ENROLLMENT	($157,006,760)	($78,503,380)	($78,503,380)	$0
212	HEALTH CARE SVCS. PLANS FINES AND PENALTIES FUND	$0	$0	($46,633,000)	$46,633,000
224	MEDI-CAL RECOVERIES SETTLEMENTS AND LEGAL COSTS	($1,730,000)	($865,000)	($865,000)	$0
	OTHER SUBTOTAL	**$283,607,870**	**$2,234,132,300**	**($4,483,890,440)**	**$2,533,366,000**
	GRAND TOTAL	**$36,527,217,130**	**$23,535,602,770**	**($4,597,857,020)**	**$17,589,471,370**

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	$6,875,575,190	$4,211,430,280	$1,896,917,340	$767,227,570
PHYSICIANS	$926,099,440	$602,295,020	$285,614,580	$38,189,840
OTHER MEDICAL	$3,966,034,210	$2,182,438,190	$1,621,720,670	$161,875,360
CO. & COMM. OUTPATIENT	$1,983,441,540	$1,426,697,070	($10,417,910)	$567,162,370
PHARMACY	$1,364,055,710	$771,952,820	$519,606,170	$72,496,720
HOSPITAL INPATIENT	$14,976,634,020	$9,550,452,230	$1,762,059,610	$3,664,122,180
COUNTY INPATIENT	$1,565,298,580	$1,263,974,420	$47,748,790	$253,575,370
COMMUNITY INPATIENT	$13,411,335,440	$8,286,477,810	$1,714,310,820	$3,410,546,810
LONG TERM CARE	$3,327,186,280	$1,679,917,740	$1,536,487,610	$110,780,930
NURSING FACILITIES	$2,919,725,170	$1,474,098,400	$1,351,989,550	$93,637,220
ICF-DD	$407,461,100	$205,819,330	$184,498,060	$17,143,710
OTHER SERVICES	$1,308,112,930	$783,679,050	$469,552,640	$54,881,240
MEDICAL TRANSPORTATION	$153,190,780	$120,120,030	$24,116,120	$8,954,630
OTHER SERVICES	$935,280,920	$552,164,370	$339,845,530	$43,271,020
HOME HEALTH	$219,641,230	$111,394,650	$105,590,990	$2,655,600
TOTAL FEE-FOR-SERVICE	**$27,851,564,130**	**$16,997,432,120**	**$6,184,623,360**	**$4,669,508,640**
MANAGED CARE	$53,759,378,860	$33,740,609,020	$7,528,009,210	$12,490,760,630
TWO PLAN MODEL	$34,318,826,290	$21,562,274,540	$4,601,648,820	$8,154,902,930
COUNTY ORGANIZED HEALTH SYSTEMS	$11,552,329,960	$7,252,412,560	$1,626,371,170	$2,673,546,230
GEOGRAPHIC MANAGED CARE	$5,391,163,030	$3,394,925,100	$820,143,150	$1,176,094,780
PHP & OTHER MANAG. CARE	$930,332,390	$527,578,410	$236,627,810	$166,126,170
REGIONAL MODEL	$1,566,727,190	$1,003,418,410	$243,218,270	$320,090,520
DENTAL	$1,311,537,700	$829,838,250	$394,250,120	$87,449,320
MENTAL HEALTH	$2,862,222,780	$2,678,293,620	($31,600,770)	$215,529,920
AUDITS/ LAWSUITS	$15,925,040	($11,468,490)	$27,393,490	$40
EPSDT SCREENS	$39,458,730	$21,928,240	$16,805,490	$725,000
MEDICARE PAYMENTS	$5,229,331,000	$1,444,083,710	$3,558,917,290	$226,330,000
STATE HOSP./DEVELOPMENTAL CNTRS.	$207,330,000	$207,330,000	$0	$0
MISC. SERVICES	$8,867,116,630	$7,982,476,530	($85,683,930)	$970,324,030
RECOVERIES	($301,486,000)	($151,509,500)	($149,976,500)	$0
DRUG MEDI-CAL	$787,064,800	$653,918,980	$35,853,040	$97,292,780
GRAND TOTAL MEDI-CAL	**$100,629,443,660**	**$64,392,932,480**	**$17,478,590,810**	**$18,757,920,370**

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2016-17 AND 2017-18

SERVICE CATEGORY	MAY 2017 EST. FOR 2016-17	MAY 2017 EST. FOR 2017-18	DOLLAR DIFFERENCE	% CHANGE
PROFESSIONAL	$6,180,760,530	$6,875,575,190	$694,814,660	11.24%
PHYSICIANS	$864,670,200	$926,099,440	$61,429,240	7.10%
OTHER MEDICAL	$3,624,580,110	$3,966,034,210	$341,454,110	9.42%
CO. & COMM. OUTPATIENT	$1,691,510,220	$1,983,441,540	$291,931,310	17.26%
PHARMACY	$933,638,370	$1,364,055,710	$430,417,340	46.10%
HOSPITAL INPATIENT	$12,555,413,960	$14,976,634,020	$2,421,220,060	19.28%
COUNTY INPATIENT	$1,232,381,510	$1,565,298,580	$332,917,060	27.01%
COMMUNITY INPATIENT	$11,323,032,440	$13,411,335,440	$2,088,303,000	18.44%
LONG TERM CARE	$3,371,845,350	$3,327,186,280	($44,659,070)	-1.32%
NURSING FACILITIES	$2,974,897,220	$2,919,725,170	($55,172,050)	-1.85%
ICF-DD	$396,948,130	$407,461,100	$10,512,980	2.65%
OTHER SERVICES	$1,141,909,910	$1,308,112,930	$166,203,020	14.55%
MEDICAL TRANSPORTATION	$124,112,130	$153,190,780	$29,078,650	23.43%
OTHER SERVICES	$797,442,870	$935,280,920	$137,838,050	17.29%
HOME HEALTH	$220,354,910	$219,641,230	($713,680)	-0.32%
TOTAL FEE-FOR-SERVICE	**$24,183,568,110**	**$27,851,564,130**	**$3,667,996,020**	**15.17%**
MANAGED CARE	$43,008,429,720	$53,759,378,860	$10,750,949,140	25.00%
TWO PLAN MODEL	$25,913,850,860	$34,318,826,290	$8,404,975,430	32.43%
COUNTY ORGANIZED HEALTH SYSTEMS	$10,292,847,810	$11,552,329,960	$1,259,482,150	12.24%
GEOGRAPHIC MANAGED CARE	$4,704,797,620	$5,391,163,030	$686,365,410	14.59%
PHP & OTHER MANAG. CARE	$749,954,410	$930,332,390	$180,377,980	24.05%
REGIONAL MODEL	$1,346,979,020	$1,566,727,190	$219,748,170	16.31%
DENTAL	$1,155,736,240	$1,311,537,700	$155,801,460	13.48%
MENTAL HEALTH	$2,295,747,000	$2,862,222,780	$566,475,780	24.68%
AUDITS/ LAWSUITS	($3,962,000)	$15,925,040	$19,887,050	-501.94%
EPSDT SCREENS	$38,281,210	$39,458,730	$1,177,520	3.08%
MEDICARE PAYMENTS	$4,996,479,000	$5,229,331,000	$232,852,000	4.66%
STATE HOSP./DEVELOPMENTAL CNTRS.	$207,330,000	$207,330,000	$0	0.00%
MISC. SERVICES	$8,986,989,470	$8,867,116,630	($119,872,840)	-1.33%
RECOVERIES	($309,233,000)	($301,486,000)	$7,747,000	-2.51%
DRUG MEDI-CAL	$205,419,000	$787,064,800	$581,645,800	283.15%
GRAND TOTAL MEDI-CAL	**$84,764,784,750**	**$100,629,443,660**	**$15,864,658,910**	**18.72%**
GENERAL FUNDS	**$17,972,051,680**	**$17,478,590,810**	**($493,460,870)**	**-2.75%**
OTHER STATE FUNDS	**$12,562,985,000**	**$18,757,920,370**	**$6,194,935,370**	**49.31%**

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
MAY 2017 ESTIMATE COMPARED TO NOVEMBER 2016 ESTIMATE
FISCAL YEAR 2017-18

SERVICE CATEGORY	NOV. 2016 EST. FOR 2017-18	MAY 2017 EST. FOR 2017-18	DOLLAR DIFFERENCE	% CHANGE
PROFESSIONAL	$7,738,570,830	$6,875,575,190	($862,995,640)	-11.15%
PHYSICIANS	$918,149,500	$926,099,440	$7,949,940	0.87%
OTHER MEDICAL	$3,894,594,890	$3,966,034,210	$71,439,320	1.83%
CO. & COMM. OUTPATIENT	$2,925,826,440	$1,983,441,540	($942,384,900)	-32.21%
PHARMACY	$1,596,755,160	$1,364,055,710	($232,699,450)	-14.57%
HOSPITAL INPATIENT	$15,772,947,960	$14,976,634,020	($796,313,940)	-5.05%
COUNTY INPATIENT	$3,325,669,730	$1,565,298,580	($1,760,371,150)	-52.93%
COMMUNITY INPATIENT	$12,447,278,230	$13,411,335,440	$964,057,210	7.75%
LONG TERM CARE	$3,255,326,970	$3,327,186,280	$71,859,310	2.21%
NURSING FACILITIES	$2,865,832,340	$2,919,725,170	$53,892,830	1.88%
ICF-DD	$389,494,630	$407,461,100	$17,966,470	4.61%
OTHER SERVICES	$1,113,988,120	$1,308,112,930	$194,124,810	17.43%
MEDICAL TRANSPORTATION	$177,311,410	$153,190,780	($24,120,630)	-13.60%
OTHER SERVICES	$703,680,620	$935,280,920	$231,600,310	32.91%
HOME HEALTH	$232,996,090	$219,641,230	($13,354,860)	-5.73%
TOTAL FEE-FOR-SERVICE	**$29,477,589,040**	**$27,851,564,130**	**($1,626,024,910)**	**-5.52%**
MANAGED CARE	$47,969,779,230	$53,759,378,860	$5,789,599,630	12.07%
TWO PLAN MODEL	$29,445,445,580	$34,318,826,290	$4,873,380,710	16.55%
COUNTY ORGANIZED HEALTH SYSTEMS	$11,099,919,530	$11,552,329,960	$452,410,430	4.08%
GEOGRAPHIC MANAGED CARE	$5,035,262,610	$5,391,163,030	$355,900,410	7.07%
PHP & OTHER MANAG. CARE	$853,827,010	$930,332,390	$76,505,380	8.96%
REGIONAL MODEL	$1,535,324,500	$1,566,727,190	$31,402,700	2.05%
DENTAL	$1,421,347,230	$1,311,537,700	($109,809,530)	-7.73%
MENTAL HEALTH	$2,703,741,580	$2,862,222,780	$158,481,200	5.86%
AUDITS/ LAWSUITS	$3,865,000	$15,925,040	$12,060,040	312.03%
EPSDT SCREENS	$54,147,000	$39,458,730	($14,688,270)	-27.13%
MEDICARE PAYMENTS	$5,338,730,000	$5,229,331,000	($109,399,000)	-2.05%
STATE HOSP./DEVELOPMENTAL CNTRS.	$207,330,000	$207,330,000	$0	0.00%
MISC. SERVICES	$10,101,215,210	$8,867,116,630	($1,234,098,580)	-12.22%
RECOVERIES	($311,818,000)	($301,486,000)	$10,332,000	-3.31%
DRUG MEDI-CAL	$822,297,000	$787,064,800	($35,232,210)	-4.28%
GRAND TOTAL MEDI-CAL	**$97,788,223,300**	**$100,629,443,660**	**$2,841,220,360**	**2.91%**
GENERAL FUNDS	**$18,118,289,040**	**$17,478,590,810**	**($639,698,220)**	**-3.53%**
OTHER STATE FUNDS	**$16,693,069,840**	**$18,757,920,370**	**$2,064,850,530**	**12.37%**

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2017 ESTIMATE COMPARED TO NOVEMBER 2016 ESTIMATE
FISCAL YEAR 2017-18

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2016 EST. FOR 2017-18		MAY 2017 EST. FOR 2017-18		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		ELIGIBILITY						
3	3	MEDI-CAL STATE INMATE PROGRAMS	$324,837,000	$0	$117,057,000	$0	($207,780,000)	$0
5	5	BREAST AND CERVICAL CANCER TREATMENT	$71,126,000	$37,702,350	$69,000,000	$36,800,000	($2,126,000)	($902,350)
6	6	MEDI-CAL COUNTY INMATE PROGRAMS	$88,194,000	$0	$301,867,000	$37,477,550	$213,673,000	$37,477,550
9	9	STATE-ONLY BCCTP COVERAGE EXTENSION	$1,625,000	$1,625,000	$1,696,000	$1,696,000	$71,000	$71,000
10	10	NON-OTLICP CHIP	$0	($497,931,100)	$0	($479,752,490)	$0	$18,178,610
11	11	NON-EMERGENCY FUNDING ADJUSTMENT	$0	$693,904,000	$0	$822,150,000	$0	$128,246,000
12	12	SCHIP FUNDING FOR PRENATAL CARE	$0	($65,386,640)	$0	($68,261,600)	$0	($2,874,960)
14	14	PARIS-VETERANS	($15,357,890)	($7,678,940)	($15,380,280)	($7,690,140)	($22,400)	($11,200)
15	15	MINIMUM WAGE INCREASE - CASELOAD SAVINGS	($140,029,000)	($29,957,000)	($144,192,000)	($29,866,020)	($4,163,000)	$90,980
16	16	OTLICP PREMIUMS	($69,672,000)	($8,360,640)	($66,749,000)	($8,009,880)	$2,923,000	$350,760
--	219	MEDI-CAL COUNTY INMATE REIMBURSEMENT	$0	$0	$0	($37,456,000)	$0	($37,456,000)
--	221	MEC OPTIONAL EXPANSION ADJUSTMENT	$0	$0	($515,297,000)	$225,870,970	($515,297,000)	$225,870,970
2	--	UNDOCUMENTED CHILDREN FULL SCOPE EXPANSION	$354,358,000	$279,533,000	$0	$0	($354,358,000)	($279,533,000)
7	--	COUNTY HEALTH INITIATIVE MATCHING (CHIM)	$6,013,000	$721,560	$0	$0	($6,013,000)	($721,560)
13	--	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN	$0	($15,951,280)	$0	$0	$0	$15,951,280
27	--	TRANSITION OF NQI ADULTS TO COVERED CALIFORNIA	($120,810,000)	($48,035,000)	$0	$0	$120,810,000	$48,035,000
		ELIGIBILITY SUBTOTAL	**$500,284,110**	**$340,185,310**	**($251,998,280)**	**$492,958,390**	**($752,282,400)**	**$152,773,080**
		AFFORDABLE CARE ACT						
17	17	COMMUNITY FIRST CHOICE OPTION	$3,366,480,000	$0	$2,535,500,000	$0	($830,980,000)	$0
19	19	HEALTH INSURER FEE	$445,644,000	$152,482,860	$502,274,000	$169,642,060	$56,630,000	$17,159,200
20	20	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	$63,306,000	$0	$19,463,000	$0	($43,843,000)	$0

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2017 ESTIMATE COMPARED TO NOVEMBER 2016 ESTIMATE
FISCAL YEAR 2017-18

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2016 EST. FOR 2017-18		MAY 2017 EST. FOR 2017-18		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		AFFORDABLE CARE ACT						
--	22	PAYMENTS TO PRIMARY CARE PHYSICIANS	$0	$0	$2,000,000	$0	$2,000,000	$0
23	23	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	($2,230,000)	$0	($2,026,000)	$0	$204,000
25	25	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	$0	($85,498,450)	$0	($36,365,640)	$0	$49,132,810
26	26	ACA MAGI SAVINGS	$0	$0	$0	$0	$0	$0
28	28	ACA DSH REDUCTION	($137,873,000)	($16,177,000)	($137,873,000)	($16,177,000)	$0	$0
209	209	TITLE XXI FEDERAL MATCH REDUCTION	($55,965,000)	$530,898,190	($112,361,000)	$392,156,330	($56,396,000)	($138,741,860)
18	--	ACA OPTIONAL EXPANSION	$2,553,413,000	$128,596,670	$0	$0	($2,553,413,000)	($128,596,670)
21	--	ACA MANDATORY EXPANSION	$253,714,000	$108,927,840	$0	$0	($253,714,000)	($108,927,840)
		AFFORDABLE CARE ACT SUBTOTAL	**$6,488,719,000**	**$817,000,110**	**$2,809,003,000**	**$507,229,750**	**($3,679,716,000)**	**($309,770,360)**
		BENEFITS						
1	1	FAMILY PACT PROGRAM	$346,263,000	$83,286,700	$310,264,000	$74,627,800	($35,999,000)	($8,658,900)
29	29	BEHAVIORAL HEALTH TREATMENT	$379,057,000	$163,971,980	$213,817,000	$93,398,740	($165,240,000)	($70,573,240)
30	30	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$217,338,000	$0	$245,649,000	$0	$28,311,000	$0
31	31	BEHAVIORAL HEALTH TREATMENT - DDS TRANSITION	$275,070,000	$118,989,480	$101,325,000	$44,260,260	($173,745,000)	($74,729,220)
32	32	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$133,369,000	$0	$131,106,000	$0	($2,263,000)	$0
33	33	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	$29,374,000	$0	$39,778,000	$0	$10,404,000	$0
34	34	CCS DEMONSTRATION PROJECT	$37,154,000	$16,944,520	$36,847,000	$16,772,780	($307,000)	($171,740)
35	35	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$19,181,000	$2,515,000	$19,680,000	$2,642,000	$499,000	$127,000
36	36	IMPLEMENT AAP BRIGHT FUTURES PERIODICITY FOR EPSDT	$17,312,000	$8,307,920	$16,372,000	$7,837,540	($940,000)	($470,380)
38	38	YOUTH REGIONAL TREATMENT CENTERS	$5,618,000	$159,000	$5,825,000	$29,000	$207,000	($130,000)

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2017 ESTIMATE COMPARED TO NOVEMBER 2016 ESTIMATE
FISCAL YEAR 2017-18

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2016 EST. FOR 2017-18		MAY 2017 EST. FOR 2017-18		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		BENEFITS						
39	39	PEDIATRIC PALLIATIVE CARE WAIVER	$4,045,000	$1,849,100	$4,415,140	$2,062,140	$370,140	$213,040
40	40	DENTAL CHILDREN'S OUTREACH AGES 0-3	$5,724,000	$2,862,000	$5,724,000	$2,862,000	$0	$0
41	41	CCT FUND TRANSFER TO CDSS AND CDDS	$2,475,000	$0	$2,458,000	$0	($17,000)	$0
42	42	DENTAL TRANSFORMATION INITIATIVE UTILIZATION	$2,804,000	$1,402,000	$6,490,000	$3,245,000	$3,686,000	$1,843,000
43	43	END OF LIFE SERVICES	$2,336,900	$2,336,900	$659,980	$659,980	($1,676,910)	($1,676,910)
44	44	DENTAL BENEFICIARY OUTREACH AND EDUCATION PROGRAM	$640,000	$320,000	$725,000	$362,500	$85,000	$42,500
45	45	MEDICAL MANAGEMENT AND TREATMENT FOR ALD	$440,000	$199,100	$440,000	$198,720	$0	($380)
46	46	ALLIED DENTAL PROFESSIONALS ENROLLMENT	$710,000	$355,000	$763,000	$381,500	$53,000	$26,500
48	48	SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER	$48,000	$0	$56,000	$0	$8,000	$0
51	51	PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINGS	($7,331,000)	($3,319,320)	($4,305,000)	($1,945,400)	$3,026,000	$1,373,920
52	52	SRP PRIOR AUTH. & PREVENTIVE DENTAL SERVICES	($2,770,000)	($1,385,000)	($3,201,000)	($1,600,500)	($431,000)	($215,500)
53	53	WOMEN'S HEALTH SERVICES	($7,921,000)	($1,782,000)	($7,932,000)	($1,787,500)	($11,000)	($5,500)
208	208	ANNUAL CONTRACEPTIVE COVERAGE	$33,593,130	$7,576,700	$36,371,230	$44,280	$2,778,100	($7,532,420)
--	229	BEHAVIORAL HEALTH TREATMENT - BIS DDS TRANSITION	$0	$0	$11,163,000	$4,912,000	$11,163,000	$4,912,000
37	--	ACUPUNCTURE SERVICES RESTORATION	$5,119,000	$1,741,590	$0	$0	($5,119,000)	($1,741,590)
47	--	CHDP PROGRAM DENTAL REFERRAL	$193,000	$87,380	$0	$0	($193,000)	($87,380)
50	--	WHOLE CHILD MODEL IMPLEMENTATION	$45,057,000	$21,142,260	$0	$0	($45,057,000)	($21,142,260)
		BENEFITS SUBTOTAL	**$1,544,899,020**	**$427,560,300**	**$1,174,490,360**	**$248,962,840**	**($370,408,670)**	**($178,597,460)**
		PHARMACY						
55	55	NEW HIGH COST TREATMENTS FOR SPECIFIC CONDITIONS	$38,071,000	$18,090,440	$84,331,350	$23,750,270	$46,260,350	$5,659,830

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2017 ESTIMATE COMPARED TO NOVEMBER 2016 ESTIMATE
FISCAL YEAR 2017-18

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2016 EST. FOR 2017-18		MAY 2017 EST. FOR 2017-18		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		PHARMACY						
56	56	NON FFP DRUGS	$0	$92,000	$0	$69,500	$0	($22,500)
57	57	BCCTP DRUG REBATES	($10,779,000)	($3,373,650)	($11,263,000)	($3,545,150)	($484,000)	($171,500)
58	58	FAMILY PACT DRUG REBATES	($16,037,000)	($1,751,800)	($17,183,000)	($2,132,400)	($1,146,000)	($380,600)
59	59	MEDICAL SUPPLY REBATES	($26,880,000)	($13,440,000)	($24,916,000)	($12,458,000)	$1,964,000	$982,000
61	61	STATE SUPPLEMENTAL DRUG REBATES	($193,190,000)	($71,603,950)	($192,285,000)	($65,423,790)	$905,000	$6,180,160
62	62	FEDERAL DRUG REBATE PROGRAM	($2,147,336,000)	($727,862,340)	($2,139,644,000)	($712,018,900)	$7,692,000	$15,843,440
		PHARMACY SUBTOTAL	**($2,356,151,000)**	**($799,849,300)**	**($2,300,959,650)**	**($771,758,470)**	**$55,191,350**	**$28,090,830**
		DRUG MEDI-CAL						
64	64	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	$661,857,000	$141,605,130	$580,548,000	$27,075,740	($81,309,000)	($114,529,390)
--	69	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	$0	$0	$14,189,000	$536,900	$14,189,000	$536,900
		DRUG MEDI-CAL SUBTOTAL	**$661,857,000**	**$141,605,130**	**$594,737,000**	**$27,612,640**	**($67,120,000)**	**($113,992,490)**
		MENTAL HEALTH						
72	72	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT	$86,410,000	$0	$253,505,000	$0	$167,095,000	$0
73	73	MHP COSTS FOR CONTINUUM OF CARE REFORM	$24,410,000	$12,962,500	$23,308,000	$12,423,500	($1,102,000)	($539,000)
74	74	PATHWAYS TO WELL-BEING	$16,156,000	$0	$17,201,000	$0	$1,045,000	$0
75	75	LATE CLAIMS FOR SMHS	$1,731,000	$1,731,000	$4,000	$4,000	($1,727,000)	($1,727,000)
76	76	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	$0	($200,000)	$0	($200,000)	$0	$0
78	78	CHART REVIEW	($1,543,000)	$0	($1,485,000)	$0	$58,000	$0
79	79	INTERIM AND FINAL COST SETTLEMENTS - SMHS	$988,000	$988,000	$20,758,000	$21,146,000	$19,770,000	$20,158,000
--	217	TRANSITIONAL SMHS CLAIMS	$0	$0	$1,472,000	$1,472,000	$1,472,000	$1,472,000
		MENTAL HEALTH SUBTOTAL	**$128,152,000**	**$15,481,500**	**$314,763,000**	**$34,845,500**	**$186,611,000**	**$19,364,000**

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2017 ESTIMATE COMPARED TO NOVEMBER 2016 ESTIMATE
FISCAL YEAR 2017-18

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2016 EST. FOR 2017-18		MAY 2017 EST. FOR 2017-18		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		WAIVER--MH/UCD & BTR						
80	80	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL	$1,600,000,000	$0	$1,600,000,000	$0	$0	$0
81	81	GLOBAL PAYMENT PROGRAM	$2,336,264,000	$0	$2,388,446,000	$0	$52,182,000	$0
82	82	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS	$720,000,000	$0	$720,000,000	$0	$0	$0
--	83	BTR - LIHP - MCE	$0	$0	$198,363,000	$0	$198,363,000	$0
--	84	LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND	$0	$0	$232,500,000	$0	$232,500,000	$0
--	85	BTR - LOW INCOME HEALTH PROGRAM - HCCI	$0	$0	$231,547,000	$0	$231,547,000	$0
86	86	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	$134,127,000	$67,063,500	$141,905,000	$70,952,500	$7,778,000	$3,889,000
--	87	MH/UCD—HEALTH CARE COVERAGE INITIATIVE	$0	$0	$23,509,000	$0	$23,509,000	$0
88	88	MH/UCD—STABILIZATION FUNDING	$55,400,000	$55,400,000	$55,400,000	$55,400,000	$0	$0
89	89	MH/UCD—SAFETY NET CARE POOL	($6,723,000)	$0	($6,723,000)	$0	$0	$0
92	92	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	$1,223,000	$0	$1,060,000	$0	($163,000)	$0
95	95	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM	$0	($75,000,000)	$0	($75,000,000)	$0	$0
--	222	CMS DEFERRED CLAIMS	$0	$0	$0	$12,378,000	$0	$12,378,000
		WAIVER--MH/UCD & BTR SUBTOTAL	**$4,840,291,000**	**$47,463,500**	**$5,586,007,000**	**$63,730,500**	**$745,716,000**	**$16,267,000**
		MANAGED CARE						
98	98	CCI-MANAGED CARE PAYMENTS	$8,430,740,000	$4,215,370,000	$9,936,539,000	$4,968,269,500	$1,505,799,000	$752,899,500
100	100	MANAGED CARE PUBLIC HOSPITAL IGTS	$533,355,000	$0	$2,880,095,000	$61,648,000	$2,346,740,000	$61,648,000
101	101	MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.RATES	$2,131,736,000	$761,789,240	$2,131,736,000	$612,223,010	$0	($149,566,230)
103	103	MANAGED CARE RATE RANGE IGTS	$2,117,021,000	$0	$3,143,888,000	$0	$1,026,867,000	$0
105	105	HQAF RATE RANGE INCREASES	$168,000,000	$0	$232,000,000	$0	$64,000,000	$0

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2017 ESTIMATE COMPARED TO NOVEMBER 2016 ESTIMATE
FISCAL YEAR 2017-18

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2016 EST. FOR 2017-18		MAY 2017 EST. FOR 2017-18		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		MANAGED CARE						
111	111	PALLIATIVE CARE SERVICES IMPLEMENTATION	$2,141,000	$1,000,630	$2,977,000	$1,334,530	$836,000	$333,900
112	112	CAPITATED RATE ADJUSTMENT FOR FY 2017-18	$338,535,000	$9,567,360	$0	$0	($338,535,000)	($9,567,360)
114	114	MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ.	$0	($761,789,000)	$0	($612,223,000)	$0	$149,566,000
115	115	MCO ENROLLMENT TAX MANAGED CARE PLANS	$0	($1,630,718,000)	$0	($1,780,284,000)	$0	($149,566,000)
--	116	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT	$0	$0	$0	($13,631,000)	$0	($13,631,000)
--	117	MCO TAX MANAGED CARE PLANS	$0	$0	$0	($414,386,000)	$0	($414,386,000)
118	118	MANAGED CARE IGT ADMIN. & PROCESSING FEE	$0	($168,266,000)	$0	($275,965,000)	$0	($107,699,000)
119	119	GENERAL FUND REIMBURSEMENTS FROM DPHS	$0	($105,186,000)	$0	($253,242,000)	$0	($148,056,000)
120	120	CENCAL HEALTH PLAN-ADDITION OF CHDP	($3,450,000)	($1,725,000)	($3,329,000)	($1,664,500)	$121,000	$60,500
--	122	MCO TAX MGD. CARE PLANS - INCR. CAP. RATES	$0	$0	$21,304,000	$10,464,000	$21,304,000	$10,464,000
123	123	MANAGED CARE DRUG REBATES	($1,066,751,000)	($345,951,190)	($1,066,751,000)	($345,951,190)	$0	$0
124	124	RETRO MC RATE ADJUSTMENTS	($3,100,789,000)	($44,868,000)	($4,048,269,000)	$191,374,000	($947,480,000)	$236,242,000
--	220	CCI-QUALITY WITHHOLD REPAYMENTS	$0	$0	$9,000,000	$4,500,000	$9,000,000	$4,500,000
--	225	MEDI-CAL NONMEDICAL TRANSPORTATION	$0	$0	$6,000,000	$1,725,530	$6,000,000	$1,725,530
109	--	NOTICES OF DISPUTE/ADMINISTRATIVE APPEALS	$2,000,000	$2,000,000	$0	$0	($2,000,000)	($2,000,000)
113	--	HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS	$15,357,000	$0	$0	$0	($15,357,000)	$0
		MANAGED CARE SUBTOTAL	**$9,567,895,000**	**$1,931,224,040**	**$13,245,190,000**	**$2,154,191,880**	**$3,677,295,000**	**$222,967,840**
		PROVIDER RATES						
125	125	MEDICARE PART B ADJUSTMENT	$53,097,000	$29,209,500	($160,682,000)	($88,557,500)	($213,779,000)	($117,767,000)
126	126	DENTAL RETROACTIVE RATE CHANGES	$64,843,000	$20,715,080	$23,693,000	$9,095,270	($41,150,000)	($11,619,810)

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2017 ESTIMATE COMPARED TO NOVEMBER 2016 ESTIMATE
FISCAL YEAR 2017-18

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2016 EST. FOR 2017-18		MAY 2017 EST. FOR 2017-18		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		PROVIDER RATES						
127	127	FQHC/RHC/CBRC RECONCILIATION PROCESS	$174,069,280	$67,323,480	$199,430,150	$75,718,460	$25,360,870	$8,394,980
128	128	AB 1629 ANNUAL RATE ADJUSTMENTS	$165,625,530	$82,812,760	$174,846,170	$87,423,090	$9,220,640	$4,610,320
130	130	DPH INTERIM & FINAL RECONS	$50,956,000	$0	$137,004,000	$0	$86,048,000	$0
131	131	DPH INTERIM RATE GROWTH	$81,807,560	$40,903,780	$37,920,420	$18,960,210	($43,887,150)	($21,943,570)
132	132	LTC RATE ADJUSTMENT	$48,460,000	$24,230,000	$31,718,000	$15,859,000	($16,742,000)	($8,371,000)
133	133	ANNUAL MEI INCREASE FOR FQHCS/RHCS	$45,732,120	$17,639,360	$51,405,790	$19,517,480	$5,673,660	$1,878,120
134	134	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	$11,000,000	($1,538,000)	$11,000,000	($2,390,000)	$0	($852,000)
135	135	HOSPICE RATE INCREASES	$20,787,850	$10,393,930	$21,480,520	$6,253,450	$692,670	($4,140,480)
136	136	DISCONTINUE PHARMACY RATE REDUCTIONS	$25,081,740	$12,540,870	$22,531,850	$11,265,920	($2,549,890)	($1,274,940)
137	137	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	$3,804,680	$1,902,340	$19,464,620	$9,732,310	$15,659,940	$7,829,970
138	138	GDSP PRENATAL SCREENING FEE INCREASE	$2,299,420	$1,149,710	$4,088,310	$2,044,150	$1,788,880	$894,440
139	139	ALAMEDA HOSP & SAN LEANDRO HOSP INTERIM RATE	$1,570,720	($1,196,890)	$1,551,580	($1,247,260)	($19,150)	($50,370)
140	140	ALTERNATIVE BIRTHING CENTER REIMBURSEMENT	$43,520	$21,760	$44,390	$22,190	$870	$440
142	142	DPH INTERIM RATE	$0	($402,454,430)	$0	($391,438,740)	$0	$11,015,690
143	143	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	$0	($484,587,000)	$0	($482,975,000)	$0	$1,612,000
144	144	LABORATORY RATE METHODOLOGY CHANGE	($42,897,690)	($21,448,850)	($23,980,830)	($11,990,410)	$18,916,860	$9,458,430
145	145	REDUCTION TO RADIOLOGY RATES	($85,211,820)	($42,605,910)	($22,711,270)	($11,355,630)	$62,500,550	$31,250,280
146	146	10% PROVIDER PAYMENT REDUCTION	($199,140,000)	($99,570,000)	($205,136,000)	($102,568,000)	($5,996,000)	($2,998,000)
		PROVIDER RATES SUBTOTAL	**$421,928,920**	**($744,558,500)**	**$323,668,690**	**($836,631,020)**	**($98,260,230)**	**($92,072,520)**
		SUPPLEMENTAL PMNTS.						
129	129	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	$81,992,000	$48,928,000	$86,243,000	$48,928,000	$4,251,000	$0

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2017 ESTIMATE COMPARED TO NOVEMBER 2016 ESTIMATE
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NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2016 EST. FOR 2017-18		MAY 2017 EST. FOR 2017-18		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		SUPPLEMENTAL PMNTS.						
147	147	EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS	$13,398,333,000	$0	$15,569,513,000	$0	$2,171,180,000	$0
148	148	PRIVATE HOSPITAL DSH REPLACEMENT	$573,232,000	$286,616,000	$573,382,000	$286,691,000	$150,000	$75,000
149	149	DSH PAYMENT	$444,414,000	$17,000,000	$444,414,000	$17,000,000	$0	$0
150	150	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	$255,100,000	$100,150,000	$300,261,000	$118,400,000	$45,161,000	$18,250,000
151	151	NDPH IGT SUPPLEMENTAL PAYMENTS	$124,886,000	($5,466,000)	$184,924,000	($2,441,000)	$60,038,000	$3,025,000
152	152	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	$113,789,190	$6,545,510	$125,117,000	$2,520,000	$11,327,810	($4,025,510)
153	153	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$383,174,000	$0	$415,351,000	$0	$32,177,000	$0
154	154	CAPITAL PROJECT DEBT REIMBURSEMENT	$139,307,000	$59,403,500	$186,120,000	$82,810,000	$46,813,000	$23,406,500
155	155	FFP FOR LOCAL TRAUMA CENTERS	$86,000,000	$0	$106,601,000	$0	$20,601,000	$0
156	156	DPH PHYSICIAN & NON-PHYS. COST	$150,948,000	$0	$154,861,000	$0	$3,913,000	$0
--	157	HOSPITAL QAF - HOSPITAL PAYMENTS	$0	$0	$100,398,000	$0	$100,398,000	$0
158	158	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	$61,364,000	$0	$73,762,000	$0	$12,398,000	$0
159	159	GEMT SUPPLEMENTAL PAYMENT PROGRAM	$88,500,000	$0	$76,800,000	$0	($11,700,000)	$0
160	160	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	$10,000,000	$5,000,000	$10,000,000	$5,000,000	$0	$0
161	161	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	$8,000,000	$4,000,000	$8,000,000	$4,000,000	$0	$0
162	162	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	$4,232,000	$0	$4,631,000	$0	$399,000	$0
163	163	IGT PAYMENTS FOR HOSPITAL SERVICES	$4,000,000	$0	$5,613,000	$0	$1,613,000	$0
164	164	NDPH SUPPLEMENTAL PAYMENT	$3,800,000	$1,773,000	$4,950,000	$1,900,000	$1,150,000	$127,000
165	165	FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS	$419,526,000	$0	$465,948,000	$0	$46,422,000	$0
--	214	DP-NF CAPITAL PROJECT DEBT REPAYMENT	$0	$0	$0	$57,224,000	$0	$57,224,000

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NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2016 EST. FOR 2017-18		MAY 2017 EST. FOR 2017-18		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		SUPPLEMENTAL PMNTS.						
--	215	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	$0	$0	$1,187,500,000	$0	$1,187,500,000	$0
		SUPPLEMENTAL PMNTS. SUBTOTAL	**$16,350,597,190**	**$523,950,010**	**$20,084,389,000**	**$622,032,000**	**$3,733,791,810**	**$98,081,990**
		OTHER						
77	77	IMD ANCILLARY SERVICES	$0	$20,542,000	$0	$29,565,000	$0	$9,023,000
166	166	INFANT DEVELOPMENT PROGRAM	$27,936,000	$0	$26,305,000	$0	($1,631,000)	$0
174	174	ARRA HITECH - PROVIDER PAYMENTS	$115,840,000	$0	$175,130,000	$0	$59,290,000	$0
176	176	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	$58,228,000	$0	$110,533,000	$0	$52,305,000	$0
180	180	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	$11,676,000	$5,957,000	$19,921,000	$8,339,000	$8,245,000	$2,382,000
181	181	OVERTIME FOR WPCS PROVIDERS	$10,099,000	$5,049,500	$12,284,000	$6,142,000	$2,185,000	$1,092,500
182	182	MEDI-CAL ESTATE RECOVERIES	$57,687,000	$28,843,500	$64,707,000	$32,353,500	$7,020,000	$3,510,000
183	183	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	$15,184,000	$7,592,000	$15,297,260	$7,648,630	$113,260	$56,630
184	184	WPCS WORKERS' COMPENSATION	$2,501,000	$1,250,500	$3,019,000	$1,509,500	$518,000	$259,000
185	185	INDIAN HEALTH SERVICES	$4,456,000	($20,795,000)	$6,239,000	($20,795,000)	$1,783,000	$0
189	189	CDDS DENTAL SERVICES	$984,000	$0	$984,000	$0	$0	$0
190	190	NURSING FACILITY/ACUTE HOSPITAL WAIVER RENEWAL	$9,829,340	$4,914,670	$6,749,700	$3,374,850	($3,079,640)	($1,539,820)
192	192	COUNTY SHARE OF OTLICP-CCS COSTS	$0	($6,509,000)	$0	($8,217,000)	$0	($1,708,000)
193	193	FUNDING ADJUST.—ACA OPT. EXPANSION	$0	($1,697,749,400)	$0	($1,764,846,210)	$0	($67,096,810)
194	194	FUNDING ADJUST.—OTLICP	$0	($154,495,910)	$154,000	($176,826,160)	$154,000	($22,330,250)
196	196	CLPP FUND	$0	($725,000)	$0	($725,000)	$0	$0
197	197	CCI-TRANSFER OF IHSS COSTS TO DHCS	$0	($881,455,000)	$0	($1,247,758,000)	$0	($366,303,000)
198	198	EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	($1,056,250,000)	$0	($1,020,525,000)	$0	$35,725,000

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NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2016 EST. FOR 2017-18		MAY 2017 EST. FOR 2017-18		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER						
199	199	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	($206,254,000)	$0	($208,524,000)	$0	($2,270,000)
200	200	MEDI-CAL RECOVERIES FIFTY PERCENT RULE	($12,160,000)	($12,160,000)	($12,160,000)	($12,160,000)	$0	$0
201	201	MEDICARE BUY-IN QUALITY REVIEW PROJECT RECOVERIES	($20,000,000)	($10,000,000)	($2,000,000)	($1,000,000)	$18,000,000	$9,000,000
--	205	AUDIT SETTLEMENTS	$0	$0	$13,928,000	$13,928,000	$13,928,000	$13,928,000
206	206	INTEGRATION OF THE SF CLSB INTO THE ALW	($746,330)	($373,170)	($746,330)	($373,170)	$0	$0
210	210	CCI-FFS SAVINGS FOR ADDITIONAL ENROLLMENT	($362,750,000)	($181,375,000)	($332,853,000)	($166,426,500)	$29,897,000	$14,948,500
212	212	HEALTH CARE SVCS. PLANS FINES AND PENALTIES FUND	$0	($65,700,000)	$0	($46,633,000)	$0	$19,067,000
--	224	MEDI-CAL RECOVERIES SETTLEMENTS AND LEGAL COSTS	$0	$0	($1,730,000)	($865,000)	($1,730,000)	($865,000)
		OTHER SUBTOTAL	**($81,235,990)**	**($4,219,692,300)**	**$105,761,630**	**($4,572,813,560)**	**$186,997,620**	**($353,121,250)**
		GRAND TOTAL	**$38,067,236,250**	**($1,519,630,210)**	**$41,685,051,740**	**($2,029,639,540)**	**$3,617,815,490**	**($510,009,330)**

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 2016-17 AND 2017-18

NO.	POLICY CHANGE TITLE	MAY 2017 EST. FOR 2016-17 TOTAL FUNDS	MAY 2017 EST. FOR 2016-17 GENERAL FUNDS	MAY 2017 EST. FOR 2017-18 TOTAL FUNDS	MAY 2017 EST. FOR 2017-18 GENERAL FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE GENERAL FUNDS
	ELIGIBILITY						
3	MEDI-CAL STATE INMATE PROGRAMS	$77,936,000	$0	$117,057,000	$0	$39,121,000	$0
5	BREAST AND CERVICAL CANCER TREATMENT	$67,000,000	$36,100,000	$69,000,000	$36,800,000	$2,000,000	$700,000
6	MEDI-CAL COUNTY INMATE PROGRAMS	$27,385,000	$9,345,500	$301,867,000	$37,477,550	$274,482,000	$28,132,050
9	STATE-ONLY BCCTP COVERAGE EXTENSION	$551,000	$551,000	$1,696,000	$1,696,000	$1,145,000	$1,145,000
10	NON-OTLICP CHIP	$0	$53,229,010	$0	($479,752,490)	$0	($532,981,500)
11	NON-EMERGENCY FUNDING ADJUSTMENT	$0	$985,633,000	$0	$822,150,000	$0	($163,483,000)
12	SCHIP FUNDING FOR PRENATAL CARE	$0	($63,757,760)	$0	($68,261,600)	$0	($4,503,840)
13	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN	$0	$5,313,000	$0	$0	$0	($5,313,000)
14	PARIS-VETERANS	($11,520,120)	($5,760,060)	($15,380,280)	($7,690,140)	($3,860,160)	($1,930,080)
15	MINIMUM WAGE INCREASE - CASELOAD SAVINGS	($7,714,000)	($1,508,000)	($144,192,000)	($29,866,020)	($136,478,000)	($28,358,020)
16	OTLICP PREMIUMS	($67,447,000)	($8,093,640)	($66,749,000)	($8,009,880)	$698,000	$83,760
219	MEDI-CAL COUNTY INMATE REIMBURSEMENT	$0	$0	$0	($37,456,000)	$0	($37,456,000)
221	MEC OPTIONAL EXPANSION ADJUSTMENT	$0	$0	($515,297,000)	$225,870,970	($515,297,000)	$225,870,970
	ELIGIBILITY SUBTOTAL	**$86,190,880**	**$1,011,052,050**	**($251,998,280)**	**$492,958,390**	**($338,189,160)**	**($518,093,660)**
	AFFORDABLE CARE ACT						
17	COMMUNITY FIRST CHOICE OPTION	$2,045,900,000	$0	$2,535,500,000	$0	$489,600,000	$0
19	HEALTH INSURER FEE	$220,166,000	$74,748,810	$502,274,000	$169,642,060	$282,108,000	$94,893,250
20	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	$101,925,000	$0	$19,463,000	$0	($82,462,000)	$0
22	PAYMENTS TO PRIMARY CARE PHYSICIANS	$8,000,000	$0	$2,000,000	$0	($6,000,000)	$0
23	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	$1,181,000	$0	($2,026,000)	$0	($3,207,000)
24	STATE-ONLY FORMER FOSTER CARE PROGRAM	$0	$398,000	$0	$0	$0	($398,000)
25	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	$0	($39,616,200)	$0	($36,365,640)	$0	$3,250,560

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2016-17 AND 2017-18

NO.	POLICY CHANGE TITLE	MAY 2017 EST. FOR 2016-17		MAY 2017 EST. FOR 2017-18		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	AFFORDABLE CARE ACT						
26	ACA MAGI SAVINGS	$0	$0	$0	$0	$0	$0
28	ACA DSH REDUCTION	$0	$0	($137,873,000)	($16,177,000)	($137,873,000)	($16,177,000)
209	TITLE XXI FEDERAL MATCH REDUCTION	$0	$0	($112,361,000)	$392,156,330	($112,361,000)	$392,156,330
	AFFORDABLE CARE ACT SUBTOTAL	**$2,375,991,000**	**$36,711,610**	**$2,809,003,000**	**$507,229,750**	**$433,012,000**	**$470,518,140**
	BENEFITS						
1	FAMILY PACT PROGRAM	$316,502,000	$76,127,800	$310,264,000	$74,627,800	($6,238,000)	($1,500,000)
29	BEHAVIORAL HEALTH TREATMENT	$235,807,000	$104,586,100	$213,817,000	$93,398,740	($21,990,000)	($11,187,360)
30	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$379,487,000	$0	$245,649,000	$0	($133,838,000)	$0
31	BEHAVIORAL HEALTH TREATMENT - DDS TRANSITION	$86,168,000	$37,639,740	$101,325,000	$44,260,260	$15,157,000	$6,620,520
32	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$123,498,000	$78,000	$131,106,000	$0	$7,608,000	($78,000)
33	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	$39,778,000	$0	$39,778,000	$0	$0	$0
34	CCS DEMONSTRATION PROJECT	$32,792,000	$14,906,240	$36,847,000	$16,772,780	$4,055,000	$1,866,540
35	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$19,545,000	$2,534,000	$19,680,000	$2,642,000	$135,000	$108,000
36	IMPLEMENT AAP BRIGHT FUTURES PERIODICITY FOR EPSDT	$12,685,570	$6,072,780	$16,372,000	$7,837,540	$3,686,430	$1,764,760
38	YOUTH REGIONAL TREATMENT CENTERS	$4,259,000	$62,000	$5,825,000	$29,000	$1,566,000	($33,000)
39	PEDIATRIC PALLIATIVE CARE WAIVER	$2,589,530	$1,915,870	$4,415,140	$2,062,140	$1,825,610	$146,270
40	DENTAL CHILDREN'S OUTREACH AGES 0-3	$3,180,000	$1,590,000	$5,724,000	$2,862,000	$2,544,000	$1,272,000
41	CCT FUND TRANSFER TO CDSS AND CDDS	$1,825,000	$0	$2,458,000	$0	$633,000	$0
42	DENTAL TRANSFORMATION INITIATIVE UTILIZATION	$4,538,000	$2,269,000	$6,490,000	$3,245,000	$1,952,000	$976,000
43	END OF LIFE SERVICES	$23,910	$23,910	$659,980	$659,980	$636,080	$636,080
44	DENTAL BENEFICIARY OUTREACH AND EDUCATION PROGRAM	$53,000	$26,500	$725,000	$362,500	$672,000	$336,000
45	MEDICAL MANAGEMENT AND TREATMENT FOR ALD	$335,460	$151,210	$440,000	$198,720	$104,540	$47,510

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2016-17 AND 2017-18

NO.	POLICY CHANGE TITLE	MAY 2017 EST. FOR 2016-17		MAY 2017 EST. FOR 2017-18		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	BENEFITS						
46	ALLIED DENTAL PROFESSIONALS ENROLLMENT	$252,000	$126,000	$763,000	$381,500	$511,000	$255,500
48	SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER	$153,000	$0	$56,000	$0	($97,000)	$0
49	QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS	$97,000	$0	$0	$0	($97,000)	$0
51	PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINGS	($1,071,000)	($483,060)	($4,305,000)	($1,945,400)	($3,234,000)	($1,462,340)
52	SRP PRIOR AUTH. & PREVENTIVE DENTAL SERVICES	($3,168,000)	($1,584,000)	($3,201,000)	($1,600,500)	($33,000)	($16,500)
53	WOMEN'S HEALTH SERVICES	($5,897,260)	($1,330,010)	($7,932,000)	($1,787,500)	($2,034,740)	($457,490)
208	ANNUAL CONTRACEPTIVE COVERAGE	$3,749,630	$845,820	$36,371,230	$44,280	$32,621,600	($801,540)
229	BEHAVIORAL HEALTH TREATMENT - BIS DDS TRANSITION	$0	$0	$11,163,000	$4,912,000	$11,163,000	$4,912,000
	BENEFITS SUBTOTAL	**$1,257,181,840**	**$245,557,900**	**$1,174,490,360**	**$248,962,840**	**($82,691,480)**	**$3,404,940**
	PHARMACY						
55	NEW HIGH COST TREATMENTS FOR SPECIFIC CONDITIONS	$26,086,750	$12,045,520	$84,331,350	$23,750,270	$58,244,600	$11,704,750
56	NON FFP DRUGS	$0	$39,000	$0	$69,500	$0	$30,500
57	BCCTP DRUG REBATES	($12,486,000)	($3,947,650)	($11,263,000)	($3,545,150)	$1,223,000	$402,500
58	FAMILY PACT DRUG REBATES	($20,748,000)	($2,585,000)	($17,183,000)	($2,132,400)	$3,565,000	$452,600
59	MEDICAL SUPPLY REBATES	($24,916,000)	($12,458,000)	($24,916,000)	($12,458,000)	$0	$0
60	LITIGATION SETTLEMENTS	($29,867,000)	($29,867,000)	$0	$0	$29,867,000	$29,867,000
61	STATE SUPPLEMENTAL DRUG REBATES	($208,826,000)	($27,590,660)	($192,285,000)	($65,423,790)	$16,541,000	($37,833,130)
62	FEDERAL DRUG REBATE PROGRAM	($2,201,821,000)	($711,404,400)	($2,139,644,000)	($712,018,900)	$62,177,000	($614,500)
204	DRUG REBATES - RETROACTIVE ACA ADJUSTMENTS	$0	$487,276,200	$0	$0	$0	($487,276,200)
	PHARMACY SUBTOTAL	**($2,472,577,250)**	**($288,491,990)**	**($2,300,959,650)**	**($771,758,470)**	**$171,617,600**	**($483,266,480)**

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2016-17 AND 2017-18

NO.	POLICY CHANGE TITLE	MAY 2017 EST. FOR 2016-17		MAY 2017 EST. FOR 2017-18		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	DRUG MEDI-CAL						
64	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	$21,503,000	$4,162,000	$580,548,000	$27,075,740	$559,045,000	$22,913,740
67	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	$2,999,000	$34,000	$0	$0	($2,999,000)	($34,000)
69	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	$0	$0	$14,189,000	$536,900	$14,189,000	$536,900
	DRUG MEDI-CAL SUBTOTAL	**$24,502,000**	**$4,196,000**	**$594,737,000**	**$27,612,640**	**$570,235,000**	**$23,416,640**
	MENTAL HEALTH						
72	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT	$0	$0	$253,505,000	$0	$253,505,000	$0
73	MHP COSTS FOR CONTINUUM OF CARE REFORM	$7,539,000	$4,527,000	$23,308,000	$12,423,500	$15,769,000	$7,896,500
74	PATHWAYS TO WELL-BEING	$5,650,000	$0	$17,201,000	$0	$11,551,000	$0
75	LATE CLAIMS FOR SMHS	$24,000	$0	$4,000	$4,000	($20,000)	$4,000
76	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	($315,000)	$70,000	$0	($200,000)	$315,000	($270,000)
78	CHART REVIEW	($1,869,000)	$0	($1,485,000)	$0	$384,000	$0
79	INTERIM AND FINAL COST SETTLEMENTS - SMHS	($59,037,000)	$2,655,000	$20,758,000	$21,146,000	$79,795,000	$18,491,000
217	TRANSITIONAL SMHS CLAIMS	$0	$0	$1,472,000	$1,472,000	$1,472,000	$1,472,000
	MENTAL HEALTH SUBTOTAL	**($48,008,000)**	**$7,252,000**	**$314,763,000**	**$34,845,500**	**$362,771,000**	**$27,593,500**
	WAIVER--MH/UCD & BTR						
80	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL	$2,622,000,000	$0	$1,600,000,000	$0	($1,022,000,000)	$0
81	GLOBAL PAYMENT PROGRAM	$2,218,904,000	$0	$2,388,446,000	$0	$169,542,000	$0
82	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS	$480,000,000	$0	$720,000,000	$0	$240,000,000	$0
83	BTR - LIHP - MCE	$125,692,000	$0	$198,363,000	$0	$72,671,000	$0
84	LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND	$0	$0	$232,500,000	$0	$232,500,000	$0

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2016-17 AND 2017-18

NO.	POLICY CHANGE TITLE	MAY 2017 EST. FOR 2016-17 TOTAL FUNDS	MAY 2017 EST. FOR 2016-17 GENERAL FUNDS	MAY 2017 EST. FOR 2017-18 TOTAL FUNDS	MAY 2017 EST. FOR 2017-18 GENERAL FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE GENERAL FUNDS
	WAIVER--MH/UCD & BTR						
85	BTR - LOW INCOME HEALTH PROGRAM - HCCI	$44,037,000	$0	$231,547,000	$0	$187,510,000	$0
86	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	$46,216,000	$23,108,000	$141,905,000	$70,952,500	$95,689,000	$47,844,500
87	MH/UCD—HEALTH CARE COVERAGE INITIATIVE	$1,343,000	$0	$23,509,000	$0	$22,166,000	$0
88	MH/UCD—STABILIZATION FUNDING	$33,686,000	$33,686,000	$55,400,000	$55,400,000	$21,714,000	$21,714,000
89	MH/UCD—SAFETY NET CARE POOL	$7,844,000	$0	($6,723,000)	$0	($14,567,000)	$0
90	MH/UCD & BTR—CCS AND GHPP	$6,025,000	$0	$0	$0	($6,025,000)	$0
91	BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE POOL	$2,913,000	$0	$0	$0	($2,913,000)	$0
92	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	$1,463,000	$0	$1,060,000	$0	($403,000)	$0
93	BTR—DESIGNATED STATE HEALTH PROGRAMS	$0	$50,518,000	$0	$0	$0	($50,518,000)
94	MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP	$0	($6,205,000)	$0	$0	$0	$6,205,000
95	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM	$0	($75,000,000)	$0	($75,000,000)	$0	$0
222	CMS DEFERRED CLAIMS	$0	$14,926,000	$0	$12,378,000	$0	($2,548,000)
223	CMS DEFERRALS & NEGATIVE BALANCE REPAYMENT	$0	$226,344,000	$0	$0	$0	($226,344,000)
	WAIVER--MH/UCD & BTR SUBTOTAL	**$5,590,123,000**	**$267,377,000**	**$5,586,007,000**	**$63,730,500**	**($4,116,000)**	**($203,646,500)**
	MANAGED CARE						
98	CCI-MANAGED CARE PAYMENTS	$10,042,736,000	$5,021,368,000	$9,936,539,000	$4,968,269,500	($106,197,000)	($53,098,500)
100	MANAGED CARE PUBLIC HOSPITAL IGTS	$247,118,000	$0	$2,880,095,000	$61,648,000	$2,632,977,000	$61,648,000
101	MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.RATES	$1,849,578,000	$521,681,640	$2,131,736,000	$612,223,010	$282,158,000	$90,541,370
103	MANAGED CARE RATE RANGE IGTS	$870,681,000	$0	$3,143,888,000	$0	$2,273,207,000	$0
105	HQAF RATE RANGE INCREASES	$125,000,000	$0	$232,000,000	$0	$107,000,000	$0
111	PALLIATIVE CARE SERVICES IMPLEMENTATION	$10,000	$5,000	$2,977,000	$1,334,530	$2,967,000	$1,329,530

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CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2016-17 AND 2017-18

NO.	POLICY CHANGE TITLE	MAY 2017 EST. FOR 2016-17		MAY 2017 EST. FOR 2017-18		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	MANAGED CARE						
112	CAPITATED RATE ADJUSTMENT FOR FY 2017-18	$0	$0	$0	$0	$0	$0
114	MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ.	$0	($521,682,000)	$0	($612,223,000)	$0	($90,541,000)
115	MCO ENROLLMENT TAX MANAGED CARE PLANS	$0	($1,190,766,000)	$0	($1,780,284,000)	$0	($589,518,000)
116	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT	$0	($128,145,000)	$0	($13,631,000)	$0	$114,514,000
117	MCO TAX MANAGED CARE PLANS	$0	($184,621,000)	$0	($414,386,000)	$0	($229,765,000)
118	MANAGED CARE IGT ADMIN. & PROCESSING FEE	$0	($69,204,000)	$0	($275,965,000)	$0	($206,761,000)
119	GENERAL FUND REIMBURSEMENTS FROM DPHS	$0	($48,535,000)	$0	($253,242,000)	$0	($204,707,000)
120	CENCAL HEALTH PLAN-ADDITION OF CHDP	($2,574,000)	($1,287,000)	($3,329,000)	($1,664,500)	($755,000)	($377,500)
121	FORMER AGNEWS' BENEFICIARIES RECOUPMENT	($6,477,000)	($3,238,500)	$0	$0	$6,477,000	$3,238,500
122	MCO TAX MGD. CARE PLANS - INCR. CAP. RATES	$25,332,000	$12,666,000	$21,304,000	$10,464,000	($4,028,000)	($2,202,000)
123	MANAGED CARE DRUG REBATES	($2,146,160,000)	($606,546,680)	($1,066,751,000)	($345,951,190)	$1,079,409,000	$260,595,490
124	RETRO MC RATE ADJUSTMENTS	$331,083,000	($208,912,100)	($4,048,269,000)	$191,374,000	($4,379,352,000)	$400,286,100
220	CCI-QUALITY WITHHOLD REPAYMENTS	$1,353,000	$676,500	$9,000,000	$4,500,000	$7,647,000	$3,823,500
225	MEDI-CAL NONMEDICAL TRANSPORTATION	$0	$0	$6,000,000	$1,725,530	$6,000,000	$1,725,530
	MANAGED CARE SUBTOTAL	**$11,337,680,000**	**$2,593,459,860**	**$13,245,190,000**	**$2,154,191,880**	**$1,907,510,000**	**($439,267,980)**
	PROVIDER RATES						
125	MEDICARE PART B ADJUSTMENT	$23,423,000	$11,711,500	($160,682,000)	($88,557,500)	($184,105,000)	($100,269,000)
126	DENTAL RETROACTIVE RATE CHANGES	$131,542,000	$42,416,380	$23,693,000	$9,095,270	($107,849,000)	($33,321,110)
127	FQHC/RHC/CBRC RECONCILIATION PROCESS	$196,942,330	$73,176,560	$199,430,150	$75,718,460	$2,487,820	$2,541,890
128	AB 1629 ANNUAL RATE ADJUSTMENTS	$93,156,430	$46,578,210	$174,846,170	$87,423,090	$81,689,740	$40,844,870
130	DPH INTERIM & FINAL RECONS	$81,174,000	$0	$137,004,000	$0	$55,830,000	$0
131	DPH INTERIM RATE GROWTH	$0	$0	$37,920,420	$18,960,210	$37,920,420	$18,960,210

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CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2016-17 AND 2017-18

NO.	POLICY CHANGE TITLE	MAY 2017 EST. FOR 2016-17		MAY 2017 EST. FOR 2017-18		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	PROVIDER RATES						
132	LTC RATE ADJUSTMENT	$13,434,200	$6,717,100	$31,718,000	$15,859,000	$18,283,800	$9,141,900
133	ANNUAL MEI INCREASE FOR FQHCS/RHCS	$38,778,220	$14,408,150	$51,405,790	$19,517,480	$12,627,560	$5,109,330
134	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	$11,188,000	($2,522,000)	$11,000,000	($2,390,000)	($188,000)	$132,000
135	HOSPICE RATE INCREASES	$2,102,750	$1,051,370	$21,480,520	$6,253,450	$19,377,770	$5,202,070
136	DISCONTINUE PHARMACY RATE REDUCTIONS	$4,532,130	$2,266,070	$22,531,850	$11,265,920	$17,999,710	$8,999,860
137	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	$650,460	$325,230	$19,464,620	$9,732,310	$18,814,160	$9,407,080
138	GDSP PRENATAL SCREENING FEE INCREASE	$0	$0	$4,088,310	$2,044,150	$4,088,310	$2,044,150
139	ALAMEDA HOSP & SAN LEANDRO HOSP INTERIM RATE	$32,060	($24,600)	$1,551,580	($1,247,260)	$1,519,510	($1,222,670)
140	ALTERNATIVE BIRTHING CENTER REIMBURSEMENT	$0	$0	$44,390	$22,190	$44,390	$22,190
141	DP/NF-B RETROACTIVE RECOUPMENT FORGIVENESS	$0	$104,415,000	$0	$0	$0	($104,415,000)
142	DPH INTERIM RATE	$0	($350,932,550)	$0	($391,438,740)	$0	($40,506,190)
143	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	$0	($481,448,000)	$0	($482,975,000)	$0	($1,527,000)
144	LABORATORY RATE METHODOLOGY CHANGE	($2,312,560)	($1,156,280)	($23,980,830)	($11,990,410)	($21,668,270)	($10,834,140)
145	REDUCTION TO RADIOLOGY RATES	($16,013,000)	($8,006,500)	($22,711,270)	($11,355,630)	($6,698,270)	($3,349,130)
146	10% PROVIDER PAYMENT REDUCTION	($197,626,000)	($98,813,000)	($205,136,000)	($102,568,000)	($7,510,000)	($3,755,000)
216	BORDER OUT-OF-STATE DIAGNOSIS RELATED GROUP	$2,734,000	$1,005,000	$0	$0	($2,734,000)	($1,005,000)
	PROVIDER RATES SUBTOTAL	**$383,738,040**	**($638,832,350)**	**$323,668,690**	**($836,631,020)**	**($60,069,350)**	**($197,798,670)**
	SUPPLEMENTAL PMNTS.						
129	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	$82,670,000	$47,165,000	$86,243,000	$48,928,000	$3,573,000	$1,763,000
147	EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS	$7,022,721,000	$0	$15,569,513,000	$0	$8,546,792,000	$0

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2016-17 AND 2017-18

NO.	POLICY CHANGE TITLE	MAY 2017 EST. FOR 2016-17		MAY 2017 EST. FOR 2017-18		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	SUPPLEMENTAL PMNTS.						
148	PRIVATE HOSPITAL DSH REPLACEMENT	$618,284,000	$309,142,000	$573,382,000	$286,691,000	($44,902,000)	($22,451,000)
149	DSH PAYMENT	$531,697,000	$14,744,000	$444,414,000	$17,000,000	($87,283,000)	$2,256,000
150	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	$364,229,000	$118,400,000	$300,261,000	$118,400,000	($63,968,000)	$0
151	NDPH IGT SUPPLEMENTAL PAYMENTS	$182,290,000	$0	$184,924,000	($2,441,000)	$2,634,000	($2,441,000)
152	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	$192,175,000	$0	$125,117,000	$2,520,000	($67,058,000)	$2,520,000
153	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$141,358,000	$0	$415,351,000	$0	$273,993,000	$0
154	CAPITAL PROJECT DEBT REIMBURSEMENT	$100,295,000	$39,472,500	$186,120,000	$82,810,000	$85,825,000	$43,337,500
155	FFP FOR LOCAL TRAUMA CENTERS	$140,582,000	$0	$106,601,000	$0	($33,981,000)	$0
156	DPH PHYSICIAN & NON-PHYS. COST	$59,450,000	$0	$154,861,000	$0	$95,411,000	$0
157	HOSPITAL QAF - HOSPITAL PAYMENTS	$0	$0	$100,398,000	$0	$100,398,000	$0
158	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	$89,940,000	$0	$73,762,000	$0	($16,178,000)	$0
159	GEMT SUPPLEMENTAL PAYMENT PROGRAM	$43,716,000	$0	$76,800,000	$0	$33,084,000	$0
160	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	$10,037,000	$5,018,500	$10,000,000	$5,000,000	($37,000)	($18,500)
161	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	$8,009,000	$4,004,500	$8,000,000	$4,000,000	($9,000)	($4,500)
162	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	$4,204,000	$0	$4,631,000	$0	$427,000	$0
163	IGT PAYMENTS FOR HOSPITAL SERVICES	$4,000,000	$0	$5,613,000	$0	$1,613,000	$0
164	NDPH SUPPLEMENTAL PAYMENT	$3,800,000	$1,900,000	$4,950,000	$1,900,000	$1,150,000	$0
165	FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS	$0	$0	$465,948,000	$0	$465,948,000	$0
214	DP-NF CAPITAL PROJECT DEBT REPAYMENT	$0	$0	$0	$57,224,000	$0	$57,224,000
215	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	$0	$0	$1,187,500,000	$0	$1,187,500,000	$0
	SUPPLEMENTAL PMNTS. SUBTOTAL	**$9,599,457,000**	**$539,846,500**	**$20,084,389,000**	**$622,032,000**	**$10,484,932,000**	**$82,185,500**

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2016-17 AND 2017-18

NO.	POLICY CHANGE TITLE	MAY 2017 EST. FOR 2016-17		MAY 2017 EST. FOR 2017-18		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER						
77	IMD ANCILLARY SERVICES	$0	$26,632,000	$0	$29,565,000	$0	$2,933,000
166	INFANT DEVELOPMENT PROGRAM	$31,899,000	$0	$26,305,000	$0	($5,594,000)	$0
172	CCI IHSS RECONCILIATION	$339,270,000	$0	$0	$0	($339,270,000)	$0
174	ARRA HITECH - PROVIDER PAYMENTS	$198,460,000	$0	$175,130,000	$0	($23,330,000)	$0
176	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	$77,067,000	$0	$110,533,000	$0	$33,466,000	$0
180	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	$12,711,000	$5,817,000	$19,921,000	$8,339,000	$7,210,000	$2,522,000
181	OVERTIME FOR WPCS PROVIDERS	$11,190,820	$5,595,410	$12,284,000	$6,142,000	$1,093,180	$546,590
182	MEDI-CAL ESTATE RECOVERIES	$12,587,000	$6,293,500	$64,707,000	$32,353,500	$52,120,000	$26,060,000
183	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	$5,406,130	$2,703,060	$15,297,260	$7,648,630	$9,891,140	$4,945,570
184	WPCS WORKERS' COMPENSATION	$7,511,000	$3,755,500	$3,019,000	$1,509,500	($4,492,000)	($2,246,000)
185	INDIAN HEALTH SERVICES	$3,208,000	($20,795,000)	$6,239,000	($20,795,000)	$3,031,000	$0
189	CDDS DENTAL SERVICES	$984,000	$0	$984,000	$0	$0	$0
190	NURSING FACILITY/ACUTE HOSPITAL WAIVER RENEWAL	$0	$0	$6,749,700	$3,374,850	$6,749,700	$3,374,850
191	MANAGED CARE ADMIN FINES AND PENALTIES REVENUE	$0	($3,404,000)	$0	$0	$0	$3,404,000
192	COUNTY SHARE OF OTLICP-CCS COSTS	$0	($7,793,000)	$0	($8,217,000)	$0	($424,000)
193	FUNDING ADJUST.—ACA OPT. EXPANSION	$0	($1,736,550,000)	$0	($1,764,846,210)	$0	($28,296,210)
194	FUNDING ADJUST.—OTLICP	$74,000	($171,665,760)	$154,000	($176,826,160)	$80,000	($5,160,400)
195	FFP REPAYMENT FOR CDDS COSTS	$0	$0	$0	$0	$0	$0
196	CLPP FUND	$0	($725,000)	$0	($725,000)	$0	$0
197	CCI-TRANSFER OF IHSS COSTS TO DHCS	$0	($1,871,911,000)	$0	($1,247,758,000)	$0	$624,153,000
198	EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	($675,175,000)	$0	($1,020,525,000)	$0	($345,350,000)
199	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	($198,560,000)	$0	($208,524,000)	$0	($9,964,000)
200	MEDI-CAL RECOVERIES FIFTY PERCENT RULE	$0	$0	($12,160,000)	($12,160,000)	($12,160,000)	($12,160,000)

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2016-17 AND 2017-18

NO.	POLICY CHANGE TITLE	MAY 2017 EST. FOR 2016-17		MAY 2017 EST. FOR 2017-18		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER						
201	MEDICARE BUY-IN QUALITY REVIEW PROJECT RECOVERIES	$0	$0	($2,000,000)	($1,000,000)	($2,000,000)	($1,000,000)
202	NONCONTRACT HOSP INPATIENT COST SETTLEMENTS	($6,096,000)	($3,048,000)	$0	$0	$6,096,000	$3,048,000
205	AUDIT SETTLEMENTS	$548,000	$548,000	$13,928,000	$13,928,000	$13,380,000	$13,380,000
206	INTEGRATION OF THE SF CLSB INTO THE ALW	$0	$0	($746,330)	($373,170)	($746,330)	($373,170)
210	CCI-FFS SAVINGS FOR ADDITIONAL ENROLLMENT	($94,594,000)	($47,297,000)	($332,853,000)	($166,426,500)	($238,259,000)	($119,129,500)
212	HEALTH CARE SVCS. PLANS FINES AND PENALTIES FUND	$0	$0	$0	($46,633,000)	$0	($46,633,000)
224	MEDI-CAL RECOVERIES SETTLEMENTS AND LEGAL COSTS	$0	$0	($1,730,000)	($865,000)	($1,730,000)	($865,000)
227	NOD - SETTLEMENT PAYMENT TO DMC PLANS	$19,999,000	$9,999,500	$0	$0	($19,999,000)	($9,999,500)
228	FY 2015-16 ACCRUAL ADJUSTMENT	$65,357,000	$65,357,000	$0	$0	($65,357,000)	($65,357,000)
	OTHER SUBTOTAL	**$685,581,940**	**($4,610,222,790)**	**$105,761,630**	**($4,572,813,560)**	**($579,820,310)**	**$37,409,230**
	GRAND TOTAL	**$28,819,860,450**	**($832,094,210)**	**$41,685,051,740**	**($2,029,639,540)**	**$12,865,191,290**	**($1,197,545,330)**

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

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

SERVICE CATEGORY	PA-OAS	NEWLY	PA-ATD	PA-AFDC	LT-OAS	H-PE
PHYSICIANS	$10,682,540	$146,055,400	$88,790,260	$39,143,300	$3,013,110	$41,926,150
OTHER MEDICAL	$58,396,130	$980,436,460	$351,879,520	$259,276,770	$5,288,540	$43,068,960
CO. & COMM. OUTPATIENT	$5,726,120	$126,539,320	$109,592,000	$28,046,480	$737,970	$44,087,690
PHARMACY	$4,374,020	$457,628,860	$511,366,910	$53,124,160	$1,919,500	$23,000,230
COUNTY INPATIENT	$5,989,210	$543,415,320	$50,450,470	$27,528,750	$3,636,150	$84,193,400
COMMUNITY INPATIENT	$67,572,390	$1,195,066,690	$640,053,640	$267,435,730	$20,772,690	$226,633,370
NURSING FACILITIES	$217,885,040	$127,585,900	$489,514,560	$3,810,500	$1,264,101,840	$1,217,000
ICF-DD	$1,057,020	$4,467,490	$180,480,140	$426,610	$40,839,480	$0
MEDICAL TRANSPORTATION	$4,979,330	$14,327,930	$14,781,710	$2,712,880	$2,589,190	$2,265,950
OTHER SERVICES	$76,414,750	$24,561,110	$410,198,640	$38,228,810	$63,670,540	$1,340,290
HOME HEALTH	$1,028,550	$1,233,450	$125,598,620	$5,360,470	$55,210	$184,250
FFS SUBTOTAL	**$454,105,100**	**$3,621,317,940**	**$2,972,706,450**	**$725,094,470**	**$1,406,624,230**	**$467,917,300**
DENTAL	$37,114,500	$322,972,850	$98,972,000	$124,220,330	$12,315,160	$0
MENTAL HEALTH	$8,834,490	$190,312,950	$991,611,910	$714,896,230	$1,108,390	$0
TWO PLAN MODEL	$2,113,737,600	$9,232,164,230	$6,854,092,890	$1,481,788,880	$0	$0
COUNTY ORGANIZED HEALTH SYSTEMS	$293,764,870	$3,442,835,700	$1,421,724,920	$289,593,030	$756,353,540	$0
GEOGRAPHIC MANAGED CARE	$199,940,310	$1,681,356,990	$1,083,198,200	$199,377,030	$0	$0
PHP & OTHER MANAG. CARE	$210,965,520	$38,699,750	$133,672,100	$24,628,560	$7,474,140	$0
EPSDT SCREENS	$0	$0	$0	$7,128,640	$0	$0
MEDICARE PAYMENTS	$1,675,781,530	$60,570,480	$1,584,517,690	$2,975,390	$161,645,620	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$11,967,550	$0	$26,995,430	$35,374,070	$1,160,160	$0
MISC. SERVICES	$553,147,440	$0	$4,496,291,250	$4,516,380	$0	$0
DRUG MEDI-CAL	$24,638,620	$227,535,720	$57,122,330	$73,671,900	$2,372,940	$0
REGIONAL MODEL	$9,466,470	$541,089,470	$278,912,330	$61,038,810	$0	$0
NON-FFS SUBTOTAL	**$5,139,358,910**	**$15,737,538,140**	**$17,027,111,050**	**$3,019,209,260**	**$942,429,950**	**$0**
TOTAL DOLLARS (1)	**$5,593,464,010**	**$19,358,856,080**	**$19,999,817,510**	**$3,744,303,740**	**$2,349,054,180**	**$467,917,300**
ELIGIBLES * **	**441,500**	**3,919,600**	**995,900**	**1,305,000**	**42,800**	**30,400**
ANNUAL $/ELIGIBLE	**$12,669**	**$4,939**	**$20,082**	**$2,869**	**$54,884**	**$15,392**
AVG. MO. $/ELIGIBLE	**$1,056**	**$412**	**$1,674**	**$239**	**$4,574**	**$1,283**

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

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

SERVICE CATEGORY	LT-ATD	POV 250	MN-OAS	MN-ATD	MN-AFDC	MI-C
PHYSICIANS	$2,254,920	$17,598,160	$21,850,880	$10,809,190	$147,362,610	$21,346,580
OTHER MEDICAL	$3,200,620	$128,415,920	$109,194,960	$68,602,760	$761,338,940	$84,512,560
CO. & COMM. OUTPATIENT	$655,270	$24,660,540	$16,643,450	$12,138,330	$107,431,660	$12,320,470
PHARMACY	$4,096,620	$38,071,910	$12,823,600	$31,719,090	$133,857,660	$33,120,580
COUNTY INPATIENT	$6,416,670	$3,987,490	$68,293,780	$27,113,200	$142,787,680	$9,564,030
COMMUNITY INPATIENT	$17,667,320	$99,690,060	$164,235,760	$70,023,440	$843,651,800	$84,245,290
NURSING FACILITIES	$282,037,500	$2,034,310	$246,702,660	$49,100,230	$17,173,920	$3,696,550
ICF-DD	$165,240,180	$139,080	$1,164,740	$9,435,550	$1,103,310	$1,861,900
MEDICAL TRANSPORTATION	$819,080	$580,770	$7,347,980	$5,526,310	$5,890,050	$1,009,730
OTHER SERVICES	$9,933,080	$15,578,130	$72,194,180	$64,135,340	$99,880,850	$16,923,520
HOME HEALTH	$8,090	$9,149,870	$936,160	$47,448,750	$9,878,350	$11,486,410
FFS SUBTOTAL	**$492,329,340**	**$339,906,240**	**$721,388,130**	**$396,052,180**	**$2,270,356,820**	**$280,087,620**
DENTAL	$12,315,160	$86,954,230	$37,114,500	$12,371,500	$360,238,940	$24,844,070
MENTAL HEALTH	$3,585,960	$18,452,280	$9,584,280	$102,963,680	$470,809,230	$72,088,410
TWO PLAN MODEL	$0	$856,127,140	$1,796,433,230	$649,834,320	$3,227,037,460	$43,370,160
COUNTY ORGANIZED HEALTH SYSTEMS	$221,830,560	$367,655,880	$396,621,720	$309,476,490	$1,014,221,660	$31,116,680
GEOGRAPHIC MANAGED CARE	$0	$154,067,450	$164,437,200	$111,948,690	$460,100,410	$4,609,720
PHP & OTHER MANAG. CARE	$273,720	$10,033,270	$185,206,510	$21,538,630	$40,744,790	$2,875,150
EPSDT SCREENS	$0	$5,085,230	$0	$0	$19,999,880	$1,091,050
MEDICARE PAYMENTS	$41,414,850	$0	$1,098,245,520	$508,725,150	$95,454,780	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$322,570	$0	$12,425,650	$4,328,920	$99,220,880	$5,426,740
MISC. SERVICES	$0	($55,255,930)	$587,252,390	$734,063,000	$12,929,190	$727,190
DRUG MEDI-CAL	$681,940	$55,786,170	$26,157,740	$9,741,230	$214,190,730	$11,941,290
REGIONAL MODEL	$0	$45,276,120	$31,118,780	$24,350,480	$162,286,480	$808,500
NON-FFS SUBTOTAL	**$280,424,750**	**$1,544,181,830**	**$4,344,597,520**	**$2,489,342,100**	**$6,177,234,430**	**$198,898,950**
TOTAL DOLLARS (1)	**$772,754,090**	**$1,884,088,070**	**$5,065,985,660**	**$2,885,394,280**	**$8,447,591,250**	**$478,986,580**
ELIGIBLES * **	**11,900**	**930,900**	**468,000**	**166,100**	**3,660,400**	**199,700**
ANNUAL $/ELIGIBLE	**$64,937**	**$2,024**	**$10,825**	**$17,371**	**$2,308**	**$2,399**
AVG. MO. $/ELIGIBLE	**$5,411**	**$169**	**$902**	**$1,448**	**$192**	**$200**

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

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

SERVICE CATEGORY	MI-A	REFUGEE	OBRA	POV 185	POV 133	POV 100
PHYSICIANS	$286,570	$294,070	$807,240	$118,422,100	$12,392,660	$5,559,620
OTHER MEDICAL	$424,600	$1,377,360	$914,020	$203,434,740	$122,898,150	$70,222,670
CO. & COMM. OUTPATIENT	$76,100	$140,540	$562,930	$26,426,270	$11,590,740	$6,741,930
PHARMACY	$730,130	$202,890	$843,160	$13,468,580	$10,748,430	$18,443,770
COUNTY INPATIENT	$20,450	$12,070	$931,130	$75,966,880	$3,467,840	$2,434,410
COMMUNITY INPATIENT	$491,050	$394,450	$11,020,150	$888,061,840	$82,788,540	$37,160,550
NURSING FACILITIES	$22,018,570	$350	$4,116,680	$2,010,930	$4,577,310	$29,710
ICF-DD	$960,250	$0	$383,330	$0	$0	$250
MEDICAL TRANSPORTATION	$68,080	$7,430	$110,150	$1,915,960	$492,730	$180,910
OTHER SERVICES	$444,240	$14,230	$46,270	$11,991,310	$17,438,350	$11,221,710
HOME HEALTH	$40	$0	$770	$3,128,690	$2,981,460	$893,850
FFS SUBTOTAL	**$25,520,070**	**$2,443,390**	**$19,735,840**	**$1,344,827,310**	**$269,376,210**	**$152,889,390**
DENTAL	$12,422,030	$12,422,030	$13,023,030	$39,069,100	$65,115,160	$39,069,100
MENTAL HEALTH	$32,600	$114,170	$231,050	$1,155,240	$6,142,310	$20,548,830
TWO PLAN MODEL	$52,380	$1,395,760	$0	$198,031,110	$754,540,950	$383,836,740
COUNTY ORGANIZED HEALTH SYSTEMS	$106,360	$216,230	$89,120	$75,318,140	$259,385,450	$139,232,420
GEOGRAPHIC MANAGED CARE	$6,410	$438,840	$0	$27,595,890	$105,151,090	$58,206,900
PHP & OTHER MANAG. CARE	$1,433,140	$0	$0	$4,299,970	$7,166,620	$4,299,970
EPSDT SCREENS	$0	$0	$0	$0	$4,147,370	$2,006,560
MEDICARE PAYMENTS	$0	$0	$0	$0	$0	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$43,370	$0	$67,770	$40,660	$0	$9,956,240
MISC. SERVICES	$100	$0	$0	$66,920	$2,066,990	$1,130,690
DRUG MEDI-CAL	$33,270	$99,800	$0	$22,531,800	$41,570,730	$20,524,790
REGIONAL MODEL	$0	$19,850	$0	$9,889,490	$36,931,310	$17,412,860
NON-FFS SUBTOTAL	**$14,129,650**	**$14,706,680**	**$13,410,970**	**$377,998,320**	**$1,282,217,980**	**$696,225,090**
TOTAL DOLLARS (1)	**$39,649,730**	**$17,150,070**	**$33,146,810**	**$1,722,825,630**	**$1,551,594,200**	**$849,114,480**
ELIGIBLES * **	**1,600**	**2,500**	**1,500**	**378,700**	**759,200**	**367,300**
ANNUAL $/ELIGIBLE	**$24,781**	**$6,860**	**$22,098**	**$4,549**	**$2,044**	**$2,312**
AVG. MO. $/ELIGIBLE	**$2,065**	**$572**	**$1,841**	**$379**	**$170**	**$193**

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

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

SERVICE CATEGORY	TOTAL
PHYSICIANS	**$688,595,360**
OTHER MEDICAL	**$3,252,883,670**
CO. & COMM. OUTPATIENT	**$534,117,800**
PHARMACY	**$1,349,540,100**
COUNTY INPATIENT	**$1,056,208,940**
COMMUNITY INPATIENT	**$4,716,964,760**
NURSING FACILITIES	**$2,737,613,550**
ICF-DD	**$407,559,330**
MEDICAL TRANSPORTATION	**$65,606,190**
OTHER SERVICES	**$934,215,360**
HOME HEALTH	**$219,373,000**
FFS SUBTOTAL	**$15,962,678,050**
DENTAL	**$1,310,553,680**
MENTAL HEALTH	**$2,612,472,000**
TWO PLAN MODEL	**$27,592,442,870**
COUNTY ORGANIZED HEALTH SYSTEMS	**$9,019,542,770**
GEOGRAPHIC MANAGED CARE	**$4,250,435,120**
PHP & OTHER MANAG. CARE	**$693,311,850**
EPSDT SCREENS	**$39,458,730**
MEDICARE PAYMENTS	**$5,229,331,000**
STATE HOSP./DEVELOPMENTAL CNTRS.	**$207,330,000**
MISC. SERVICES	**$6,336,935,630**
DRUG MEDI-CAL	**$788,601,000**
REGIONAL MODEL	**$1,218,600,950**
NON-FFS SUBTOTAL	**$59,299,015,590**
TOTAL DOLLARS (1)	**$75,261,693,640**
ELIGIBLES * **	**13,683,000**
ANNUAL $/ELIGIBLE	**$5,500**
AVG. MO. $/ELIGIBLE	**$458**

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

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

EXCLUDED POLICY CHANGES: 79

1	FAMILY PACT PROGRAM
4	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL
5	BREAST AND CERVICAL CANCER TREATMENT
7	COUNTY HEALTH INITIATIVE MATCHING (CHIM)
8	MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL
10	NON-OTLICP CHIP
13	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN
23	1% FMAP INCREASE FOR PREVENTIVE SERVICES
26	ACA MAGI SAVINGS
28	ACA DSH REDUCTION
58	FAMILY PACT DRUG REBATES
67	DRUG MEDI-CAL PROGRAM COST SETTLEMENT
72	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT
76	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT
80	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL
81	GLOBAL PAYMENT PROGRAM
82	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS
83	BTR - LIHP - MCE
84	LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND
85	BTR - LOW INCOME HEALTH PROGRAM - HCCI
87	MH/UCD—HEALTH CARE COVERAGE INITIATIVE
88	MH/UCD—STABILIZATION FUNDING
89	MH/UCD—SAFETY NET CARE POOL
90	MH/UCD & BTR—CCS AND GHPP
91	BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE POOL
92	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG
93	BTR—DESIGNATED STATE HEALTH PROGRAMS
94	MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP
95	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM
110	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)
111	PALLIATIVE CARE SERVICES IMPLEMENTATION
114	MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ.
115	MCO ENROLLMENT TAX MANAGED CARE PLANS
116	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT

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

EXCLUDED POLICY CHANGES: 79

117	MCO TAX MANAGED CARE PLANS
118	MANAGED CARE IGT ADMIN. & PROCESSING FEE
119	GENERAL FUND REIMBURSEMENTS FROM DPHS
126	DENTAL RETROACTIVE RATE CHANGES
129	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS
134	EMERGENCY MEDICAL AIR TRANSPORTATION ACT
141	DP/NF-B RETROACTIVE RECOUPMENT FORGIVENESS
143	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES
147	EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS
148	PRIVATE HOSPITAL DSH REPLACEMENT
149	DSH PAYMENT
150	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
151	NDPH IGT SUPPLEMENTAL PAYMENTS
153	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS
154	CAPITAL PROJECT DEBT REIMBURSEMENT
155	FFP FOR LOCAL TRAUMA CENTERS
156	DPH PHYSICIAN & NON-PHYS. COST
157	HOSPITAL QAF - HOSPITAL PAYMENTS
158	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS
159	GEMT SUPPLEMENTAL PAYMENT PROGRAM
160	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH
161	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH
162	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS
163	IGT PAYMENTS FOR HOSPITAL SERVICES
164	NDPH SUPPLEMENTAL PAYMENT
165	FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS
174	ARRA HITECH - PROVIDER PAYMENTS
178	MEDI-CAL TCM PROGRAM
189	CDDS DENTAL SERVICES
191	MANAGED CARE ADMIN FINES AND PENALTIES REVENUE
196	CLPP FUND
197	CCI-TRANSFER OF IHSS COSTS TO DHCS
198	EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE
199	CIGARETTE AND TOBACCO SURTAX FUNDS

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

EXCLUDED POLICY CHANGES: 79

205	AUDIT SETTLEMENTS
212	HEALTH CARE SVCS. PLANS FINES AND PENALTIES FUND
214	DP-NF CAPITAL PROJECT DEBT REPAYMENT
215	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS
216	BORDER OUT-OF-STATE DIAGNOSIS RELATED GROUP
217	TRANSITIONAL SMHS CLAIMS
221	MEC OPTIONAL EXPANSION ADJUSTMENT
222	CMS DEFERRED CLAIMS
223	CMS DEFERRALS & NEGATIVE BALANCE REPAYMENT
227	NOD - SETTLEMENT PAYMENT TO DMC PLANS
228	FY 2015-16 ACCRUAL ADJUSTMENT

Estimated Average Monthly Certified Eligibles
May 2017 Estimate
Fiscal Years 2015-2016, 2016-2017 & 2017-2018

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

	2015-2016	2016-2017	2017-2018	15-16 To 16-17 % Change	16-17 To 17-18 % Change
Public Assistance	**2,846,700**	**2,746,900**	**2,742,400**	**-3.51%**	**-0.16%**
Seniors	434,300	435,900	441,500	0.37%	1.28%
Persons with Disabilities [6]	1,012,600	998,200	995,900	-1.42%	-0.23%
Families [2]	1,399,800	1,312,800	1,305,000	-6.22%	-0.59%
Long Term	**56,200**	**54,700**	**54,700**	**-2.67%**	**0.00%**
Seniors	43,300	42,700	42,800	-1.39%	0.23%
Persons with Disabilities [6]	12,900	12,000	11,900	-6.98%	-0.83%
Medically Needy [1]	**4,457,900**	**4,298,600**	**4,278,500**	**-3.57%**	**-0.47%**
Seniors	421,800	445,000	458,400	5.50%	3.01%
Persons with Disabilities [6]	172,200	161,900	159,700	-5.98%	-1.36%
Families [2]	3,863,900	3,691,700	3,660,400	-4.46%	-0.85%
Medically Indigent	**241,900**	**203,200**	**201,300**	**-16.00%**	**-0.94%**
Children	240,600	201,600	199,700	-16.21%	-0.94%
Adults	1,300	1,600	1,600	23.08%	0.00%
Other	**5,780,600**	**6,248,300**	**6,411,200**	**8.09%**	**2.61%**
Refugees	1,600	2,200	2,500	37.50%	13.64%
OBRA [3]	33,900	3,100	1,500	-90.86%	-51.61%
185% Poverty [4]	360,800	375,400	378,700	4.05%	0.88%
133% Poverty	617,000	744,200	759,200	20.62%	2.02%
100% Poverty	325,100	359,600	367,300	10.61%	2.14%
Opt. Targeted Low Income Children	966,900	940,500	930,900	-2.73%	-1.02%
ACA Optional Expansion	3,430,500	3,773,100	3,919,600	9.99%	3.88%
Hospital PE	26,600	30,400	30,400	14.29%	0.00%
Medi-Cal Access Program [7]	4,700	4,400	5,100	-6.38%	15.91%
QMB	13,500	15,400	16,000	14.07%	3.90%
GRAND TOTAL [5]	**13,383,300**	**13,551,700**	**13,688,100**	**1.26%**	**1.01%**
Seniors and Persons with Disabilities	**2,097,100**	**2,095,700**	**2,110,200**	-0.07%	0.69%
Families and Children [8]	**7,172,700**	**7,048,800**	**7,022,800**	-1.73%	-0.37%

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:

	2015-2016	2016-2017	2017-2018
Presumptive Eligibility	17,800	17,400	17,600

[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, 133% Poverty, 100% Poverty, and Optional Targeted Low Income Children categories. Medically Indigent Children category is not included because of the placement of the temporary placement of adults in 8E when their eligibility determination was over 45 days.

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 2015-16	2016-17	2017-18
PC 3 Medi-Cal State Inmates	LT Seniors	117	42	42
	MN Seniors	70	22	22
	MN Persons with Disabilities	14	4	4
	MI Children	5	7	7
	185% Poverty	5	1	1
	ACA Optional Expansion	515	259	259
	Total	**726**	**336**	**336**
PC 4 Medi-Cal Access Program Mothers 213-322%	MCAP Mothers	3,055	3,507	4,229
	Total	**3,055**	**3,507**	**4,229**
PC 8 Medi-Cal Access Program Infants 266-322%	MCAP Infants	1,678	852	853
	Total	**1,678**	**852**	**853**
PC 14 PARIS-Veterans	PA Seniors	0	0	0
	PA Persons with Disabilities	0	0	0
	PA Families	0	(1)	(1)
	LT Seniors	(1)	(3)	(3)
	MN Seniors	(2)	(5)	(8)
	MN Persons with Disabilities	(2)	(3)	(1)
	MN Families	0	(2)	(2)
	MI Adults	(7)	(13)	(13)
	Total	**(12)**	**(27)**	**(27)**
PC 15 Minimum Wage Increase - Caseload Savings	MN Families	0	(792)	(792)
	MI Children	0	(56)	(56)
	185% Poverty	0	0	0
	133% Poverty	0	0	0
	100% Poverty	0	(68)	(68)
	OTLICP	0	0	0
	ACA Optional Expansion	0	(1,920)	(1,920)
	Total	**0**	**(2,837)**	**(2,837)**

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 2015-16	2016-17	2017-18
	By Aid Category Group			
	PA Seniors	0	0	0
	PA Persons with Disabilities	0	0	0
Total by aid code group	PA Families	0	(1)	(1)
	LT Seniors	116	39	39
	LT Persons with Disabilities	0	0	0
	MN Seniors	68	17	14
	MN Persons with Disabilities	12	1	3
	MN Families	0	(795)	(794)
	MI Children	5	(49)	(49)
	MI Adults	(7)	(13)	(13)
	Undocumented Persons	0	0	0
	185% Poverty	5	1	1
	133% Poverty	0	0	0
	100% Poverty	0	(68)	(68)
	OTLICP	0	0	0
	ACA Optional Expansion	515	(1,661)	(1,661)
	MCAP Infants	1,678	852	853
	MCAP Mothers	3,055	3,507	4,229
	Refugees	0	0	0
	Total	**5,447**	**1,831**	**2,554**

Comparison of Average Monthly Certified Eligibles
May 2017 Estimate
Fiscal Year 2016-17

(With Estimated Impact of Eligibility Policy Changes)

	Appropriaton 2016-2017	Nov 2016 2016-2017	May 2017 2016-2017	Appropriation to Nov % Change	Nov to May % Change
Public Assistance	**2,873,800**	**2,780,800**	**2,746,900**	**-3.24%**	**-1.22%**
Seniors	440,700	437,800	435,900	-0.66%	-0.43%
Persons with Disabilities [2]	1,031,400	1,016,200	998,200	-1.47%	-1.77%
Families	1,401,700	1,326,800	1,312,800	-5.34%	-1.06%
Long Term	**56,300**	**55,100**	**54,700**	**-2.13%**	**-0.73%**
Seniors	43,400	42,800	42,700	-1.38%	-0.23%
Persons with Disabilities [2]	12,900	12,300	12,000	-4.65%	-2.44%
Medically Needy [1]	**4,634,500**	**4,463,500**	**4,298,600**	**-3.69%**	**-3.69%**
Seniors	456,500	452,300	445,000	-0.92%	-1.61%
Persons with Disabilities [2]	182,000	169,000	161,900	-7.14%	-4.20%
Families	3,996,000	3,842,200	3,691,700	-3.85%	-3.92%
Medically Indigent	**225,300**	**215,800**	**203,200**	**-4.22%**	**-5.84%**
Children	224,700	215,200	201,600	-4.23%	-6.32%
Adults	600	600	1,600	0.00%	166.67%
Other	**6,327,800**	**6,510,300**	**6,248,300**	**2.88%**	**-4.02%**
Refugees	1,800	1,800	2,200	0.00%	22.22%
OBRA	34,300	12,700	3,100	-62.97%	-75.59%
185% Poverty	384,100	394,200	375,400	2.63%	-4.77%
133% Poverty	670,700	737,400	744,200	9.94%	0.92%
100% Poverty	348,100	361,700	359,600	3.91%	-0.58%
Opt. Targeted Low Income Children	1,007,200	985,600	940,500	-2.14%	-4.58%
ACA Optional Expansion	3,842,200	3,972,100	3,773,100	3.38%	-5.01%
Hospital PE	26,000	26,800	30,400	3.08%	13.43%
Medi-Cal Access Program [3]	0	4,100	4,400	n/a	7.32%
QMB	13,400	13,900	15,400	3.73%	10.79%
GRAND TOTAL	**14,117,700**	**14,025,500**	**13,551,700**	**-0.65%**	**-3.38%**

[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 purposes.

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

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

(With Estimated Impact of Eligibility Policy Changes)

	November 2016 2017-18	May 2017 2017-18	% Change
Public Assistance	**2,803,500**	**2,742,400**	**-2.18%**
Seniors	444,400	441,500	-0.65%
Persons with Disabilities [2]	1,030,300	995,900	-3.34%
Families	1,328,800	1,305,000	-1.79%
Long Term	**55,100**	**54,700**	**-0.73%**
Seniors	42,800	42,800	0.00%
Persons with Disabilities [2]	12,300	11,900	-3.25%
Medically Needy [1]	**4,510,800**	**4,278,500**	**-5.15%**
Seniors	471,800	458,400	-2.84%
Persons with Disabilities [2]	175,700	159,700	-9.11%
Families	3,863,300	3,660,400	-5.25%
Medically Indigent	**216,400**	**201,300**	**-6.98%**
Children	215,800	199,700	-7.46%
Adults	600	1,600	166.67%
Other	**6,696,100**	**6,411,200**	**-4.25%**
Refugees	1,800	2,500	38.89%
OBRA	12,700	1,500	-88.19%
185% Poverty	406,400	378,700	-6.82%
133% Poverty	749,800	759,200	1.25%
100% Poverty	370,200	367,300	-0.78%
Opt. Targeted Low Income Children	1,006,200	930,900	-7.48%
ACA Optional Expansion	4,104,000	3,919,600	-4.49%
Hospital PE	26,700	30,400	13.86%
Medi-Cal Access Program	4,400	5,100	15.91%
QMB	13,900	16,000	15.11%
GRAND TOTAL	**14,281,900**	**13,688,100**	**-4.16%**

[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 purposes.

Estimated Average Monthly Certified Eligibles
May 2017 Estimate
Fiscal Years 2015-2016, 2016-2017 & 2017-2018

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

	2015-2016	2016-2017	2017-2018	15-16 To 16-17 % Change	16-17 To 17-18 % Change
Public Assistance	**2,364,650**	**2,339,170**	**2,349,000**	**-1.08%**	**0.42%**
Seniors	316,290	317,530	326,300	0.39%	2.76%
Persons with Disabilities [4]	828,600	838,750	844,450	1.22%	0.68%
Families [2]	1,219,760	1,182,890	1,178,250	-3.02%	-0.39%
Long Term	**28,170**	**26,350**	**27,700**	**-6.46%**	**5.12%**
Seniors	21,900	20,730	21,920	-5.34%	5.74%
Persons with Disabilities [4]	6,270	5,620	5,780	-10.37%	2.85%
Medically Needy [1]	**3,146,250**	**3,206,380**	**3,206,790**	**1.91%**	**0.01%**
Seniors	270,800	294,170	308,170	8.63%	4.76%
Persons with Disabilities [4]	111,460	105,500	107,000	-5.35%	1.42%
Families [2]	2,763,990	2,806,710	2,791,620	1.55%	-0.54%
Medically Indigent	**51,820**	**46,060**	**45,470**	**-11.12%**	**-1.28%**
Children	51,670	45,970	45,380	-11.03%	-1.28%
Adults	150	90	90	-40.00%	0.00%
Other	**4,708,230**	**5,164,110**	**5,271,650**	**9.68%**	**2.08%**
Refugees	930	1,250	1,360	34.41%	8.80%
OBRA	650	60	40	-90.77%	-33.33%
185% Poverty	173,800	193,640	195,180	11.42%	0.80%
133% Poverty	560,070	689,940	704,510	23.19%	2.11%
100% Poverty	293,950	338,130	344,280	15.03%	1.82%
Opt. Targeted Low Income Childrer	888,350	874,960	865,760	-1.51%	-1.05%
ACA Optional Expansion	2,787,360	3,063,370	3,157,160	9.90%	3.06%
Medi-Cal Access Program [5]	3,120	2,760	3,360	-11.54%	21.74%
GRAND TOTAL [3]	**10,299,120**	**10,782,070**	**10,900,610**	**4.69%**	**1.10%**
Percent of Statewide	**76.96%**	**79.56%**	**79.64%**		

***** 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
May 2017 Estimate
Fiscal Years 2015-2016, 2016-2017 & 2017-2018

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

	2015-2016	2016-2017	2017-2018	15-16 To 16-17 % Change	16-17 To 17-18 % Change
Public Assistance	**482,050**	**407,730**	**393,400**	**-15.42%**	**-3.51%**
Seniors	118,010	118,370	115,200	0.31%	-2.68%
Persons with Disabilities [3]	184,000	159,450	151,450	-13.34%	-5.02%
Families [2]	180,040	129,910	126,750	-27.84%	-2.43%
Long Term	**28,030**	**28,350**	**27,000**	**1.14%**	**-4.76%**
Seniors	21,400	21,970	20,880	2.66%	-4.96%
Persons with Disabilities [3]	6,630	6,380	6,120	-3.77%	-4.08%
Medically Needy [1]	**1,311,650**	**1,092,220**	**1,071,710**	**-16.73%**	**-1.88%**
Seniors	151,000	150,830	150,230	-0.11%	-0.40%
Persons with Disabilities [3]	60,740	56,400	52,700	-7.15%	-6.56%
Families [2]	1,099,910	884,990	868,780	-19.54%	-1.83%
Medically Indigent	**190,080**	**157,140**	**155,830**	**-17.33%**	**-0.83%**
Children	188,930	155,630	154,320	-17.63%	-0.84%
Adults	1,150	1,510	1,510	31.30%	0.00%
Other	**1,072,370**	**1,084,190**	**1,139,550**	**1.10%**	**5.11%**
Refugees	670	950	1,140	41.79%	20.00%
OBRA	33,250	3,040	1,460	-90.86%	-51.97%
185% Poverty	187,000	181,760	183,520	-2.80%	0.97%
133% Poverty	56,930	54,260	54,690	-4.69%	0.79%
100% Poverty	31,150	21,470	23,020	-31.08%	7.22%
Opt. Targeted Low Income Children	78,550	65,540	65,140	-16.56%	-0.61%
ACA Optional Expansion	643,140	709,730	762,440	10.35%	7.43%
Hospital PE	26,600	30,400	30,400	14.29%	0.00%
Medi-Cal Access Program [4]	1,580	1,640	1,740	3.80%	6.10%
QMB	13,500	15,400	16,000	14.07%	3.90%
GRAND TOTAL	**3,084,180**	**2,769,630**	**2,787,490**	**-10.20%**	**0.64%**
Percent of Statewide	**23.04%**	**20.44%**	**20.36%**		

***** 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.

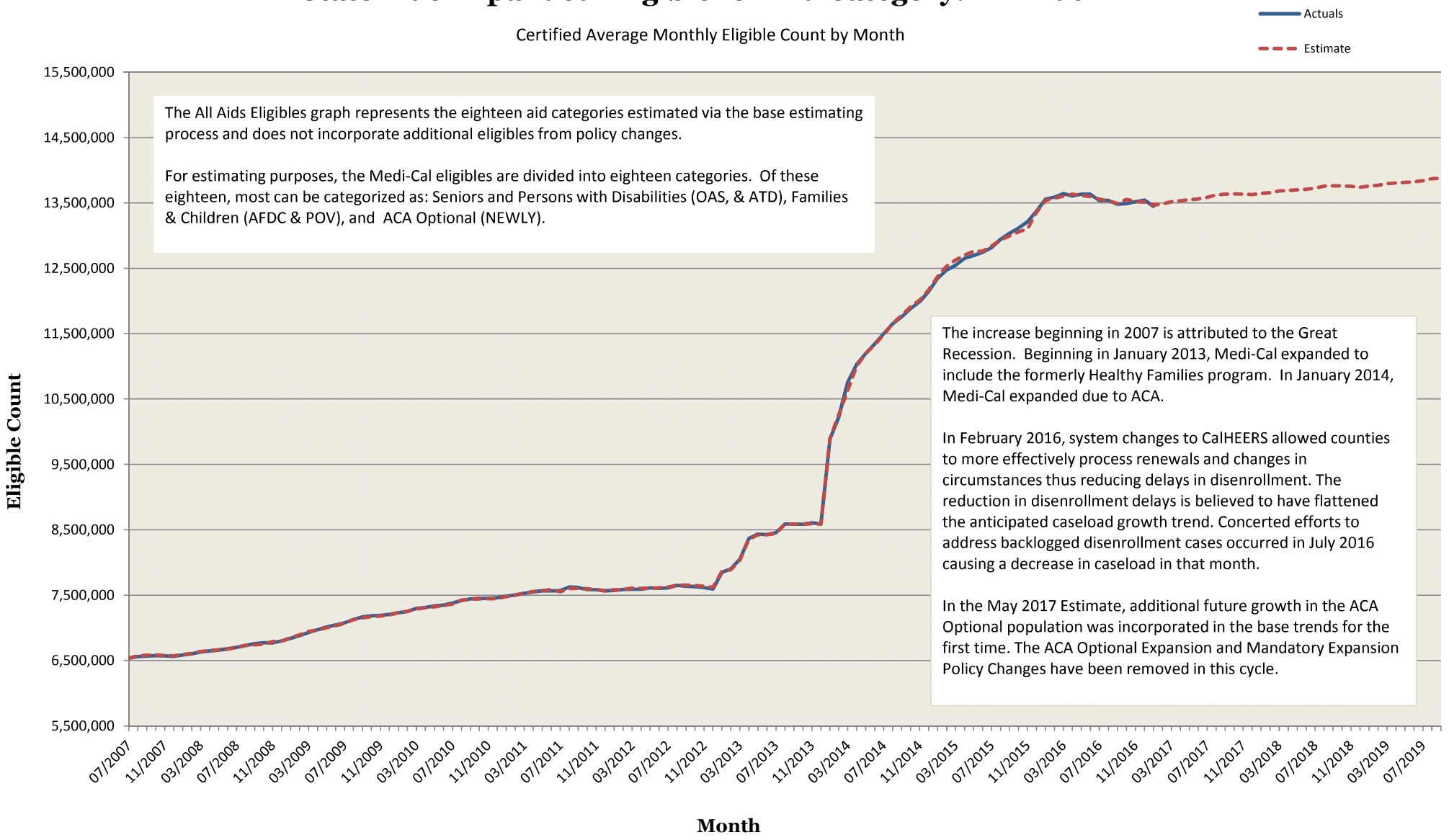
[2] The 1931(b) category of eligibility is included in MN-Families and PA-Families.

[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



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

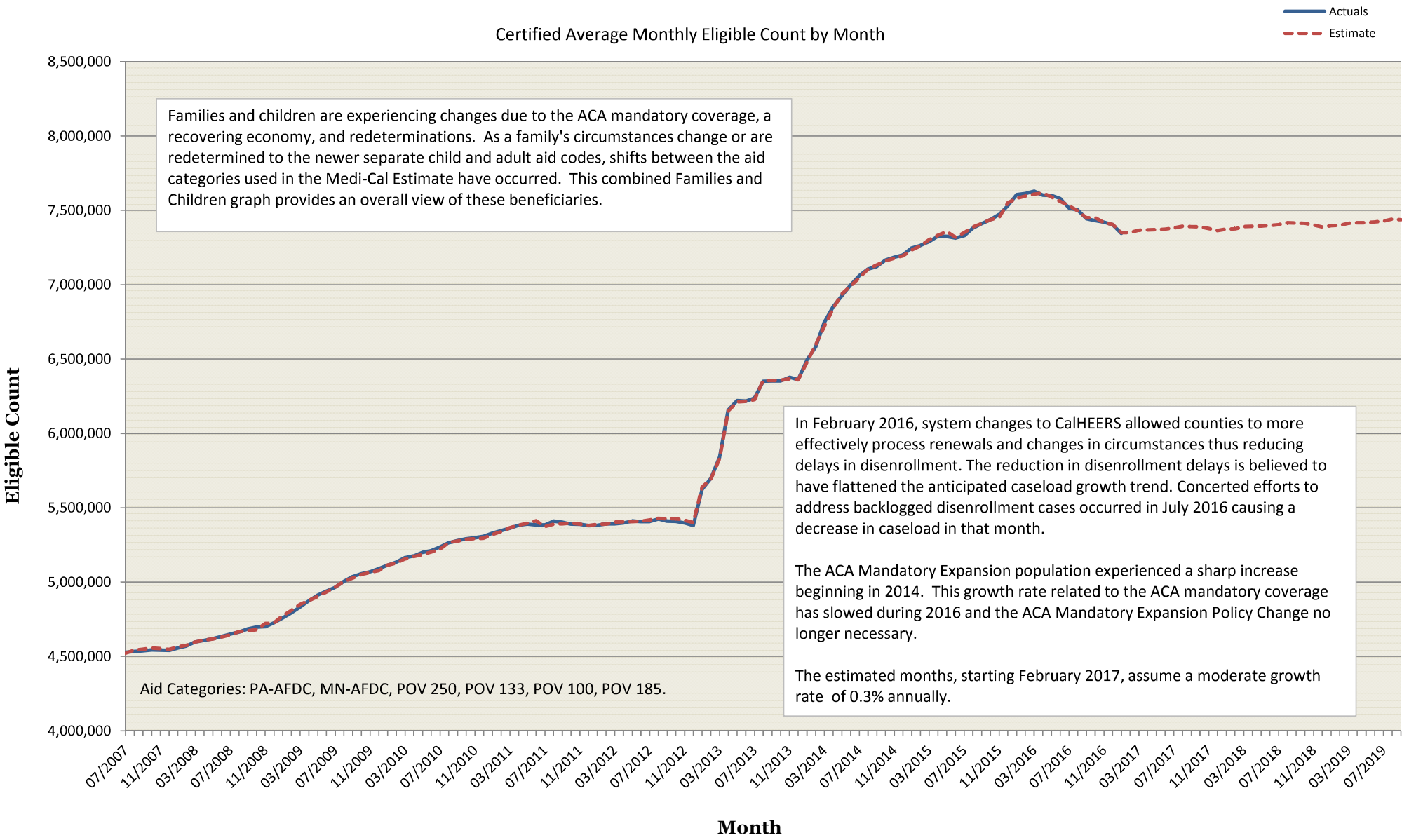
For estimating purposes, the Medi-Cal eligibles are divided into eighteen categories. Of these eighteen, most can be categorized as: Seniors and Persons with Disabilities (OAS, & ATD), Families & Children (AFDC & POV), and ACA Optional (NEWLY).

The increase beginning in 2007 is attributed to the Great Recession. Beginning in January 2013, Medi-Cal expanded to include the formerly Healthy Families program. In January 2014, Medi-Cal expanded due to ACA.

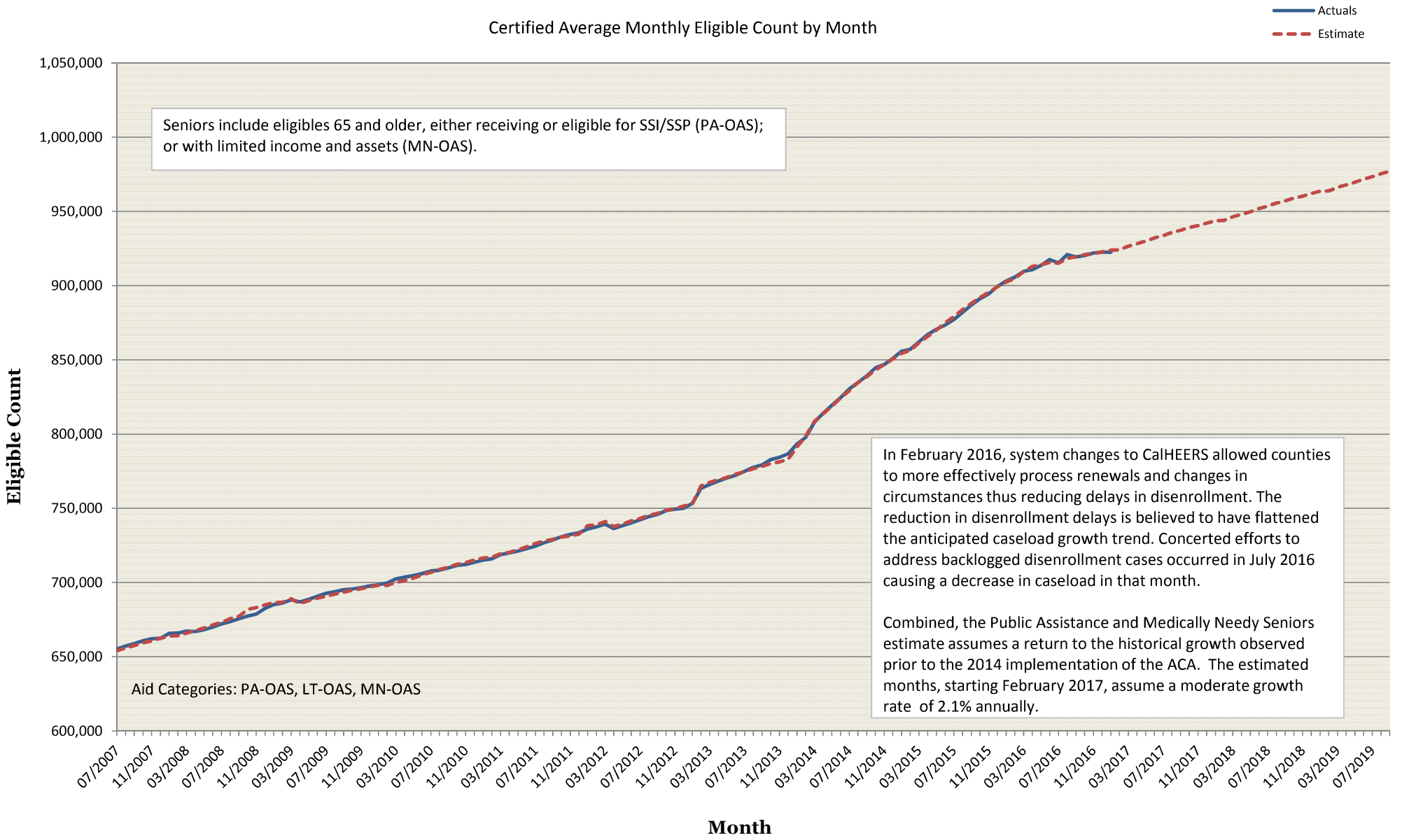
In February 2016, system changes to CalHEERS allowed counties to more effectively process renewals and changes in circumstances thus reducing delays in disenrollment. The reduction in disenrollment delays is believed to have flattened the anticipated caseload growth trend. Concerted efforts to address backlogged disenrollment cases occurred in July 2016 causing a decrease in caseload in that month.

In the May 2017 Estimate, additional future growth in the ACA Optional population was incorporated in the base trends for the first time. The ACA Optional Expansion and Mandatory Expansion Policy Changes have been removed in this cycle.

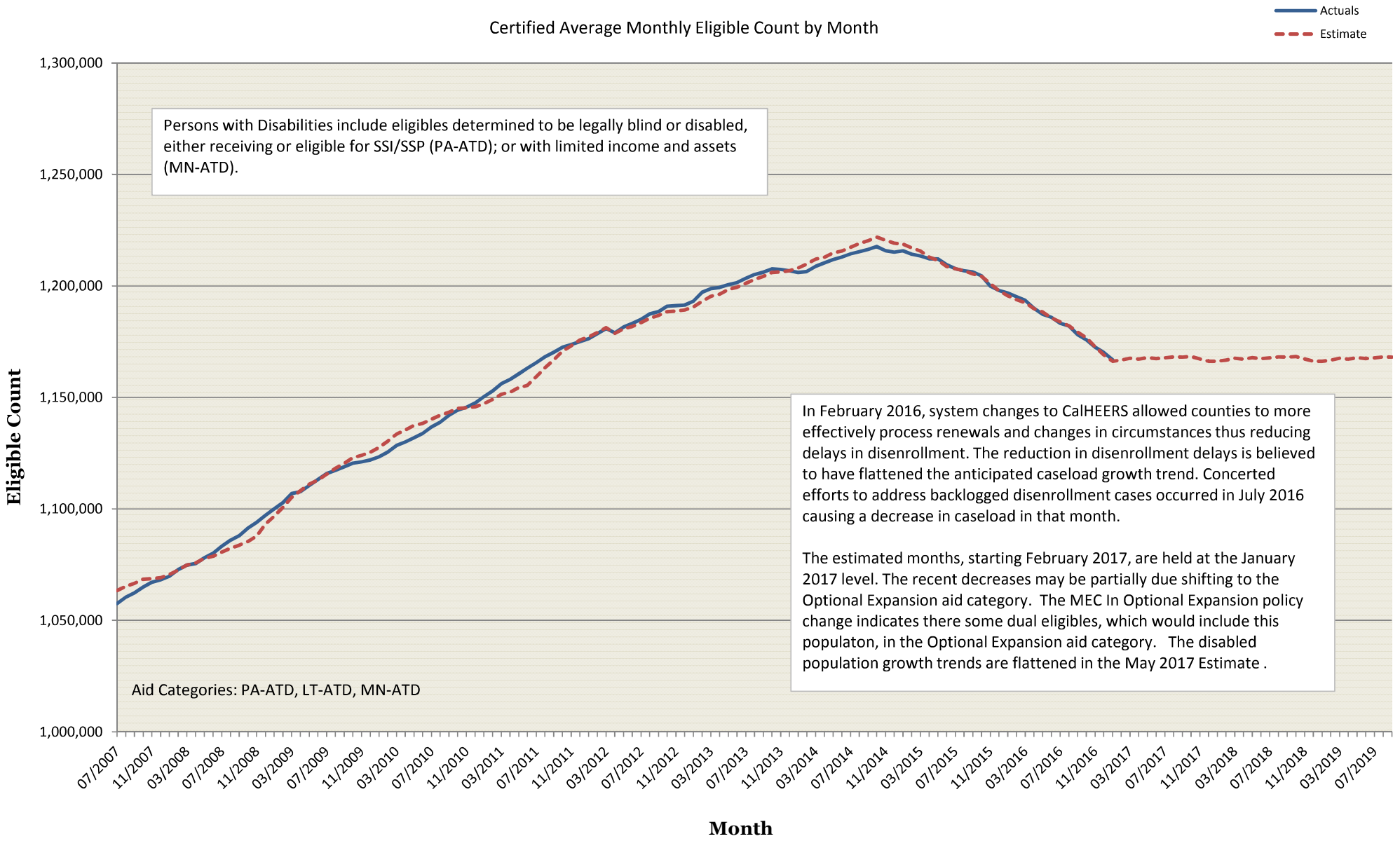
Statewide Expanded Eligible for Aid Category: Families and Children with POV-185



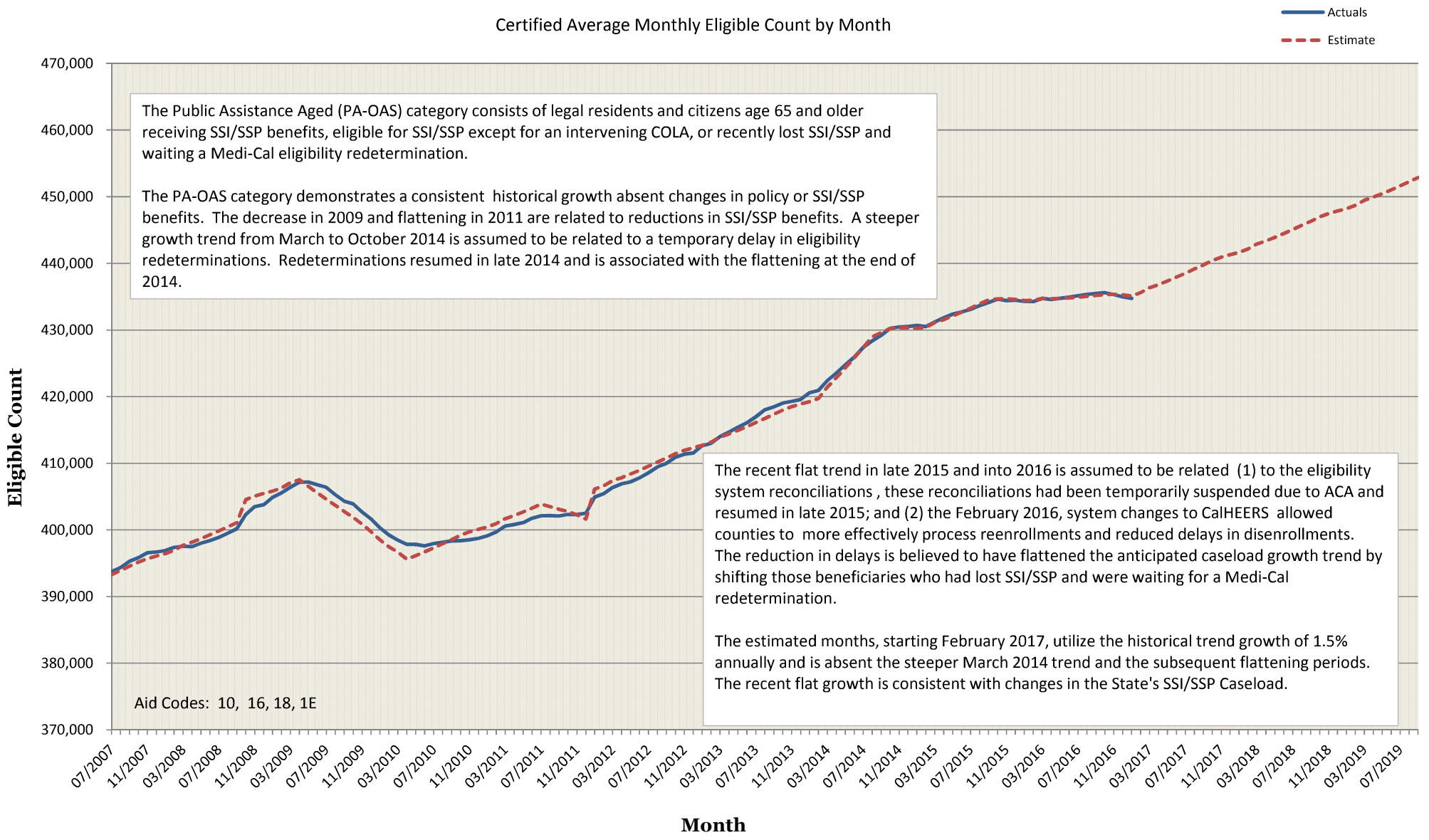
Statewide Expanded Eligible for Aid Category: Seniors



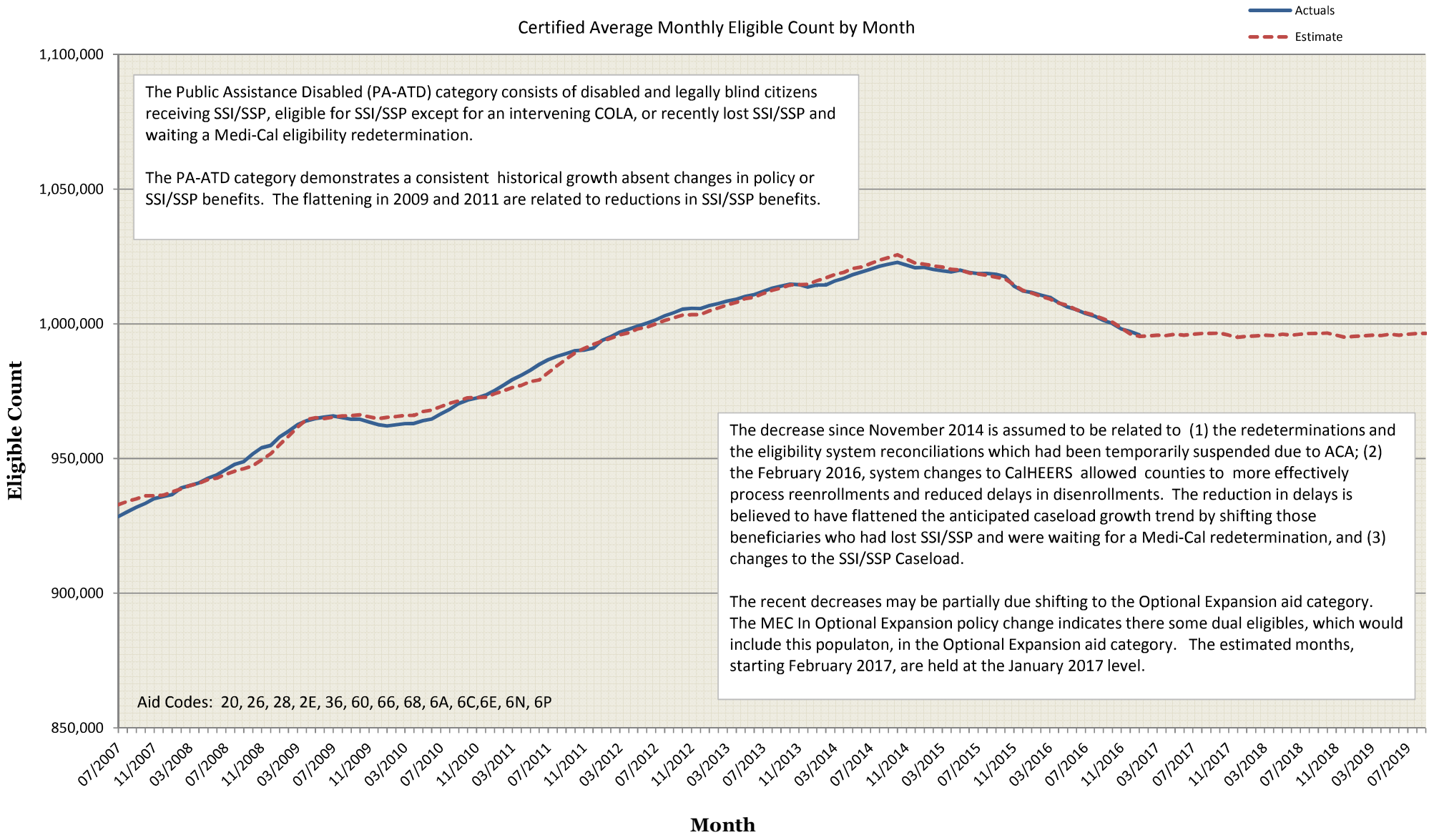
Statewide Expanded Eligible for Aid Category: Persons with Disabilities



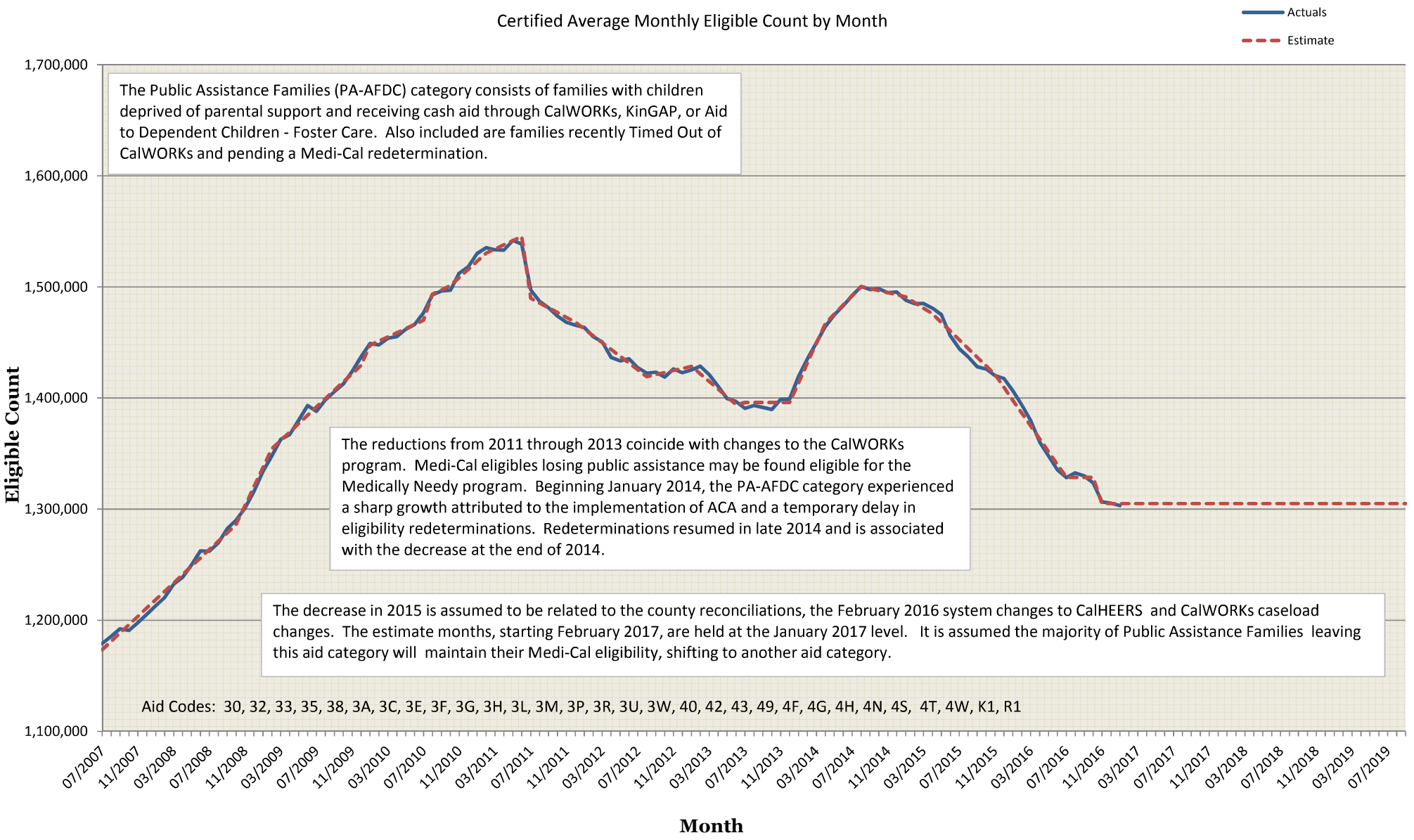
Statewide Expanded Eligible: Public Assistance Seniors (PA-OAS)



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

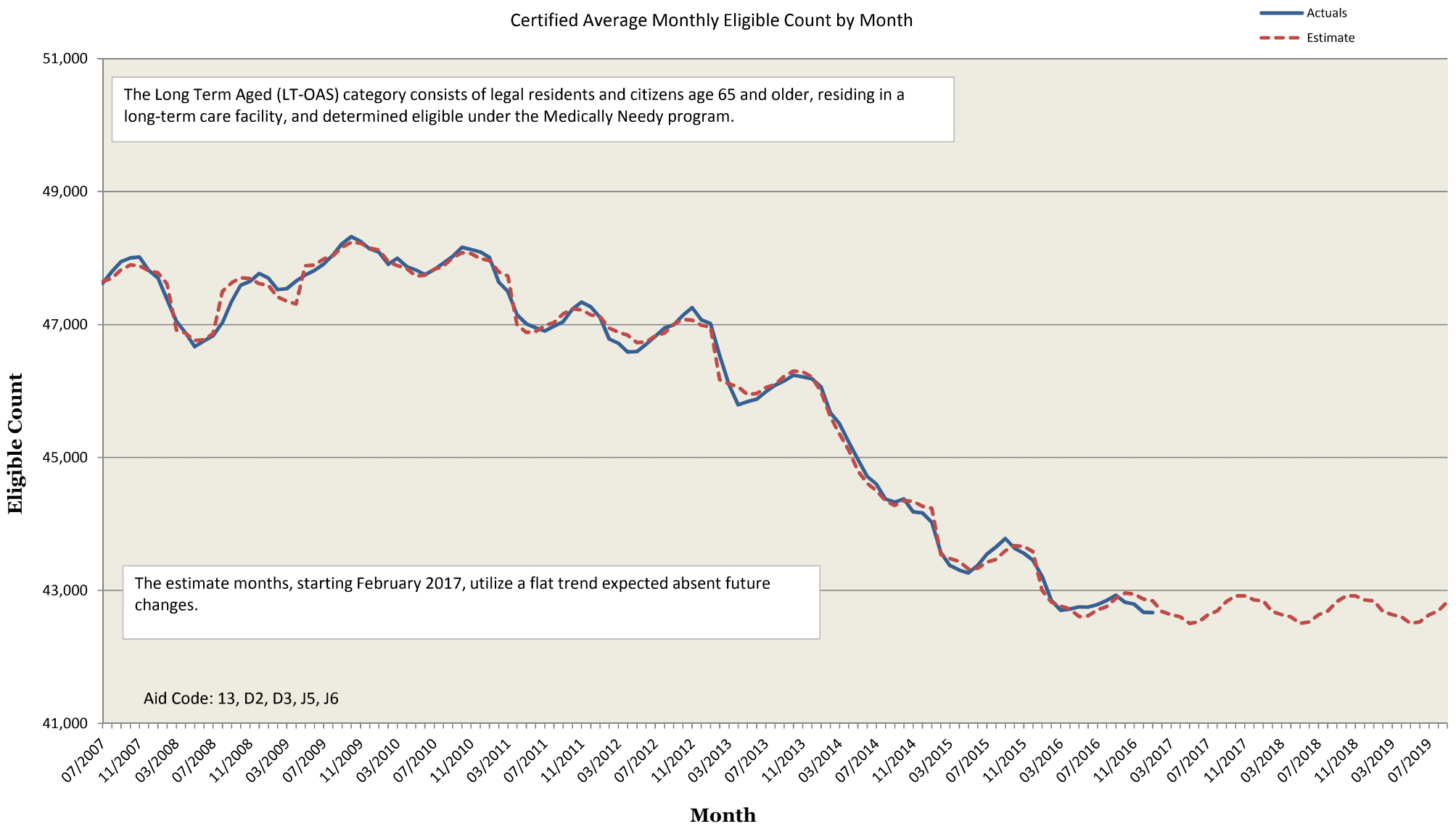


Statewide Expanded Eligible: Public Assistance Families (PA-AFDC)

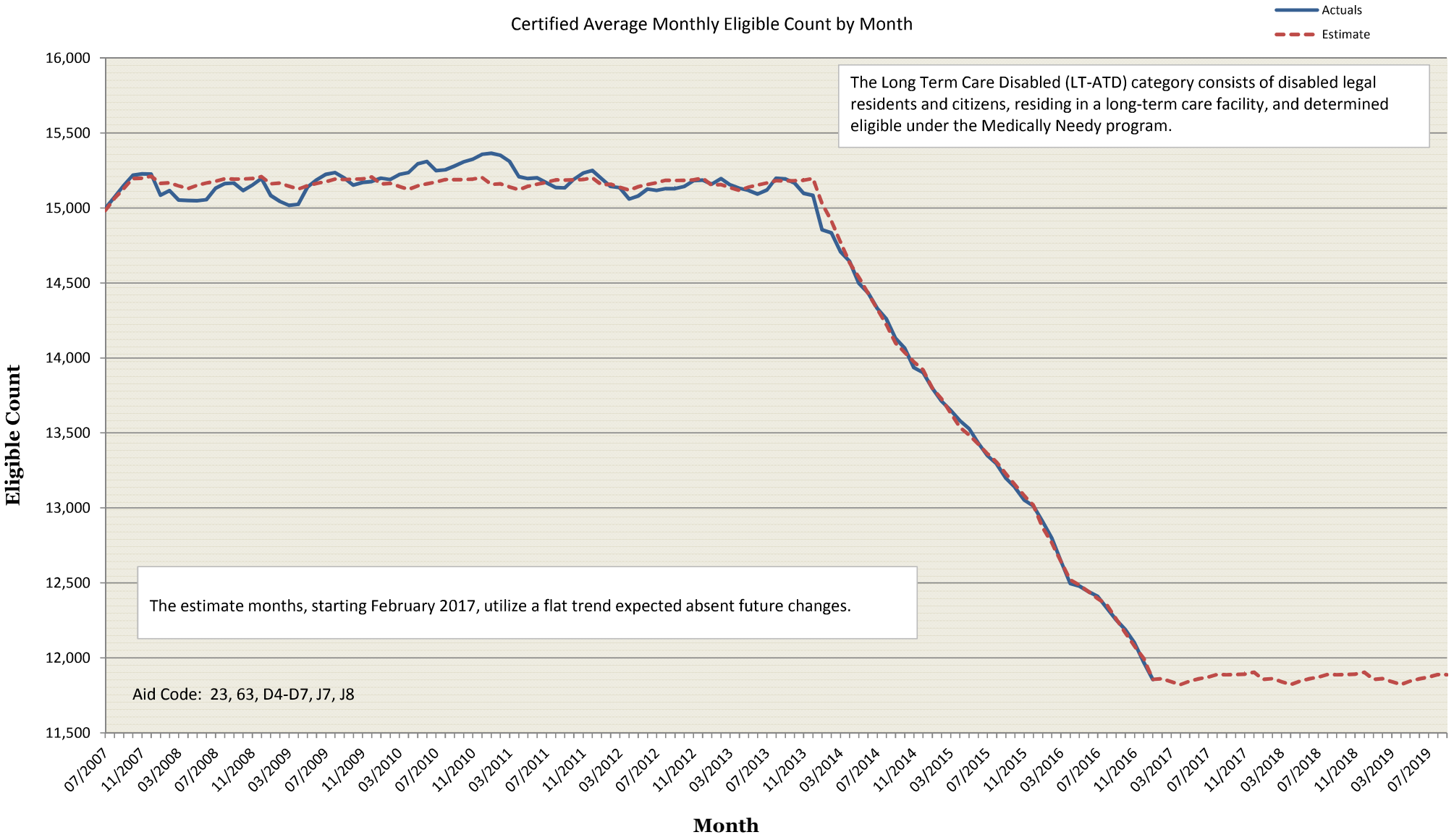


Statewide Expanded Eligible: Long Term Seniors (LT-OAS)

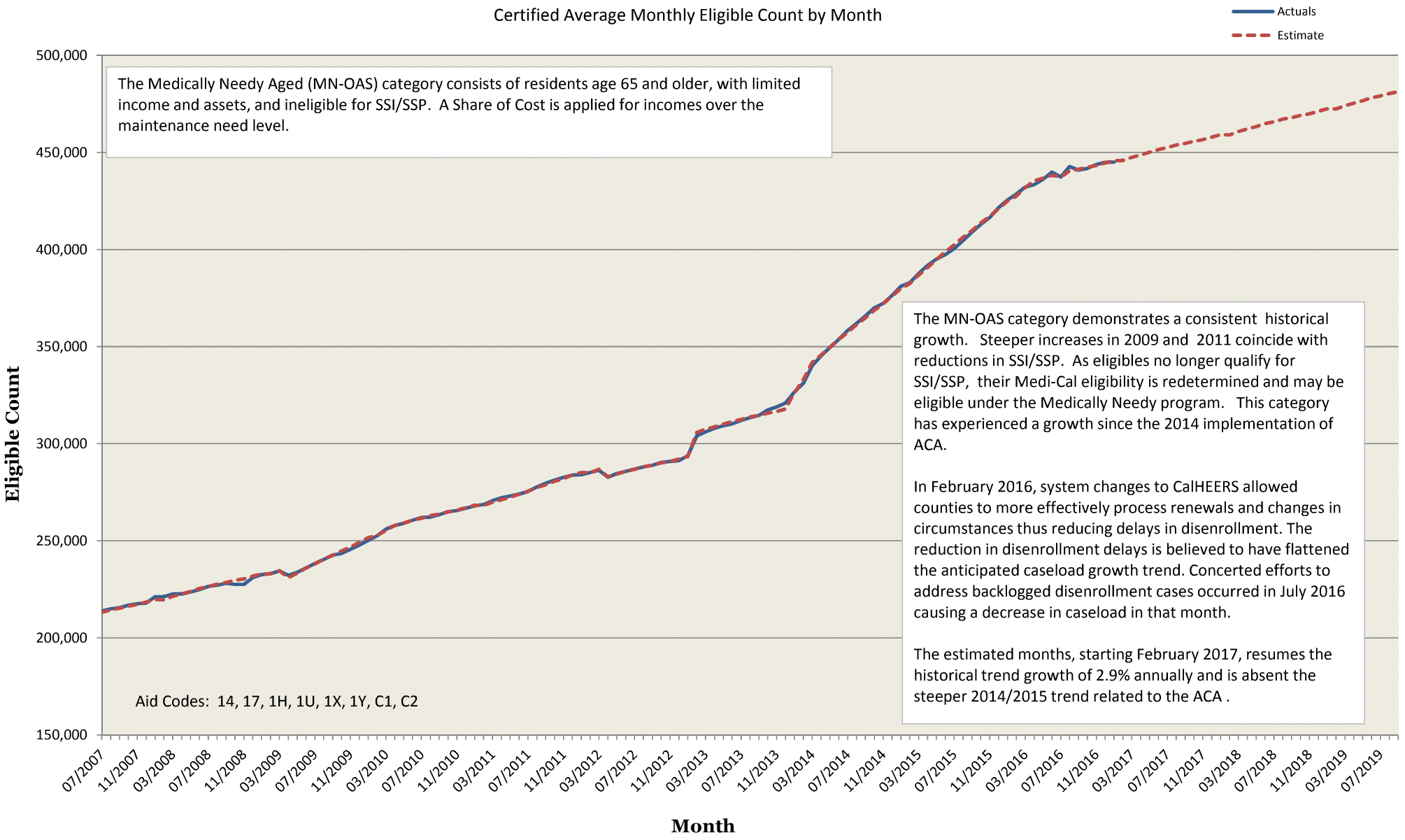
Certified Average Monthly Eligible Count by Month



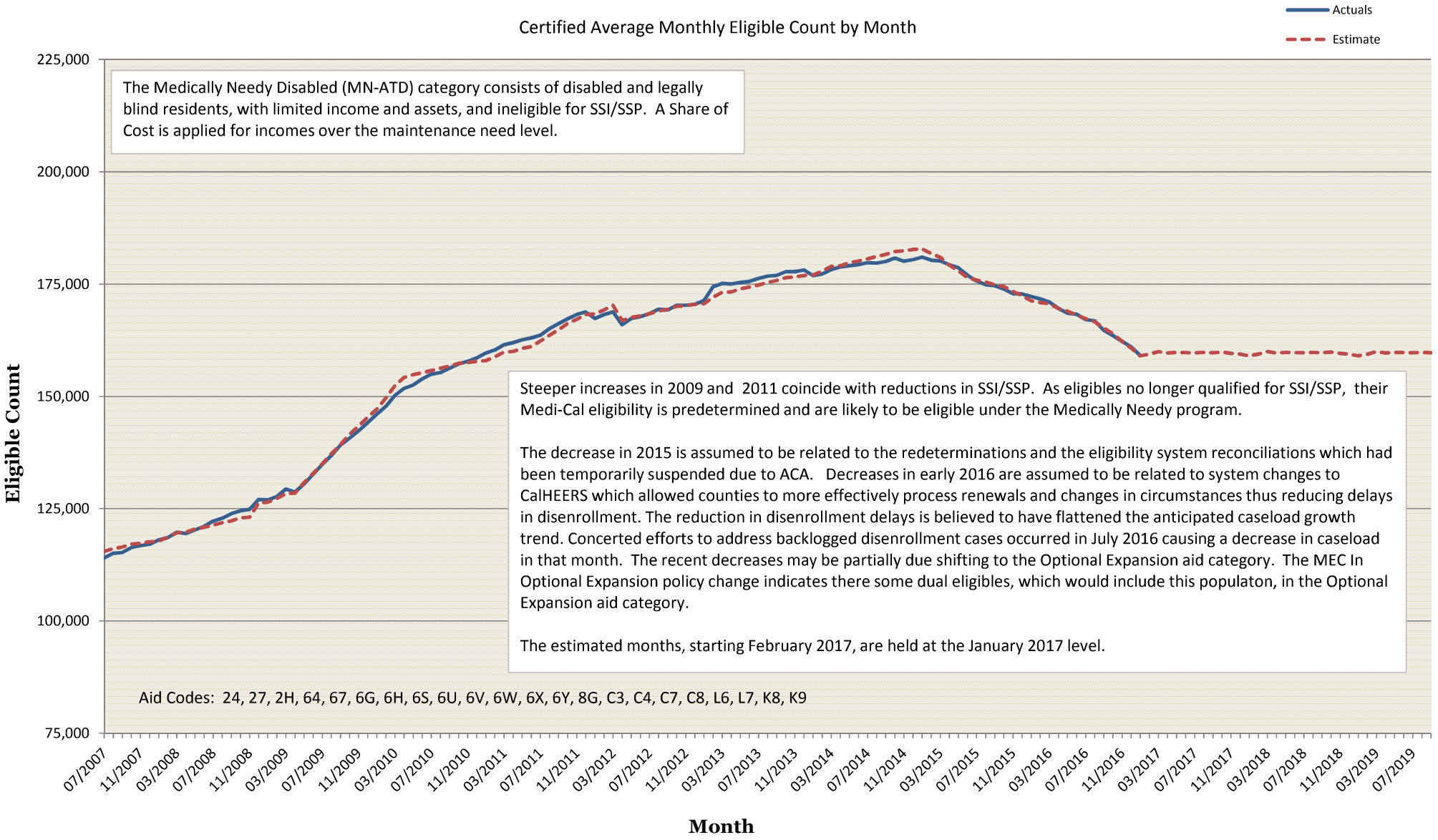
Statewide Expanded Eligible: Long Term Persons with Disabilities (LT-ATD)



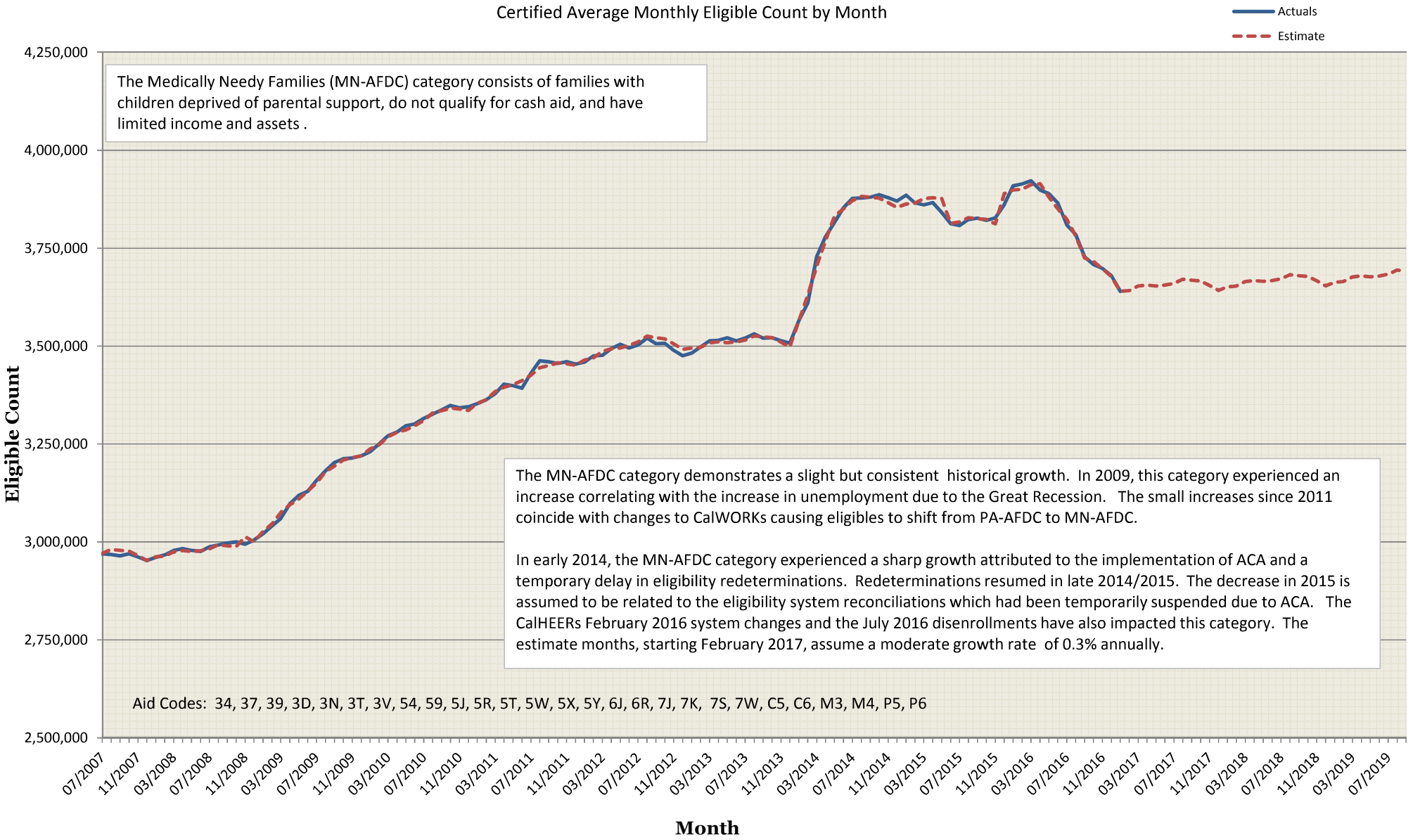
Statewide Expanded Eligible: Medically Needy Seniors (MN-OAS)



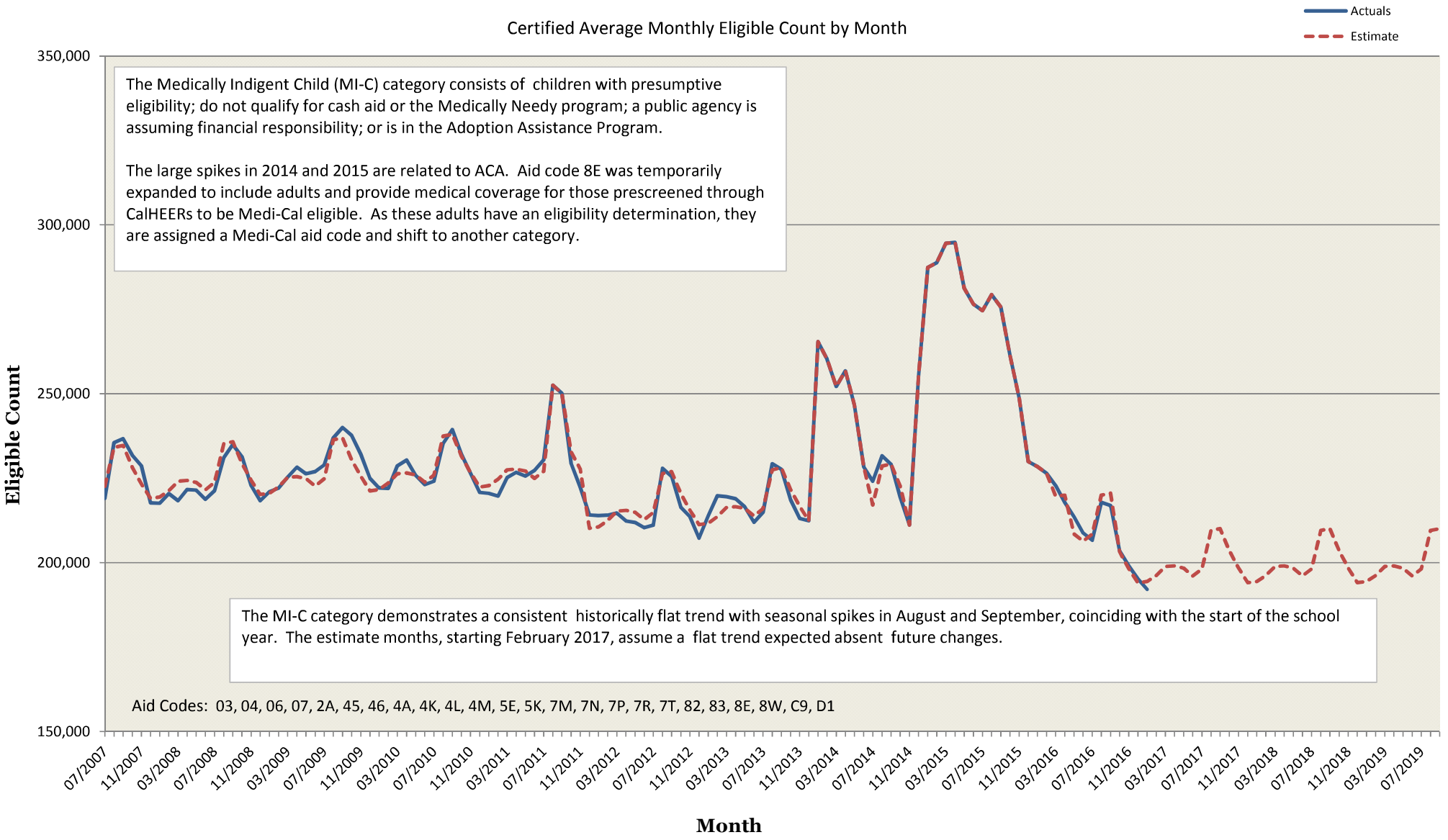
Statewide Expanded Eligible: Medically Needy Persons with Disabilities (MN-ATD)



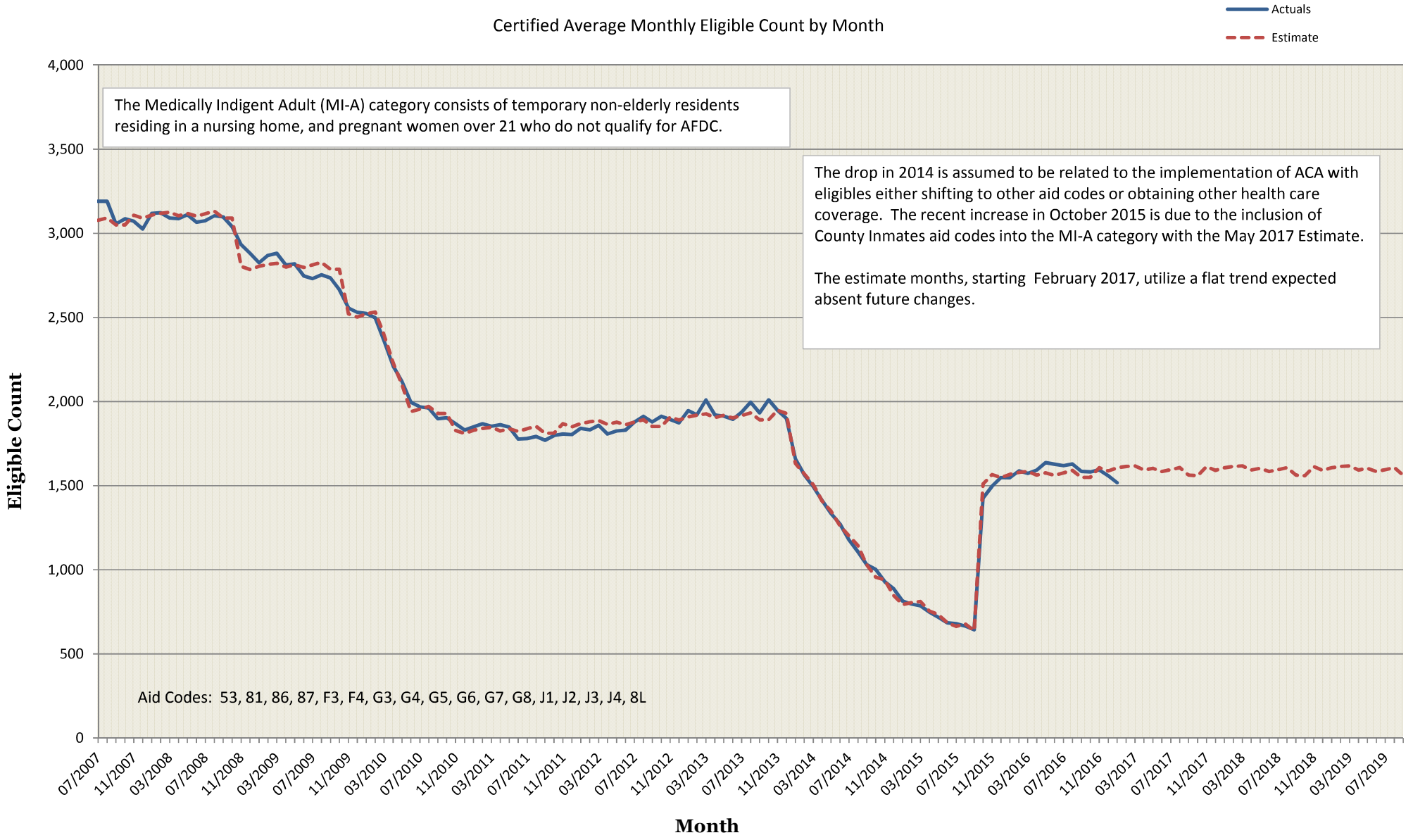
Statewide Expanded Eligible: Medically Needy Families (MN-AFDC)



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

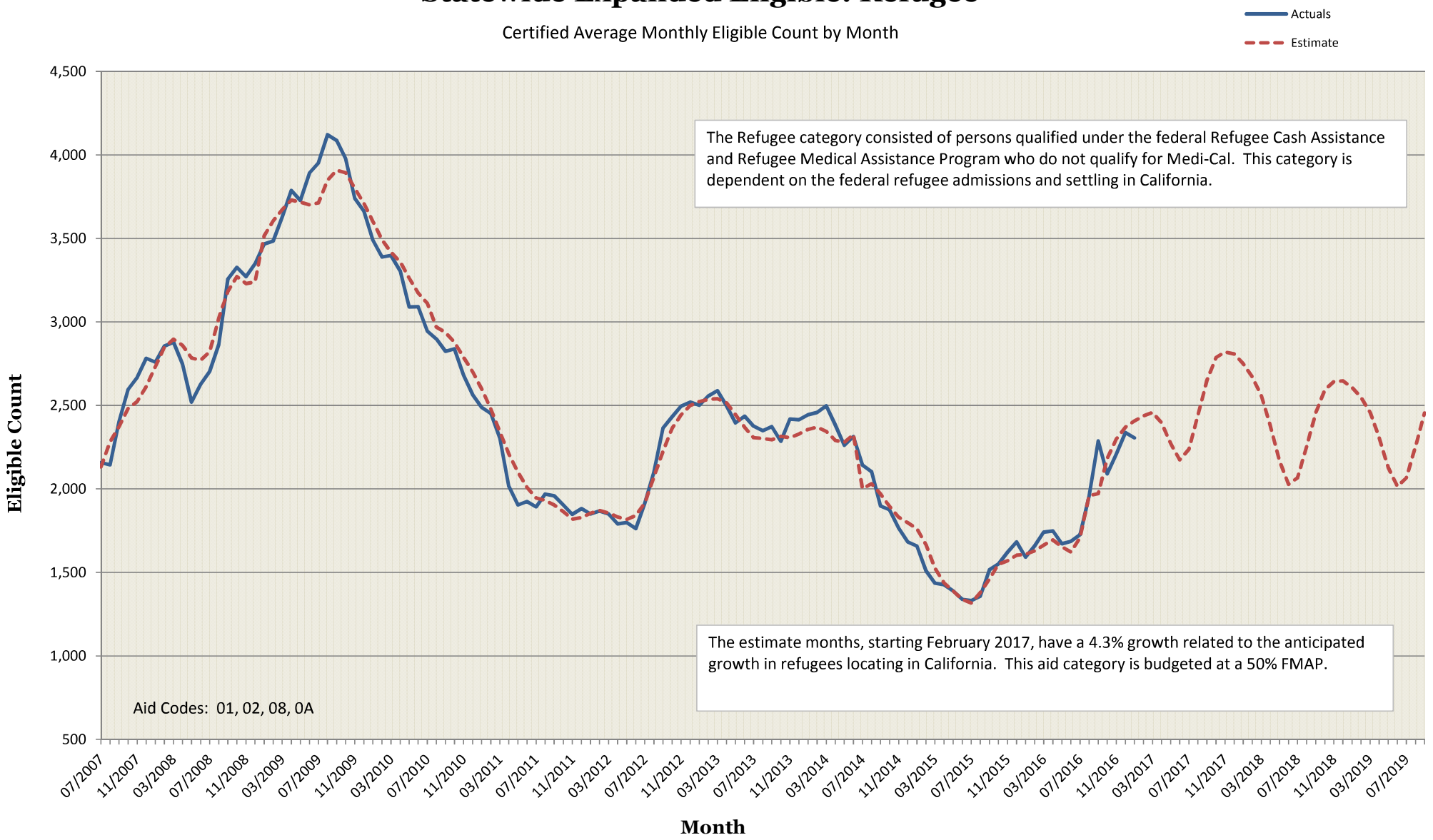


Statewide Expanded Eligible: Medically Indigent Adults (MI-A)



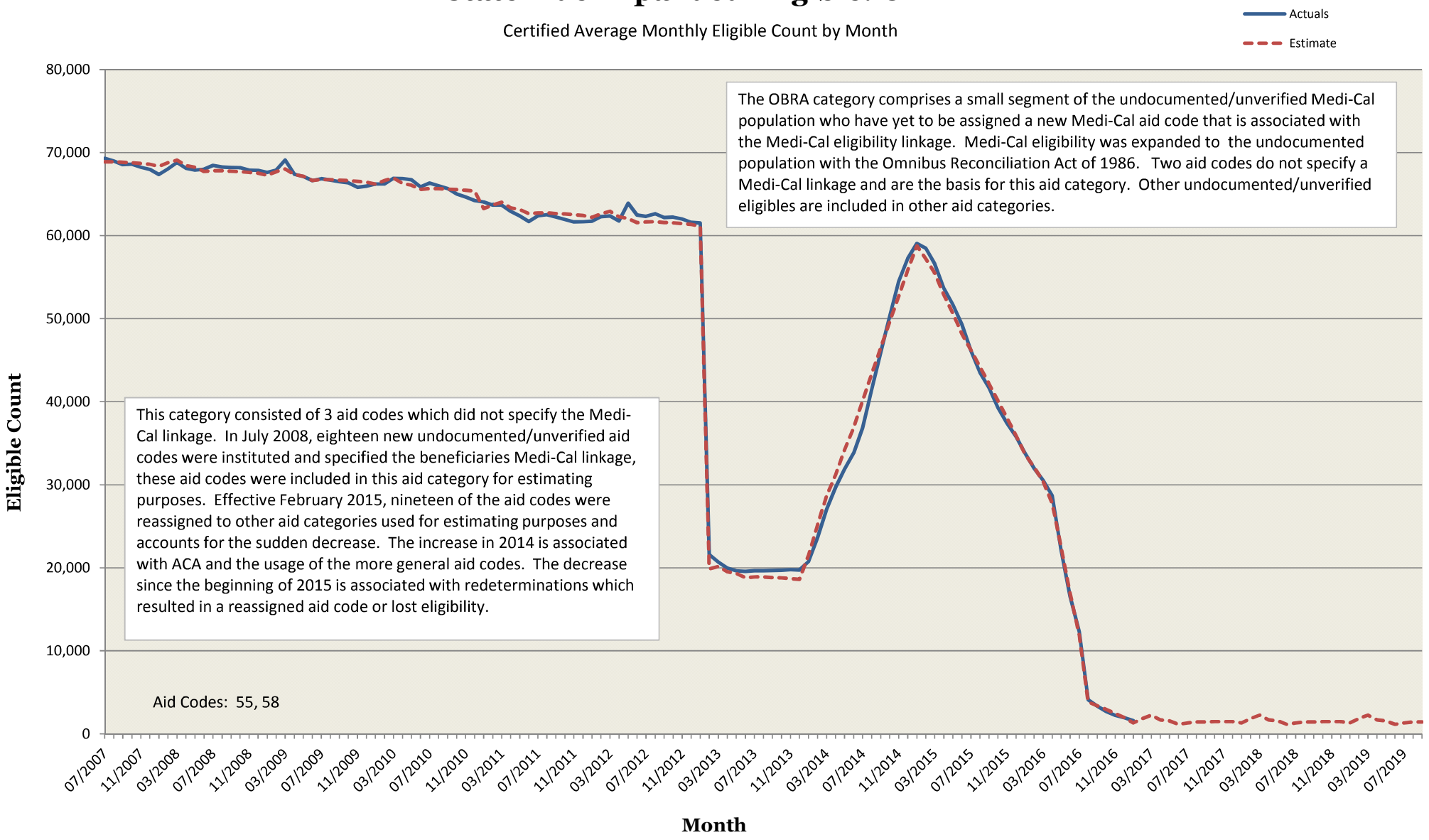
Statewide Expanded Eligible: Refugee

Certified Average Monthly Eligible Count by Month

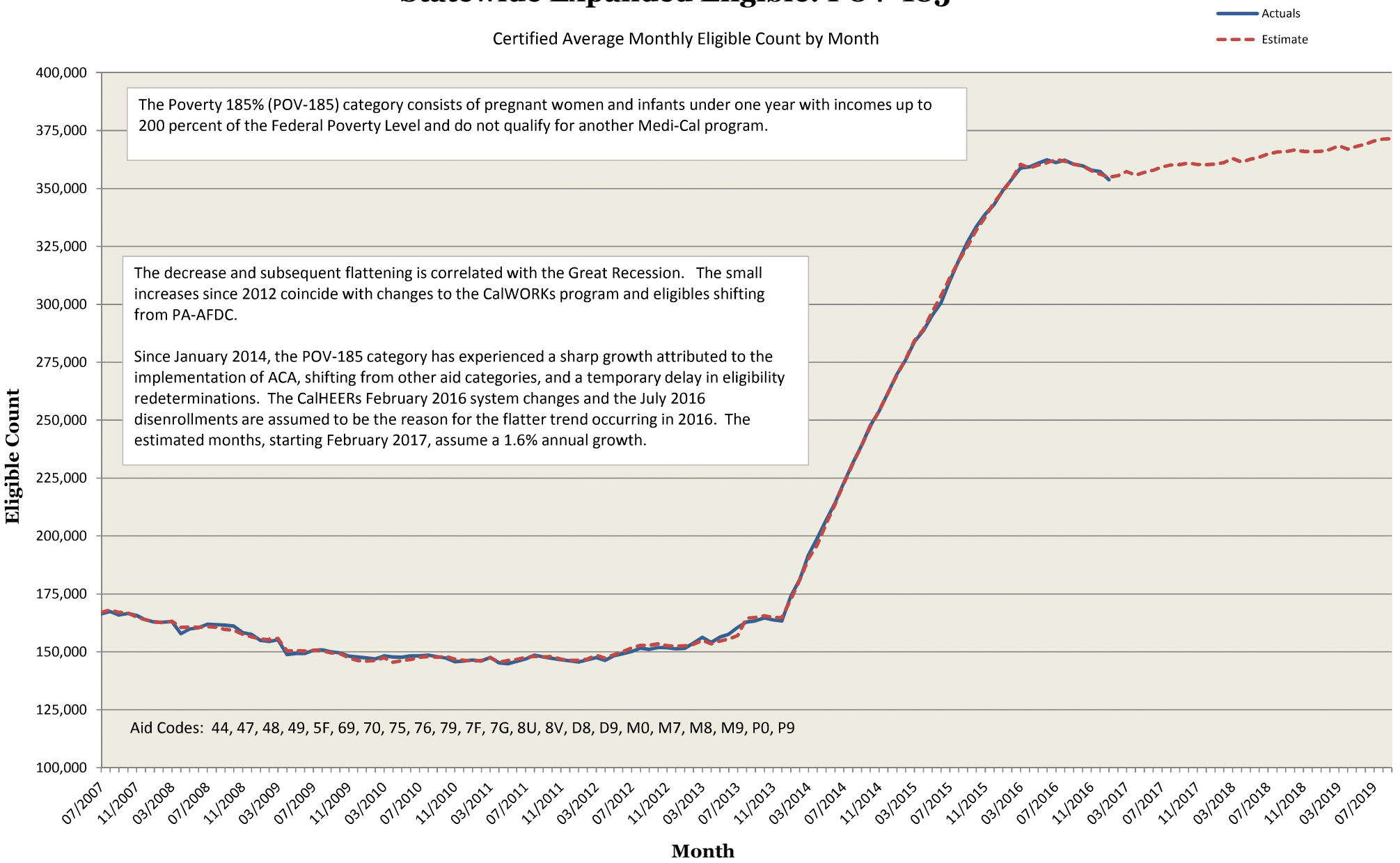


Statewide Expanded Eligible: OBRA

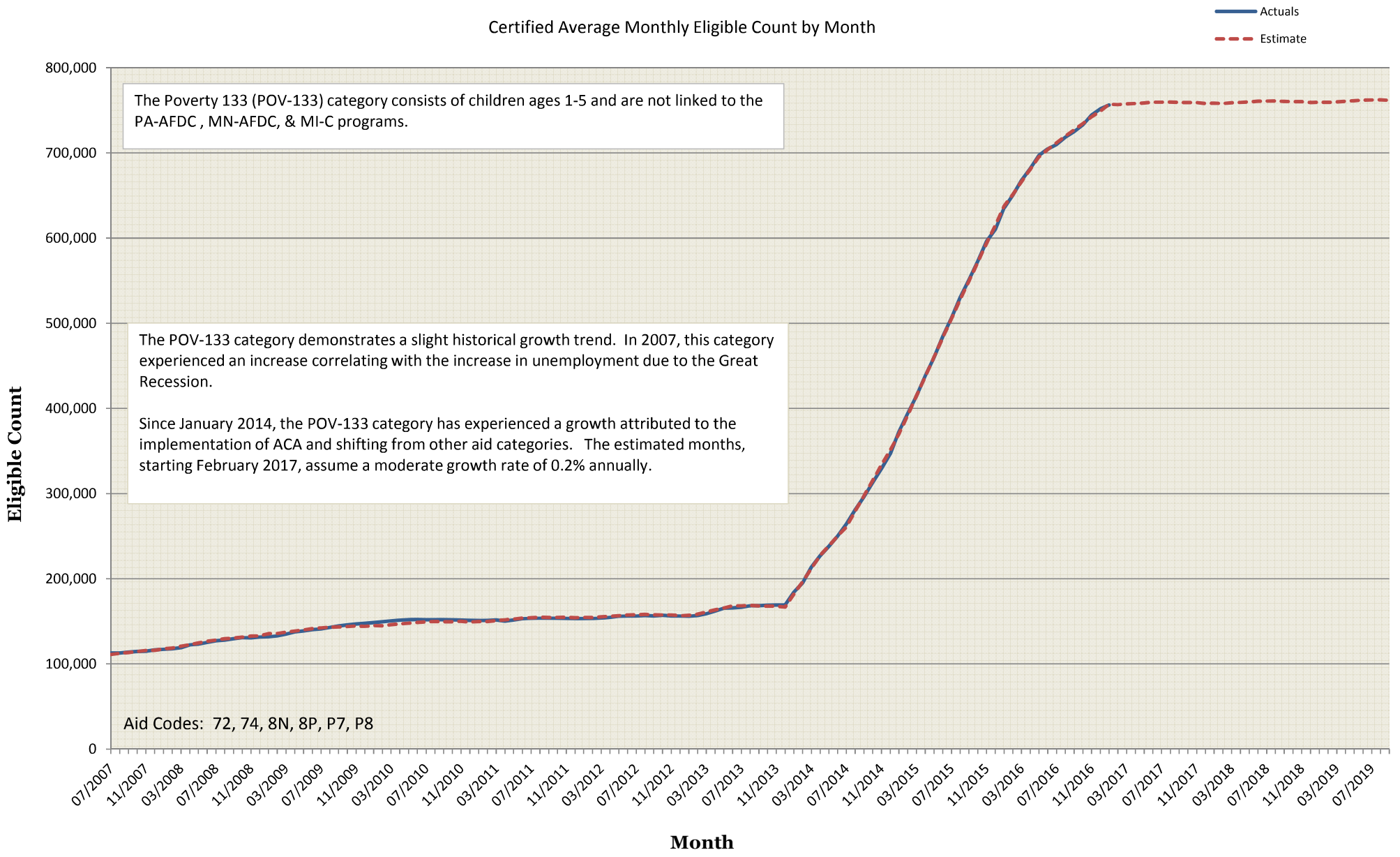
Certified Average Monthly Eligible Count by Month



Statewide Expanded Eligible: POV-185

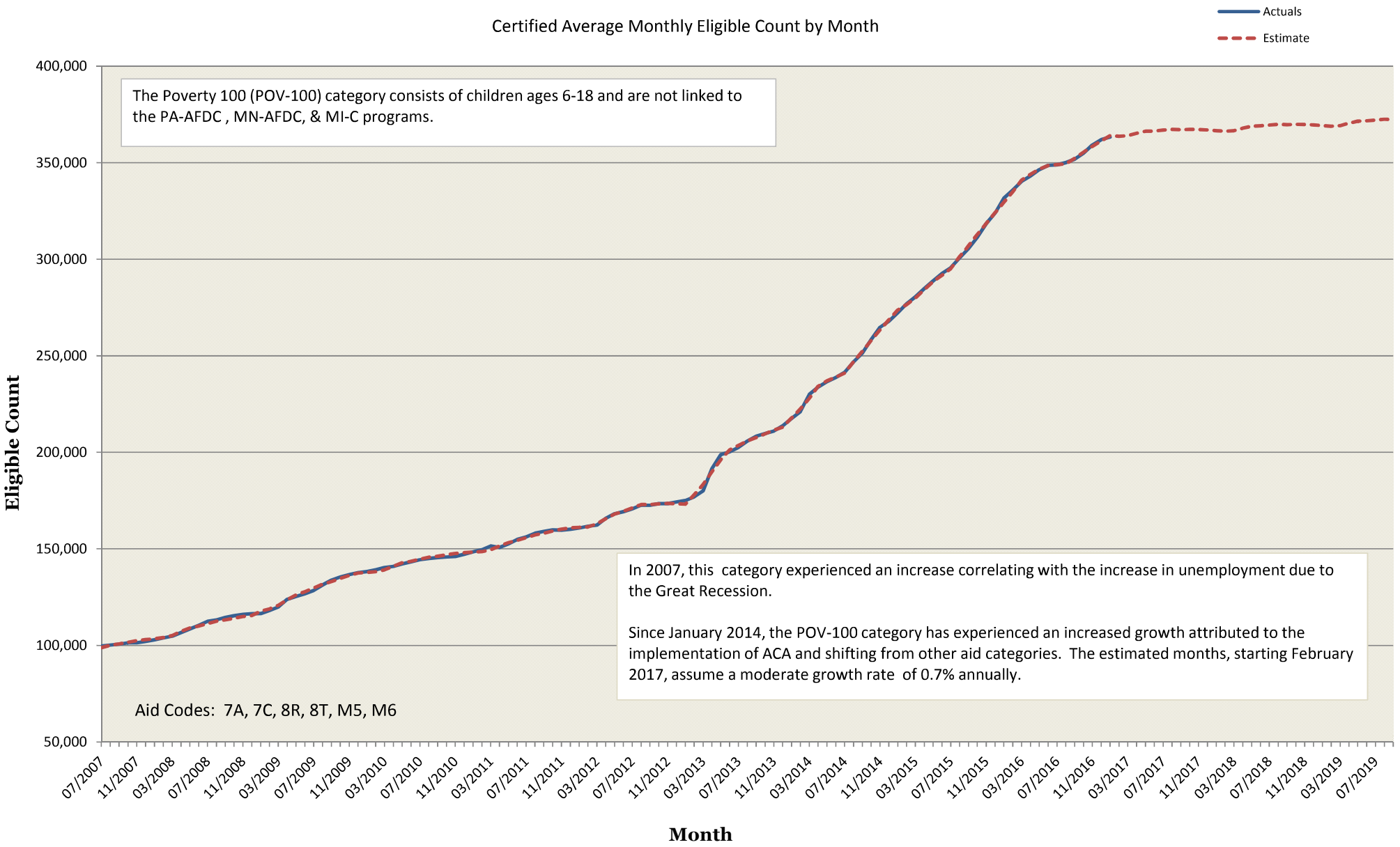


Statewide Expanded Eligible: POV-133



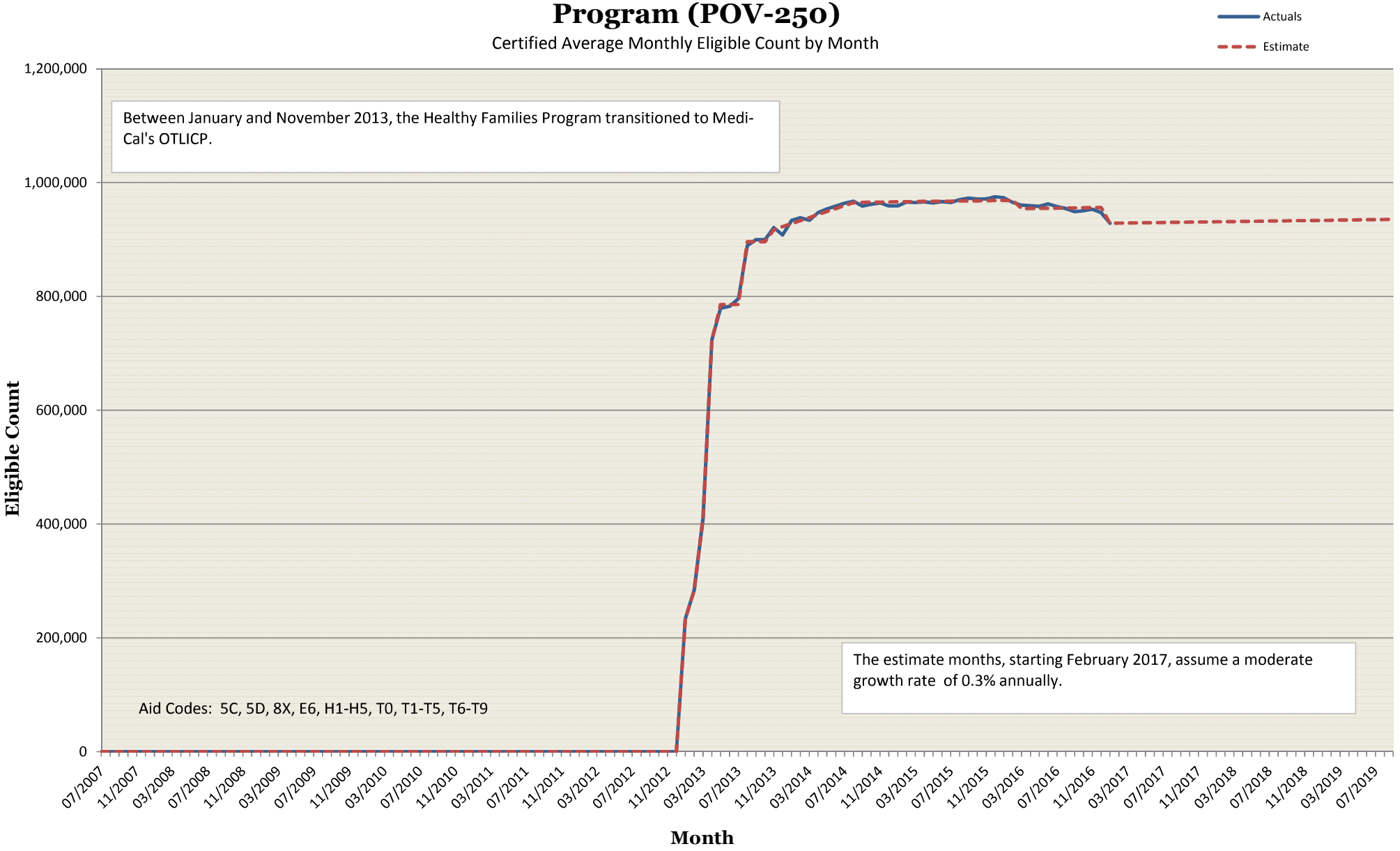
Statewide Expanded Eligible: POV-100

Certified Average Monthly Eligible Count by Month



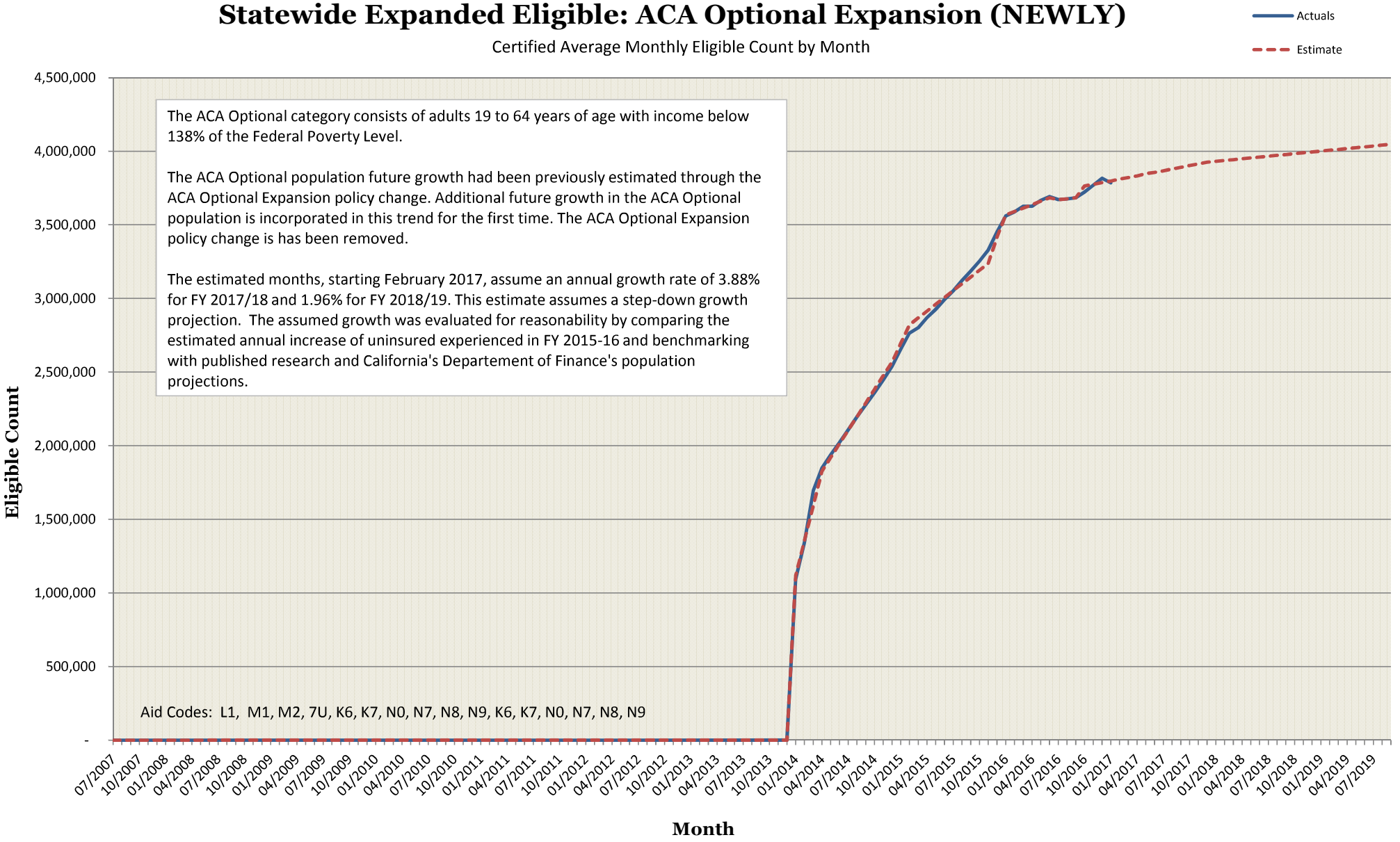
Statewide Expanded Eligible: Optional Targeted Low-Income Children's Program (POV-250)

Certified Average Monthly Eligible Count by Month



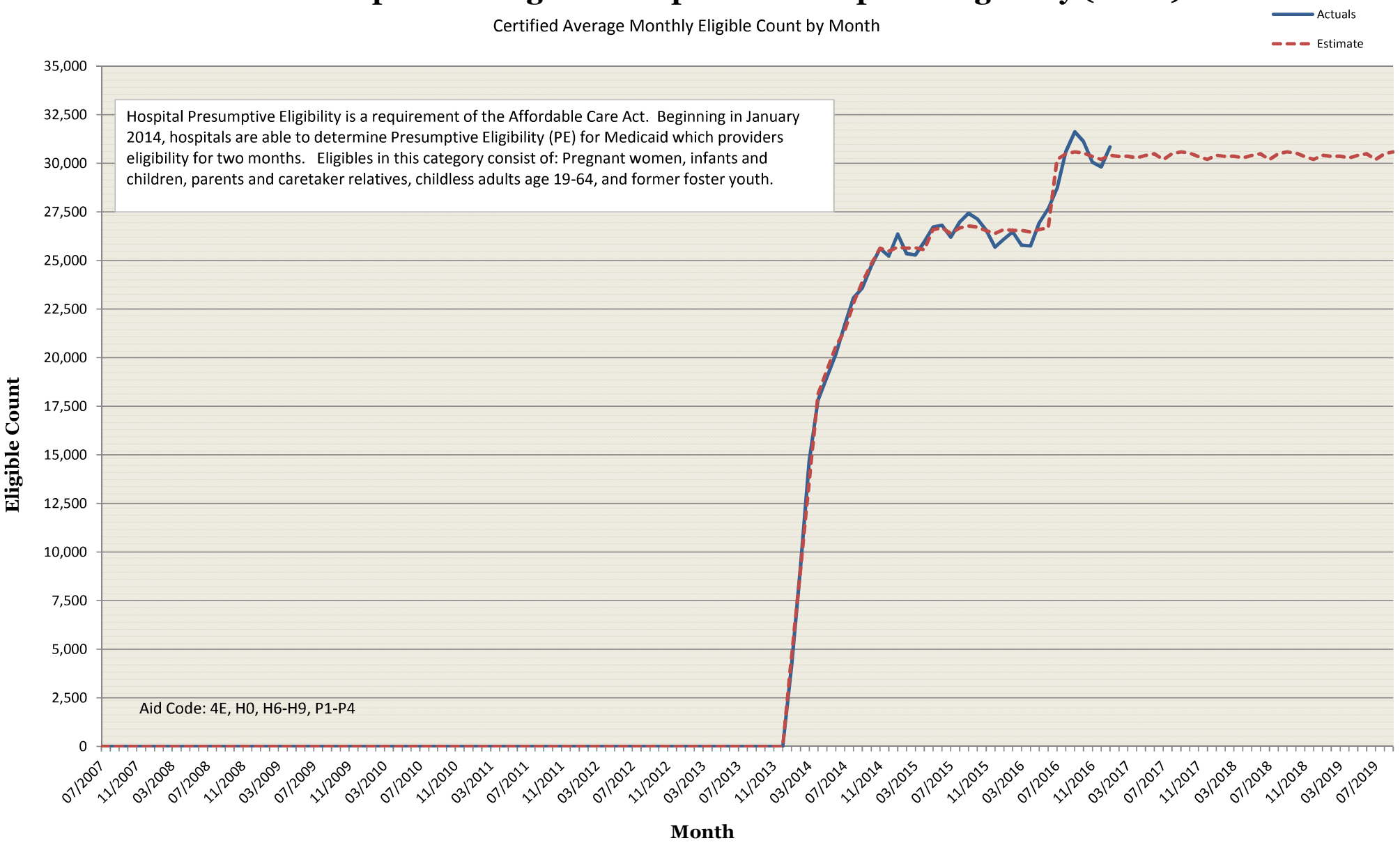
Statewide Expanded Eligible: ACA Optional Expansion (NEWLY)

Certified Average Monthly Eligible Count by Month



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

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.

May 2017 FFS Base Estimate

Fiscal Year		May 2017 Estimate Total Expenditure	
PY	FY 2015-16	$17,282,953,900*	--
CY	FY 2016-17	$16,880,723,000	-2.3%
BY	FY 2017-18	$17,394,766,300	3.0%

Fiscal Year	FFS Base Expenditure		
	November 2016 Estimate	May 2017 Estimate	% Chng
FY 2016-17	$16,961,345,200	$16,880,723,000	-0.5%
FY 2017-18	$17,406,577,300	$17,394,766,300	-0.1%

* Including an adjustments of $52.7 million related to Pharmacy and $38 million related to Physicians and County & Community Outpatient. See these two Service Category write-ups for additional information.

Overall, the May 2017 FFS Base is estimated at $16.9 billion and 17.4 billion, respectively, for FY 2016-17 and FY 2017-18. Compared to the November 2016 Estimate, the May 2017 FFS Base Estimate is lower by 0.5% for FY 2016-17 and 0.1% for FY 2017-18.

Several factors are contributing to these changes. The larger changes are discussed below. 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 May 2017 FFS base estimate.

Overall Caseload Fluctuations: Overall caseload continues to fluctuate. The Affordable Care Act (ACA) Optional Expansion caseload continues to grow, but at a lower rate. The ACA Optional population future growth had been previously estimated through the ACA Optional Expansion Policy Change. With the May 2017 Estimate, additional future growth in the ACA Optional population is incorporated in the base trend for the first time. The ACA Optional Expansion Policy Change is eliminated in this cycle.

The Public Assistance and Medically Needy Persons with Disabilities caseload has continued to decrease since 2015. The disabled caseload estimate, starting February 2017, are held at the January 2017 level. A portion of this population may be included in the Optional Expansion caseload projections.

The Families and Children caseload shows recent decreases of later actuals, and is lower than the November 2016 Estimate. It is difficult for to tell if the lower caseload is a continued effect of systems changes and more effective renewal process or a recovering economy.

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 varies from year to year. PY has 257 processing days, which equates to 52 checkwrite weeks, while CY and BY have 251 processing days equating to 51 checkwrite weeks. As a result, Utilization, and therefore expenditures, is estimated to increase in CY and decrease in BY.

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 MAY 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
2014-15 *	1	2,147,740	4.28	$200.08	$856.00	$5,515,409,100
2014-15 *	2	2,023,430	3.75	$195.70	$733.26	$4,451,107,300
2014-15 *	3	2,075,600	3.62	$202.52	$733.89	$4,569,802,800
2014-15 *	4	1,808,410	3.32	$205.90	$683.26	$3,706,853,300
2014-15 *	TOTAL	2,013,800	3.76	$200.74	$754.92	$18,243,172,500
2015-16 *	1	2,033,000	3.71	$216.20	$801.95	$4,891,099,300
2015-16 *	2	1,989,130	3.41	$214.10	$729.72	$4,354,491,200
2015-16 *	3	1,916,590	3.35	$205.66	$688.46	$3,958,483,800
2015-16 *	4	1,947,110	3.35	$203.65	$682.75	$3,988,148,600
2015-16 *	TOTAL	1,971,460	3.46	$210.19	$726.71	$17,192,222,900
2016-17 *	1	2,058,050	3.54	$216.50	$766.43	$4,732,035,200
2016-17 *	2	1,931,100	3.19	$223.16	$712.31	$4,126,609,900
2016-17 **	3	1,937,780	3.28	$225.64	$740.68	$4,305,832,500
2016-17 **	4	1,750,810	3.18	$222.45	$707.53	$3,716,245,300
2016-17 **	TOTAL	1,919,430	3.31	$221.71	$732.89	$16,880,723,000
2017-18 **	1	2,008,190	3.57	$231.35	$825.38	$4,972,538,600
2017-18 **	2	1,927,460	3.22	$226.70	$728.89	$4,214,736,200
2017-18 **	3	1,934,310	3.32	$228.89	$758.89	$4,403,823,000
2017-18 **	4	1,754,890	3.20	$225.92	$722.49	$3,803,668,500
2017-18 **	TOTAL	1,906,210	3.33	$228.39	$760.44	$17,394,766,300

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

Physicians Fee-for-Service Base Estimate

Analyst: Peter Bjorkman

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

Fiscal Year		Users		Utilization (Claims per User)		Rate (Cost per Unit)		Total Expenditure	
PY	FY 2015-16	439,320	--	2.48	--	$67.23	--	$912,245,300*	--
CY	FY 2016-17	372,380	-15.2%	2.32	-6.5%	$73.07	8.7%	$756,877,500	-17.0%
BY	FY 2017-18	365,690	-1.8%	2.34	0.9%	$73.40	0.5%	$752,170,100	-0.6%

* Including an adjustment of 32 million.

Users: Users are estimated to decrease in CY due to the 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 and user count. CY assumes a return to the historical levels absent the PCP increase. Additional PCP retroactive payments expected after January 2017 are budgeted through the Payments to Primary Care Physicians Policy Change.

Utilization: Utilization is estimated to decrease by 6.5% in CY due to the retroactive PCP rate increase payments made in PY. Utilization assumes a return to the historical levels absent the PCP increase and remain near this level in BY.

Rate: The estimated CY increase is due to a one-time adjustment of approximately -$32 million related to the Reduction to Radiology Rate (RRR) recoupment. The processing of the adjustment occurred in PY. 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 shifted to October 1, 2012. The recoupments are budgeted in the Reduction to Radiology Rate Policy Change. CY assumes a return to the AB97 10% level absent the RRR recoupment and PCP increase and maintained at this lower level in BY.

Total Expenditure: Total expenditure is estimated to decrease by 17% in CY, as PY includes the PCP payments partially offset by the recoupment of retro savings from RRR. BY projections are estimated to remain relatively unchanged.

Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	N16	M17	% Chng
FY 2016-17	$780,037,600	$756,877,500	-3.0%
FY 2017-18	$780,996,800	$752,170,100	-3.7%

Compared to the November 2016 Estimate, the May 2017 Estimate is lower by 3.0% and 3.7%, respectively, for FY 2016-17 and FY 2017-18. This decrease reflects expenditures for physician services without the PCP payments.

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

PHYSICIANS

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2014-15 *	1	546,320	2.31	$84.52	$195.48	$320,385,400
2014-15 *	2	496,730	2.23	$81.82	$182.17	$271,463,000
2014-15 *	3	530,270	2.53	$102.04	$258.51	$411,243,000
2014-15 *	4	410,420	2.13	$73.07	$155.38	$191,320,100
2014-15 *	TOTAL	495,930	2.31	$86.82	$200.70	$1,194,411,500
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	395,500	2.29	$71.36	$163.47	$193,954,200
2016-17 **	4	337,040	2.25	$74.15	$167.15	$169,010,500
2016-17 **	TOTAL	372,380	2.32	$73.07	$169.38	$756,877,500
2017-18 **	1	391,360	2.44	$74.27	$180.96	$212,464,500
2017-18 **	2	341,010	2.33	$74.17	$173.13	$177,122,400
2017-18 **	3	393,540	2.30	$71.02	$163.48	$193,008,500
2017-18 **	4	336,830	2.26	$74.33	$167.81	$169,574,800
2017-18 **	TOTAL	365,690	2.34	$73.40	$171.41	$752,170,100

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

Other Medical Fee-for-Service Base Estimate

Analyst: Peter Bjorkman

Background: The Other Medical service category consists of clinics and specialist service providers. Payments to Federally Qualified Heath Care Centers and Rural Health Centers (FQHC/RHC) are 80% 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 2015-16	1,079,610	--	1.55	--	$148.96	--	$2,990,969,200	--
CY	FY 2016-17	1,103,520	2.2%	1.55	0.0%	$153.47	3.0%	$3,146,728,600	5.2%
BY	FY 2017-18	1,108,920	0.5%	1.55	0.0%	$153.43	0.0%	$3,159,301,800	0.4%

Users: Users are estimated to increase by 2.2% in CY and is mainly due to additional growth in the ACA Optional population. Users are estimated to remain relatively unchanged in BY.

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

Rate: Rates are estimated to increase by 3.0% in CY and remain unchanged in BY. The above estimate incorporates the full impact of the July 2016 rate increase for Los Angeles' Cost Based Reimbursement Clinics; October 2016 rate increase for Medicare Economic Index (MEI) rate increase for FQHC/RHCs; and January 2016 rate increase for Indian Health Services. Rates were held level in BY as future rate increases are estimated through Policy Changes.

Total Expenditure: CY Expenditure is estimated to increase by 5.2% due to higher Users and Rates. BY expenditure projection is held level with CY, as all future rate increases will be incorporated through Policy Changes.

Reason for Change From Prior Estimate

Fiscal Year	Total Expenditure		
	N16	M17	% Chng
FY 2016-17	$2,983,456,000	$3,146,728,600	5.5%
FY 2017-18	$2,989,890,200	$3,159,301,800	5.7%

Compared to the November 2016 Estimate, the May 2017 Estimate is higher by 5.5% and 5.7%, respectively, for FY 2016-17 and FY 2017-18. The May 2017 Estimate incorporates the additional impact of 2016-17 rate increases and additional impact of future growth in the ACA Optional population, previously budgeted in Policy Changes.

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

OTHER MEDICAL

YEAR	QUARTER	AVERAGE MONTHLY USERS	AVERAGE MONTHLY UNIT PER USER	AVERAGE MONTHLY COST PER UNIT	AVERAGE MONTHLY COST PER USER	TOTAL COST
2014-15 *	1	1,090,960	1.65	$145.53	$239.67	$784,417,100
2014-15 *	2	1,027,560	1.55	$142.34	$221.20	$681,889,500
2014-15 *	3	1,065,800	1.53	$144.55	$221.84	$709,296,200
2014-15 *	4	955,740	1.52	$144.58	$219.57	$629,569,700
2014-15 *	TOTAL	1,035,010	1.57	$144.28	$225.86	$2,805,172,400
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	1,095,420	1.55	$153.77	$237.93	$781,892,400
2016-17 **	4	989,960	1.49	$152.29	$227.67	$676,160,100
2016-17 **	TOTAL	1,103,520	1.55	$153.47	$237.63	$3,146,728,600
2017-18 **	1	1,204,040	1.60	$153.16	$245.46	$886,645,900
2017-18 **	2	1,122,310	1.54	$154.35	$237.47	$799,552,700
2017-18 **	3	1,104,000	1.54	$153.79	$237.44	$786,418,200
2017-18 **	4	1,005,330	1.50	$152.29	$227.68	$686,685,000
2017-18 **	TOTAL	1,108,920	1.55	$153.43	$237.42	$3,159,301,800

* 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 2015-16	242,540	--	1.51	--	$130.54	--	$581,116,900*	--
CY	FY 2016-17	228,020	-6.0%	1.52	0.7%	$130.66	0.1%	$545,127,100	-6.2%
BY	FY 2017-18	226,280	-0.8%	1.52	0.0%	$131.53	0.7%	$544,247,800	-0.2%

* Includes an adjustment of 6 million.

Users: Users are projected to decrease by 6.0% in CY correlated to the decrease in caseload for Families and remain relatively unchanged in BY.

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

Rate: PY includes a one-time adjustment of approximately -$6 million related to the Reduction to Radiology Rate (RRR) recoupment. The recoupments are budgeted in the Reduction to Radiology Rate Policy Change. Rate is estimated to remain relatively unchanged in CY and BY.

Total Expenditure: Total expenditure is estimated to decrease by 6.2% in CY due to lower Users. BY total expenditure is estimated to remain consistent with CY.

Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	N16	M17	% Chng
FY 2016-17	$587,393,900	$545,127,100	-7.2%
FY 2017-18	$586,862,200	$544,247,800	-7.3%

Compared to the November 2016 Estimate, the May 2017 Estimate is lower by 7.2% and 7.3%, respectively, for FY 2016-17 and FY 2017-18. . The estimated decreases are primarily the lower Families caseload affecting FFS Users.

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

CO. & COMM. OUTPATIENT

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2014-15 *	1	350,920	1.67	$97.15	$162.69	$171,271,800
2014-15 *	2	281,960	1.61	$98.48	$158.25	$133,857,300
2014-15 *	3	256,170	1.49	$124.53	$186.00	$142,941,600
2014-15 *	4	232,740	1.48	$119.04	$176.16	$122,996,900
2014-15 *	TOTAL	280,450	1.58	$107.68	$169.69	$571,067,600
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	225,000	1.52	$129.22	$196.24	$132,465,900
2016-17 **	4	206,610	1.49	$126.25	$188.06	$116,566,100
2016-17 **	TOTAL	228,020	1.52	$130.66	$199.23	$545,127,100
2017-18 **	1	253,890	1.57	$136.56	$214.19	$163,146,000
2017-18 **	2	217,380	1.52	$131.45	$199.18	$129,891,500
2017-18 **	3	225,250	1.51	$130.31	$197.34	$133,354,700
2017-18 **	4	208,600	1.49	$126.49	$188.32	$117,855,600
2017-18 **	TOTAL	226,280	1.52	$131.53	$200.43	$544,247,800

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

Pharmacy Fee-for-Service Base Estimate

Analyst: Toni Richardson

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

Fiscal Year		Users		Utilization (Prescriptions per User)		Rate (Cost per Prescription)		Total Expenditure	
PY	FY 2015-16	514,100	--	2.95	--	$202.94	--	$3,751,586,600*	--
CY	FY 2016-17	481,150	-6.4%	2.82	-4.4%	$204.09	0.6%	$3,318,243,500	-11.6%
BY	FY 2017-18	487,020	1.2%	2.81	-0.4%	$223.10	9.3%	$3,660,649,400	10.3%

* Includes an adjustment of $52.7 million.

Users: The estimated CY User decrease is primarily due to decreases in the Families caseload and partially offset by the increase in the ACA Optional population. The estimated BY User increase is primarily due to the future growth in ACA Optional population.

Utilization: Utilization is estimated to decrease by 4.4% from PY to CY and remain relatively unchanged from CY to BY. The variance between PY and CY is attributed to less claims processing days in CY compared to PY, which results in less prescriptions paid in CY and BY compared to PY.

Rate: Rate is estimated to increase slightly in CY due to PY's one-time adjustment of $52.7 million related to the Pharmacy recoupment of the 10% Provider Payment Reductions, reducing the PY expenditures reflected on the following page. Absent this adjustment the Pharmacy rate would be lower in CY comparted to PY due to the implementation of updated federal maximum reimbursements (federal upper limit (FULs)) for some generically equivalent drugs dispensed in pharmacies on April 15, 2016. CY includes a full year savings of the updated FUL rates, while PY includes a 2-month savings. In addition, BY is projected to increase by 9.3%, related to a historical rate growth in prescription drugs.

Total Expenditure: Total expenditure is estimated to decrease by 11.6% from PY to CY due to lower Users and the implementation of the FULs, and increase by 10.3% from CY to BY relate to the historical growth in rates.

Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	N16	M17	% Chng
FY 2016-17	$3,565,944,000	$3,318,243,500	-6.9%
FY 2017-18	$3,893,143,500	$3,660,649,400	-6.0%

Compared to the November 2016 Estimate, the May 2017 Estimate is lower by 6.9% and 6.0%, respectively, for FY 2016-17 and FY 2017-18, primarily due to the lower Families caseload.

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

PHARMACY

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2014-15 *	1	639,240	3.21	$148.65	$477.92	$916,511,100
2014-15 *	2	579,450	2.89	$163.55	$471.94	$820,392,500
2014-15 *	3	557,430	2.87	$176.83	$506.68	$847,307,900
2014-15 *	4	467,210	2.83	$189.82	$536.83	$752,435,600
2014-15 *	TOTAL	560,830	2.96	$167.36	$495.79	$3,336,647,100
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	492,010	2.78	$206.17	$573.11	$845,928,400
2016-17 **	4	437,430	2.67	$213.57	$571.21	$749,588,400
2016-17 **	TOTAL	481,150	2.82	$204.09	$574.70	$3,318,243,500
2017-18 **	1	516,480	2.99	$220.87	$661.09	$1,024,325,200
2017-18 **	2	489,170	2.75	$221.54	$610.16	$895,410,800
2017-18 **	3	498,810	2.78	$222.06	$618.41	$925,412,400
2017-18 **	4	443,610	2.68	$228.99	$612.77	$815,501,000
2017-18 **	TOTAL	487,020	2.81	$223.10	$626.37	$3,660,649,400

* 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 2015-16	5,340	--	5.41	--	$2,468.02	--	$855,103,700	--
CY	FY 2016-17	4,970	-6.9%	5.37	-0.7%	$2,621.20	6.2%	$839,233,800	-1.9%
BY	FY 2017-18	4,960	-0.2%	5.52	2.8%	$2,684.05	2.4%	$881,980,600	5.1%

Users: The estimated User decrease in CY is primarily due to decreases in the Families caseload. Users are projected to remain at relatively unchanged for BY.

Utilization: Utilization or the number of days stay per user is estimated to remain around 5.4 days for CY and 5.5 days for BY.

Rate: Rate is estimated to increase in CY and BY, due to the incorporation of the FY 2016-17 DPH interim rate increase of 3.92% implemented in July 2016. Rate shown above does not include the increase of 4.37% beginning July 2017. The 4.37% increase is budgeted in the DPH Interim Rate Growth Regular Policy Change.

Total Expenditure: Total expenditure is estimated to decrease by -1.9% in CY is due to the estimated decreases in caseload offset by the FY 2016-17 DPH interim rate increase. Total expenditure is estimated to increase by 5.1% in BY due to the FY 2016-17 DPH interim rate increase and higher Utilization.

Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	N16	M17	% Chng
FY 2016-17	$868,312,100	$839,233,800	-3.3%
FY 2017-18	$883,074,300	$881,980,600	-0.1%

Compared to the November 2016 Estimate, the May 2017 Estimate is lower by -3.3% for FY 2016-17 as Medi-Cal Caseload changes have occurred, and remain relatively unchanged for FY 2017-18.

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

COUNTY INPATIENT

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2014-15 *	1	7,890	5.61	$2,007.13	$11,252.27	$266,195,100
2014-15 *	2	6,050	5.66	$2,239.01	$12,674.44	$229,977,800
2014-15 *	3	5,660	5.45	$2,303.69	$12,556.15	$213,153,200
2014-15 *	4	5,530	5.45	$2,328.08	$12,690.40	$210,406,900
2014-15 *	TOTAL	6,280	5.55	$2,199.03	$12,204.85	$919,732,900
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	4,930	5.54	$2,667.02	$14,776.24	$218,392,400
2016-17 **	4	4,580	5.48	$2,681.74	$14,697.43	$201,828,300
2016-17 **	TOTAL	4,970	5.37	$2,621.20	$14,074.68	$839,233,800
2017-18 **	1	5,830	5.58	$2,602.29	$14,509.55	$253,639,600
2017-18 **	2	4,600	5.45	$2,762.91	$15,067.66	$207,757,500
2017-18 **	3	4,900	5.56	$2,690.24	$14,954.96	$220,059,500
2017-18 **	4	4,530	5.46	$2,704.77	$14,758.41	$200,524,000
2017-18 **	TOTAL	4,960	5.52	$2,684.06	$14,805.51	$881,980,600

* 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 2015-16	35,710	--	4.69	--	$2,094.92	--	$4,209,508,000	--
CY	FY 2016-17	33,460	-6.3%	4.67	-0.4%	$2,220.23	6.0%	$4,163,901,300	-1.1%
BY	FY 2017-18	32,980	-1.4%	4.71	0.9%	$2,268.50	2.2%	$4,225,013,900	1.5%

Users: The estimated User decreases in CY and BY are correlated to changes in the Medi-Cal Caseload.

Utilization: Utilization is projected to remain relatively stable at 4.7 days per user.

Rate: Rate is estimated to increase in CY and BY following historical trends and incorporating FY 2016-17 DPH interim rate increase for the DPHs. FY 2017-18 DPH rate growth not accounted for by this estimate is budgeted in the DPH Interim Rate Growth Policy Change.

Total Expenditure: Total expenditure is estimated to decrease by 1.1% in CY, due to lower Users, partially offset by higher Rates. Total expenditure is estimated to increase by 1.5% in BY primarily due to higher Rates.

Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	N16	M17	% Chng
FY 2016-17	$4,152,790,100	$4,163,901,300	0.3%
FY 2017-18	$4,215,172,100	$4,225,013,900	0.2%

Compared to the November 2016 Estimate, the May 2017 Estimate is higher by 0.3% and 0.2%, respectively, for FY 2016-17 and FY 2017-18. The total expenditure change between estimates is minor; increases in the Rate are offset by decreases in Users.

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

COMMUNITY INPATIENT

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2014-15 *	1	50,740	4.31	$2,027.55	$8,742.57	$1,330,811,200
2014-15 *	2	41,520	4.18	$2,034.25	$8,501.81	$1,059,045,300
2014-15 *	3	41,360	4.34	$1,999.68	$8,688.56	$1,078,024,600
2014-15 *	4	35,460	4.46	$2,005.61	$8,943.39	$951,272,400
2014-15 *	TOTAL	42,270	4.32	$2,017.53	$8,712.34	$4,419,153,400
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	34,970	4.71	$2,208.38	$10,400.50	$1,091,045,500
2016-17 **	4	29,290	4.60	$2,248.20	$10,342.62	$908,706,700
2016-17 **	TOTAL	33,460	4.67	$2,220.23	$10,370.72	$4,163,901,300
2017-18 **	1	37,540	4.75	$2,260.05	$10,741.81	$1,209,622,400
2017-18 **	2	31,030	4.70	$2,262.89	$10,637.93	$990,350,400
2017-18 **	3	34,280	4.74	$2,268.99	$10,751.29	$1,105,512,600
2017-18 **	4	29,070	4.61	$2,285.25	$10,545.12	$919,528,500
2017-18 **	TOTAL	32,980	4.71	$2,268.50	$10,676.50	$4,225,013,900

* 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 2015-16	32,660	--	32.65	--	$203.48	--	$2,603,899,300	--
CY	FY 2016-17	32,760	0.3%	32.64	-0.03%	$209.22	2.8%	$2,684,288,500	3.1%
BY	FY 2017-18	31,710	-3.2%	32.59	-0.2%	$211.46	1.1%	$2,622,081,200	-2.3%

Users: Users are projected to remain relatively unchanged in CY from PY. Users are estimated to decrease by 3.1% in BY.

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

Rate: The Rate is estimated to increase in CY and BY, due to the partial incorporation of the final AB 1629 facilities FY 2015-16 rate increases and the other facilities FY 2016-17 rate increases. Future rate increases and rate increases not fully incorporated in the above estimate are budgeted in the AB 1629 Annual Rate Adjustment and LTC Rate Adjustment Policy Changes.

Total Expenditure: CY expenditure is estimated to increase 3.1% in CY due to higher Rates. Total expenditure is estimated to decrease by 2.3% in BY.

Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	N16	M17	% Chng
FY 2016-17	$2,638,920,400	$2,684,288,500	1.7%
FY 2017-18	$2,642,406,700	$2,622,081,200	-0.8%

The May 2017 Estimate for FY 2016-17 is 1.7% higher than the November 2016 Estimate. Higher Rate and Utilization explain most of the difference. The May 2017 Estimate partially incorporates the final AB 1629 facilities FY 2015-16 rate increase. The May 2017 Estimate for FY 2017-18 is relatively unchanged from the November 2016 Estimate.

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

NURSING FACILITIES

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2014-15 *	1	60,360	35.45	$199.75	$7,081.79	$1,282,356,400
2014-15 *	2	52,440	30.58	$187.48	$5,732.16	$901,721,100
2014-15 *	3	44,500	31.51	$192.13	$6,054.24	$808,168,400
2014-15 *	4	34,190	28.71	$187.89	$5,394.64	$553,306,800
2014-15 *	TOTAL	47,870	32.00	$192.89	$6,172.18	$3,545,552,700
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	32,570	32.40	$211.40	$6,850.04	$669,323,000
2016-17 **	4	30,110	29.17	$208.69	$6,086.78	$549,737,100
2016-17 **	TOTAL	32,760	32.64	$209.22	$6,828.21	$2,684,288,500
2017-18 **	1	33,840	36.14	$215.07	$7,772.48	$788,960,900
2017-18 **	2	31,670	32.22	$209.49	$6,750.60	$641,378,900
2017-18 **	3	31,390	32.39	$211.52	$6,851.66	$645,280,400
2017-18 **	4	29,940	29.17	$208.63	$6,084.75	$546,460,900
2017-18 **	TOTAL	31,710	32.59	$211.46	$6,891.06	$2,622,081,200

* 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 (Cost per Day)		Total Expenditure	
PY	FY 2015-16	5,060	--	32.59	--	$190.46	--	$376,785,300	--
CY	FY 2016-17	4,960	-2.0%	31.67	-2.8%	$204.55	7.4%	$385,297,400	2.3%
BY	FY 2017-18	4,960	0.0%	31.67	0.0%	$206.97	1.2%	$390,464,500	1.3%

Users: Users are projected to decrease by 2.0% from PY to CY and remain unchanged from CY and BY.

Utilization: Utilization is projected to decrease by 2.8% from PY to CY due to fewer claims processing days in CY than PY. The number of claims processing days reflect the number of days Medi-Cal will adjudicate and make payments to the providers. BY is estimated to remain unchanged from CY, as the number claims processing days in CY is the same as in BY.

Rate: Rate is estimated to increase by 7.4% from PY to CY and 1.2% from CY and BY, due to the incorporation of the FY 2016-17 ICF/DD rate increase implemented in September 2016 FY 2017-18 ICF/DD rate increase is budgeted in the LTC Rate Adjustment policy change.

Total Expenditure: Total expenditure is estimated to increase by 2.3% from PY to CY, due to higher Rates, partially offset by less processing days; and increase 1.3% from CY to BY, primarily due to higher Rates.

Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	N16	M17	% Chng
FY 2016-17	$367,214,500	$385,297,400	4.9%
FY 2017-18	$368,273,100	$390,464,500	6.0%

Compared to the November 2016 Estimate, the May 2017 Estimate is higher by 4.9 % and 6.0%, respectively, for FY 2016-17 and FY 2017-18. The May 2017 Estimate incorporates the impact of FY 2016-17 ICF/DD rate increase, previously budgeted in the LTC Rate Adjustment Policy Change.

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FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2017 BASE ESTIMATES)

ICF-DD

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2014-15 *	1	5,060	37.48	$177.28	$6,644.86	$100,968,700
2014-15 *	2	5,160	30.81	$180.51	$5,562.35	$86,110,700
2014-15 *	3	5,120	31.67	$190.14	$6,022.33	$92,575,300
2014-15 *	4	4,850	27.62	$181.46	$5,012.37	$72,910,000
2014-15 *	TOTAL	5,050	31.94	$182.18	$5,818.48	$352,564,700
2015-16 *	1	5,170	37.70	$181.36	$6,836.55	$106,007,600
2015-16 *	2	5,090	34.13	$189.52	$6,467.98	$98,778,900
2015-16 *	3	5,070	28.96	$190.86	$5,527.35	$84,126,300
2015-16 *	4	4,900	29.38	$203.49	$5,977.72	$87,872,500
2015-16 *	TOTAL	5,060	32.59	$190.46	$6,207.54	$376,785,300
2016-17 *	1	5,060	36.76	$194.13	$7,136.23	$108,356,600
2016-17 *	2	4,970	31.45	$211.90	$6,665.05	$99,395,800
2016-17 **	3	4,930	31.13	$207.35	$6,455.82	$95,502,700
2016-17 **	4	4,860	27.14	$207.26	$5,624.01	$82,042,300
2016-17 **	TOTAL	4,960	31.67	$204.55	$6,477.97	$385,297,400
2017-18 **	1	5,020	37.01	$205.73	$7,613.70	$114,724,800
2017-18 **	2	4,970	31.12	$208.45	$6,487.60	$96,728,900
2017-18 **	3	4,970	31.30	$206.80	$6,472.90	$96,546,500
2017-18 **	4	4,890	27.13	$207.20	$5,621.68	$82,464,400
2017-18 **	TOTAL	4,960	31.67	$206.97	$6,555.54	$390,464,500

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

Medical Transportation Fee-for-Service Base Estimate

Analyst: Felicia Oropeza

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

Fiscal Year		Users		Utilization (Claims per User)		Rate (Cost per Claim)		Total Expenditure	
PY	FY 2015-16	25,470	--	2.80	--	$98.15	--	$84,099,900	--
CY	FY 2016-17	22,910	-10.1%	3.17	13.2%	$79.39	-19.1%	$69,161,300	-17.8%
BY	FY 2017-18	22,660	-1.1%	3.15	-0.6%	$77.71	-2.1%	$66,489,900	-3.9%

Users: Users are estimated to decrease from PY to CY and remain steady in BY.

Utilization: Utilization is estimated to increase by 13.2% from PY to CY. This higher Utilization is partially offset by lower Users and Rates in CY. Utilization is projected to remain relatively unchanged in BY.

Rate: Rate is estimated to decrease by 19.1% from PY to CY. BY is projected at levels consistent with CY.

Total Expenditure: Total expenditure is estimated to decrease by 17.8% from PY to CY due to the estimated lower level of Users and Rates, partially offset by higher Utilization.

Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	N16	M17	% Chng
FY 2016-17	$77,272,900	$69,161,300	-10.5%
FY 2017-18	$79,060,000	$66,489,900	-15.9%

Compared to the November 2016 Estimate, the May 2017 Estimate is lower by 10.5% and 15.9%, respectively, for FY 2016-17 and FY 2017-18, due to lower Rates and Users, partially offset by higher Utilization.

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

MEDICAL TRANSPORTATION

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2014-15 *	1	41,720	3.76	$89.68	$337.36	$42,223,700
2014-15 *	2	34,210	3.37	$90.20	$304.13	$31,211,800
2014-15 *	3	31,960	3.22	$91.71	$295.40	$28,320,700
2014-15 *	4	25,010	2.83	$96.46	$273.17	$20,499,900
2014-15 *	TOTAL	33,230	3.36	$91.36	$306.64	$122,256,100
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	23,920	3.37	$73.87	$248.83	$17,853,500
2016-17 **	4	19,530	2.99	$77.94	$233.29	$13,666,500
2016-17 **	TOTAL	22,910	3.17	$79.39	$251.60	$69,161,300
2017-18 **	1	25,370	3.18	$79.44	$252.95	$19,253,800
2017-18 **	2	21,950	3.10	$78.53	$243.16	$16,014,200
2017-18 **	3	23,610	3.30	$74.81	$246.56	$17,463,700
2017-18 **	4	19,710	2.97	$78.20	$232.66	$13,758,200
2017-18 **	TOTAL	22,660	3.15	$77.71	$244.50	$66,489,900

* 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 another FFS service category. Certified Hospice Services and Local Education Agency represent nearly half of the expenditures. Other provider types in this Service Category are listed in the Information Only Section.

Fiscal Year		Users		Utilization (Claims per User)		Rate (Cost per Claim)		Total Expenditure	
PY	FY 2015-16	199,830	--	3.26	--	$86.49	--	$675,165,000	--
CY	FY 2016-17	191,940	-3.9%	2.99	-8.3%	$109.10	26.1%	$751,170,600	11.3%
BY	FY 2017-18	188,300	-1.9%	3.21	7.4%	$119.53	9.6%	$868,193,500	15.6%

Users: Users are estimated to decrease in CY and BY due to changes in the Medi-Cal Caseload.

Utilization: Utilization is projected to decrease by 8.3% from PY to CY, due to a lower than usual utilization level in four months of CY related to Local Education Agency (LEA) service. BY is projected to return to the normalized level.

Rate: Rate is projected to increase in CY and BY, due to rate increases provided in FY 2015-16 are fully incorporated. Rate increases for Genetic Disease Testing and Hospice Services were effective in FY 2015-16. New rate increases are budgeted via policy changes.

Total Expenditure: Total expenditure is estimated to increase in CY and BY, due to rate increases and changes in utilization.

Reason for Change from Prior Estimate:

Fiscal Year	Total Expenditure		
	N16	**M17**	**% Chng**
FY 2016-17	$705,022,400	$751,170,600	6.5%
FY 2017-18	$720,413,800	$868,193,500	20.5%

Compared to the November 2016 Estimate, the May 2017 Estimate is higher by 6.5% and 20.5%, respectively, for FY 2016-17 and FY 2017-18.

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
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OTHER SERVICES

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2014-15 *	1	207,680	3.46	$105.60	$364.92	$227,359,800
2014-15 *	2	206,950	3.15	$89.56	$282.50	$175,386,300
2014-15 *	3	228,040	2.93	$89.00	$260.91	$178,493,800
2014-15 *	4	195,090	3.19	$79.94	$255.12	$149,315,400
2014-15 *	TOTAL	209,440	3.18	$91.49	$290.68	$730,555,200
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	192,890	2.87	$122.98	$353.27	$204,426,300
2016-17 **	4	184,860	3.30	$110.39	$364.49	$202,141,300
2016-17 **	TOTAL	191,940	2.99	$109.10	$326.13	$751,170,600
2017-18 **	1	182,810	3.39	$126.70	$429.60	$235,605,400
2017-18 **	2	184,020	3.09	$119.77	$370.21	$204,379,600
2017-18 **	3	201,620	3.06	$121.05	$370.73	$224,238,700
2017-18 **	4	184,760	3.33	$110.56	$368.00	$203,969,800
2017-18 **	TOTAL	188,300	3.21	$119.53	$384.22	$868,193,500

* 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 2015-16	5,160	--	3.18	--	$1,232.12	--	$242,474,600	--
CY	FY 2016-17	4,350	-15.7%	3.40	6.9%	$1,242.78	0.9%	$220,693,300	-9.0%
BY	FY 2017-18	4,370	0.5%	3.42	0.6%	$1,248.63	0.5%	$224,173,500	1.6%

Users: Users are estimated to decrease in CY and remain fairly level in BY.

Utilization: Utilization is estimated to increase in CY. BY is projected at levels consistent with CY.

Rate: Rate is projected to remain stable.

Total Expenditure: Total expenditure is estimated to decrease by 9.0% in CY, due to the estimated lower User level, partially offset by higher Utilization.

Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	N16	M17	% Chng
FY 2016-17	$234,981,200	$220,693,300	-6.1%
FY 2017-18	$247,284,700	$224,173,500	-9.3%

Compared to the November 2016 Estimate, the May 2017 Estimate is lower by 6.1% and 9.3% respectively, in FY 2016-17 and FY 2017-18. These changes are primarily due to a lower Users estimate.

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

HOME HEALTH

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2014-15 *	1	5,310	3.46	$1,322.40	$4,574.54	$72,909,000
2014-15 *	2	4,770	3.22	$1,303.58	$4,194.75	$60,052,000
2014-15 *	3	5,210	3.14	$1,229.59	$3,859.04	$60,278,200
2014-15 *	4	4,830	2.86	$1,271.35	$3,641.98	$52,819,600
2014-15 *	TOTAL	5,030	3.18	$1,283.09	$4,075.37	$246,058,800
2015-16 *	1	5,320	3.45	$1,278.48	$4,412.89	$70,376,700
2015-16 *	2	5,320	3.28	$1,202.85	$3,939.73	$62,933,200
2015-16 *	3	5,120	2.92	$1,223.01	$3,569.60	$54,843,400
2015-16 *	4	4,890	3.04	$1,218.38	$3,700.87	$54,321,300
2015-16 *	TOTAL	5,160	3.18	$1,232.12	$3,913.15	$242,474,600
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	4,460	3.35	$1,229.16	$4,117.39	$55,048,300
2016-17 **	4	4,070	3.08	$1,246.14	$3,835.44	$46,798,000
2016-17 **	TOTAL	4,350	3.40	$1,242.78	$4,228.07	$220,693,300
2017-18 **	1	4,570	3.71	$1,262.88	$4,683.72	$64,150,000
2017-18 **	2	4,310	3.47	$1,249.53	$4,337.98	$56,149,300
2017-18 **	3	4,540	3.36	$1,233.15	$4,148.50	$56,527,900
2017-18 **	4	4,070	3.11	$1,247.18	$3,880.38	$47,346,300
2017-18 **	TOTAL	4,370	3.42	$1,248.63	$4,272.61	$224,173,500

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

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

PA-OAS

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2014-15 *	1	157,390	4.79	$129.83	$622.40	$293,875,900
2014-15 *	2	135,090	4.25	$121.12	$514.55	$208,534,900
2014-15 *	3	121,850	4.43	$120.03	$532.16	$194,538,400
2014-15 *	4	78,810	3.63	$141.56	$513.89	$121,498,200
2014-15 *	TOTAL	123,290	4.37	$126.61	$553.22	$818,447,400
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	63,280	4.14	$148.33	$613.63	$116,489,200
2016-17 **	4	57,080	3.76	$148.38	$557.92	$95,544,200
2016-17 **	TOTAL	62,780	3.94	$151.06	$594.56	$447,889,000
2017-18 **	1	65,460	4.26	$165.97	$706.72	$138,783,800
2017-18 **	2	57,650	3.88	$159.90	$620.63	$107,339,800
2017-18 **	3	61,870	4.17	$147.29	$614.24	$114,005,600
2017-18 **	4	55,510	3.83	$148.43	$568.52	$94,674,300
2017-18 **	TOTAL	60,120	4.05	$155.79	$630.39	$454,803,500

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

QUARTERLY SUMMARY
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FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND MAY 2017 BASE ESTIMATES)

NEWLY

YEAR	QUARTER	AVERAGE MONTHLY USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2014-15 *	1	315,480	2.87	$263.95	$756.22	$715,722,600
2014-15 *	2	322,580	2.49	$271.45	$675.10	$653,320,000
2014-15 *	3	348,900	2.44	$276.98	$674.74	$706,253,500
2014-15 *	4	330,660	2.39	$282.99	$677.33	$671,904,400
2014-15 *	TOTAL	329,410	2.54	$273.56	$694.99	$2,747,200,500
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	430,710	2.47	$286.26	$707.37	$914,011,700
2016-17 **	4	420,700	2.37	$280.03	$662.83	$836,548,500
2016-17 **	TOTAL	436,200	2.48	$280.44	$695.20	$3,638,933,500
2017-18 **	1	501,940	2.61	$282.21	$736.82	$1,109,520,600
2017-18 **	2	496,010	2.34	$283.11	$663.15	$986,788,200
2017-18 **	3	459,520	2.42	$290.22	$701.42	$966,946,900
2017-18 **	4	439,200	2.35	$285.21	$669.36	$881,947,400
2017-18 **	TOTAL	474,170	2.43	$285.03	$693.36	$3,945,203,000

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

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

PA-ATD

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2014-15 *	1	369,850	5.74	$209.64	$1,204.26	$1,336,196,800
2014-15 *	2	345,140	5.04	$210.84	$1,061.98	$1,099,580,500
2014-15 *	3	330,600	4.94	$225.15	$1,111.32	$1,102,215,000
2014-15 *	4	275,070	4.59	$233.55	$1,071.92	$884,545,000
2014-15 *	TOTAL	330,160	5.12	$218.16	$1,116.25	$4,422,537,300
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	281,900	4.41	$259.22	$1,142.43	$966,166,300
2016-17 **	4	255,920	4.40	$251.65	$1,106.58	$849,592,300
2016-17 **	TOTAL	270,240	4.58	$252.09	$1,155.10	$3,745,806,400
2017-18 **	1	263,910	5.30	$265.16	$1,404.79	$1,112,224,900
2017-18 **	2	253,020	4.62	$260.90	$1,206.11	$915,524,100
2017-18 **	3	270,560	4.65	$263.38	$1,223.75	$993,291,700
2017-18 **	4	246,820	4.54	$257.34	$1,168.53	$865,239,200
2017-18 **	TOTAL	258,580	4.78	$261.93	$1,252.45	$3,886,279,800

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

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

PA-AFDC

YEAR	QUARTER	AVERAGE MONTHLY USERS	AVERAGE MONTHLY UNIT PER USER	AVERAGE MONTHLY COST PER UNIT	AVERAGE MONTHLY COST PER USER	TOTAL COST
2014-15 *	1	185,690	2.31	$184.03	$424.86	$236,671,600
2014-15 *	2	182,760	2.18	$173.37	$378.78	$207,679,500
2014-15 *	3	193,720	2.20	$178.10	$392.41	$228,047,100
2014-15 *	4	171,430	2.22	$169.62	$376.81	$193,786,700
2014-15 *	TOTAL	183,400	2.23	$176.52	$393.58	$866,184,900
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	152,730	2.25	$192.90	$434.68	$199,169,200
2016-17 **	4	127,190	2.32	$185.11	$429.38	$163,840,400
2016-17 **	TOTAL	152,510	2.27	$188.41	$427.38	$782,179,600
2017-18 **	1	144,390	2.46	$203.56	$501.74	$217,340,300
2017-18 **	2	143,020	2.28	$193.15	$441.30	$189,339,200
2017-18 **	3	145,400	2.36	$191.68	$451.72	$197,045,500
2017-18 **	4	123,710	2.37	$188.06	$445.33	$165,271,200
2017-18 **	TOTAL	139,130	2.37	$194.45	$460.60	$768,996,100

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

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

LT-OAS

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2014-15 *	1	34,040	33.37	$178.88	$5,968.56	$609,491,300
2014-15 *	2	30,840	27.93	$165.39	$4,619.43	$427,380,800
2014-15 *	3	29,380	27.01	$162.74	$4,394.83	$387,298,500
2014-15 *	4	21,960	24.28	$164.58	$3,995.13	$263,239,300
2014-15 *	TOTAL	29,050	28.60	$169.24	$4,839.82	$1,687,409,800
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	21,140	28.49	$188.13	$5,360.13	$339,925,300
2016-17 **	4	19,380	25.45	$188.10	$4,788.11	$278,441,800
2016-17 **	TOTAL	20,830	29.06	$185.99	$5,404.45	$1,351,049,200
2017-18 **	1	20,600	32.73	$191.78	$6,276.11	$387,792,300
2017-18 **	2	20,510	27.89	$186.44	$5,199.46	$319,963,400
2017-18 **	3	20,140	28.68	$187.45	$5,376.35	$324,774,300
2017-18 **	4	18,290	26.83	$187.91	$5,041.44	$276,621,600
2017-18 **	TOTAL	19,880	29.10	$188.56	$5,486.71	$1,309,151,700

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

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

H-PE

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2014-15 *	1	37,390	4.48	$337.88	$1,512.12	$169,635,700
2014-15 *	2	39,310	4.07	$311.66	$1,267.00	$149,431,900
2014-15 *	3	42,880	3.89	$326.79	$1,270.01	$163,364,500
2014-15 *	4	36,570	3.59	$328.18	$1,176.55	$129,074,400
2014-15 *	TOTAL	39,040	4.00	$326.18	$1,305.34	$611,506,600
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	40,900	3.54	$269.18	$953.01	$116,925,200
2016-17 **	4	37,010	3.41	$269.18	$918.60	$101,991,900
2016-17 **	TOTAL	40,300	3.58	$257.42	$922.23	$446,010,800
2017-18 **	1	44,040	3.71	$278.87	$1,034.40	$136,656,600
2017-18 **	2	39,760	3.55	$254.02	$902.72	$107,672,000
2017-18 **	3	41,480	3.53	$274.75	$969.93	$120,699,800
2017-18 **	4	36,900	3.42	$271.96	$929.52	$102,889,000
2017-18 **	TOTAL	40,540	3.56	$270.23	$961.77	$467,917,300

* 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 MAY 2017 BASE ESTIMATES)

LT-ATD

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2014-15 *	1	11,330	34.94	$213.12	$7,445.79	$253,179,100
2014-15 *	2	10,410	28.49	$198.75	$5,662.79	$176,916,800
2014-15 *	3	9,940	27.67	$196.51	$5,437.32	$162,200,600
2014-15 *	4	8,000	23.66	$191.16	$4,523.52	$108,541,900
2014-15 *	TOTAL	9,920	29.15	$201.89	$5,885.89	$700,838,500
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	6,770	27.92	$212.52	$5,932.86	$120,510,400
2016-17 **	4	6,310	24.89	$209.60	$5,217.10	$98,763,200
2016-17 **	TOTAL	6,740	28.66	$209.66	$6,007.97	$486,261,500
2017-18 **	1	6,750	32.82	$216.22	$7,096.35	$143,653,900
2017-18 **	2	6,380	29.10	$211.05	$6,141.04	$117,518,500
2017-18 **	3	6,380	28.88	$209.40	$6,046.76	$115,683,700
2017-18 **	4	6,000	26.02	$209.77	$5,457.38	$98,179,600
2017-18 **	TOTAL	6,380	29.30	$211.91	$6,209.48	$475,035,700

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

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

POV 250

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2014-15 *	1	87,370	2.32	$177.17	$410.17	$107,511,700
2014-15 *	2	85,490	2.13	$155.79	$332.55	$85,284,300
2014-15 *	3	89,620	2.10	$164.66	$345.73	$92,957,800
2014-15 *	4	81,180	2.15	$156.95	$337.44	$82,178,100
2014-15 *	TOTAL	85,920	2.17	$164.08	$356.87	$367,931,800
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	97,300	2.08	$199.67	$415.70	$121,345,500
2016-17 **	4	91,870	2.18	$174.68	$380.74	$104,939,900
2016-17 **	TOTAL	96,480	2.11	$191.13	$404.07	$467,824,600
2017-18 **	1	101,670	2.25	$197.73	$443.93	$135,403,600
2017-18 **	2	97,550	2.13	$188.24	$401.84	$117,602,100
2017-18 **	3	99,040	2.16	$192.92	$416.31	$123,698,900
2017-18 **	4	91,870	2.19	$175.69	$384.14	$105,878,200
2017-18 **	TOTAL	97,540	2.18	$189.00	$412.31	$482,582,800

* ACTUAL
** ESTIMATED
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QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND MAY 2017 BASE ESTIMATES)

MN-OAS

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2014-15 *	1	93,580	4.98	$150.56	$749.21	$210,338,200
2014-15 *	2	84,950	4.57	$144.40	$660.48	$168,316,700
2014-15 *	3	81,580	4.70	$156.93	$737.90	$180,602,400
2014-15 *	4	65,870	4.35	$163.79	$711.82	$140,658,100
2014-15 *	TOTAL	81,500	4.68	$153.08	$715.70	$699,915,300
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	78,250	4.04	$180.05	$726.74	$170,604,400
2016-17 **	4	72,510	3.78	$180.05	$681.11	$148,154,500
2016-17 **	TOTAL	75,480	4.17	$180.01	$750.75	$679,955,500
2017-18 **	1	76,240	4.72	$189.23	$893.46	$204,341,200
2017-18 **	2	69,570	4.38	$182.32	$798.43	$166,637,900
2017-18 **	3	77,280	4.10	$180.32	$738.64	$171,252,200
2017-18 **	4	72,450	3.84	$179.83	$690.60	$150,107,900
2017-18 **	TOTAL	73,890	4.26	$183.24	$780.87	$692,339,200

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

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

MN-ATD

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2014-15 *	1	70,510	5.82	$238.49	$1,387.50	$293,498,500
2014-15 *	2	62,490	5.02	$214.53	$1,076.04	$201,720,300
2014-15 *	3	58,530	4.91	$215.67	$1,059.09	$185,971,700
2014-15 *	4	49,090	4.56	$212.48	$968.07	$142,561,900
2014-15 *	TOTAL	60,150	5.13	$222.38	$1,141.16	$823,752,500
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	43,600	4.33	$198.27	$858.89	$112,352,700
2016-17 **	4	39,710	4.32	$186.65	$805.61	$95,977,500
2016-17 **	TOTAL	42,270	4.47	$195.51	$873.33	$443,036,100
2017-18 **	1	41,770	5.08	$202.72	$1,030.59	$129,158,500
2017-18 **	2	37,240	4.52	$195.15	$883.01	$98,636,900
2017-18 **	3	40,720	4.52	$201.25	$909.63	$111,125,800
2017-18 **	4	37,660	4.42	$190.11	$839.86	$94,898,600
2017-18 **	TOTAL	39,350	4.65	$197.74	$918.74	$433,819,800

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

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

MN-AFDC

YEAR	QUARTER	AVERAGE MONTHLY USERS	AVERAGE MONTHLY UNIT PER USER	AVERAGE MONTHLY COST PER UNIT	AVERAGE MONTHLY COST PER USER	TOTAL COST
2014-15 *	1	486,380	2.66	$203.58	$542.48	$791,548,800
2014-15 *	2	461,340	2.45	$192.67	$471.20	$652,159,100
2014-15 *	3	474,420	2.45	$199.52	$489.20	$696,253,100
2014-15 *	4	422,810	2.44	$183.93	$448.83	$569,298,400
2014-15 *	TOTAL	461,240	2.50	$195.50	$489.49	$2,709,259,500
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	402,820	2.49	$199.54	$497.39	$601,083,300
2016-17 **	4	334,830	2.50	$196.49	$490.66	$492,862,100
2016-17 **	TOTAL	407,140	2.49	$195.70	$487.80	$2,383,256,500
2017-18 **	1	404,110	2.71	$204.67	$555.29	$673,180,400
2017-18 **	2	393,660	2.49	$199.68	$496.81	$586,714,700
2017-18 **	3	387,660	2.58	$200.77	$517.15	$601,443,500
2017-18 **	4	332,340	2.53	$198.35	$501.66	$500,166,600
2017-18 **	TOTAL	379,440	2.58	$201.07	$518.64	$2,361,505,200

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

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

MI-C

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2014-15 *	1	88,300	2.75	$141.98	$390.49	$103,443,000
2014-15 *	2	73,400	2.58	$141.61	$364.98	$80,363,800
2014-15 *	3	78,920	2.75	$149.10	$410.08	$97,088,100
2014-15 *	4	72,090	2.68	$142.01	$380.87	$82,368,600
2014-15 *	TOTAL	78,180	2.69	$143.74	$387.23	$363,263,500
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	65,540	2.63	$151.78	$398.61	$78,380,600
2016-17 **	4	58,190	2.37	$154.77	$366.51	$63,983,700
2016-17 **	TOTAL	62,260	2.60	$151.66	$394.93	$295,043,600
2017-18 **	1	70,960	2.57	$155.45	$398.93	$84,929,800
2017-18 **	2	59,950	2.50	$155.54	$389.36	$70,026,100
2017-18 **	3	65,590	2.65	$158.89	$420.34	$82,706,400
2017-18 **	4	58,190	2.39	$161.06	$384.58	$67,138,100
2017-18 **	TOTAL	63,670	2.53	$157.61	$398.91	$304,800,500

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

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

MI-A

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2014-15 *	1	930	14.09	$230.79	$3,251.01	$9,070,300
2014-15 *	2	630	17.56	$205.89	$3,616.21	$6,870,800
2014-15 *	3	530	20.55	$223.80	$4,599.55	$7,304,100
2014-15 *	4	450	14.94	$207.12	$3,094.61	$4,208,700
2014-15 *	TOTAL	640	16.45	$218.53	$3,594.38	$27,453,900
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	440	24.94	$204.65	$5,103.04	$6,796,400
2016-17 **	4	440	21.00	$201.32	$4,228.72	$5,633,300
2016-17 **	TOTAL	460	23.85	$203.10	$4,844.88	$26,903,500
2017-18 **	1	490	24.46	$206.28	$5,046.07	$7,348,200
2017-18 **	2	470	23.40	$199.86	$4,676.25	$6,604,900
2017-18 **	3	450	24.73	$202.76	$5,013.99	$6,797,000
2017-18 **	4	440	21.01	$202.24	$4,248.57	$5,659,700
2017-18 **	TOTAL	460	23.43	$202.87	$4,753.03	$26,409,800

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

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

REFUGEE

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2014-15 *	1	630	2.80	$118.88	$332.45	$629,300
2014-15 *	2	540	2.48	$118.93	$294.45	$476,400
2014-15 *	3	460	2.57	$145.46	$373.21	$511,300
2014-15 *	4	380	2.18	$139.26	$303.77	$343,600
2014-15 *	TOTAL	500	2.54	$128.30	$326.12	$1,960,600
2015-16 *	1	420	2.63	$122.73	$323.21	$406,600
2015-16 *	2	550	2.90	$147.91	$428.28	$709,700
2015-16 *	3	420	2.70	$160.31	$433.50	$551,000
2015-16 *	4	470	2.55	$101.11	$257.47	$366,600
2015-16 *	TOTAL	470	2.70	$134.04	$362.54	$2,033,900
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	620	2.38	$121.86	$289.96	$543,400
2016-17 **	4	640	2.29	$116.85	$267.16	$516,200
2016-17 **	TOTAL	580	2.53	$126.13	$319.49	$2,231,600
2017-18 **	1	600	2.76	$125.94	$347.55	$625,300
2017-18 **	2	780	2.83	$119.24	$337.02	$785,000
2017-18 **	3	870	2.51	$119.72	$300.32	$787,700
2017-18 **	4	710	2.17	$115.68	$250.85	$534,300
2017-18 **	TOTAL	740	2.56	$120.12	$307.65	$2,732,300

* 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 MAY 2017 BASE ESTIMATES)

OBRA

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2014-15 *	1	6,910	4.92	$220.82	$1,087.02	$22,534,000
2014-15 *	2	8,010	4.17	$206.55	$862.35	$20,718,900
2014-15 *	3	9,330	4.01	$216.28	$866.51	$24,244,000
2014-15 *	4	8,390	3.73	$210.06	$784.37	$19,738,700
2014-15 *	TOTAL	8,160	4.17	$213.60	$891.07	$87,235,600
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	870	6.60	$336.74	$2,223.81	$5,809,400
2016-17 **	4	710	6.31	$255.22	$1,611.71	$3,438,300
2016-17 **	TOTAL	1,480	4.74	$276.94	$1,312.40	$23,302,600
2017-18 **	1	1,240	6.93	$259.75	$1,800.95	$6,720,100
2017-18 **	2	590	8.29	$250.36	$2,076.21	$3,664,700
2017-18 **	3	620	9.06	$373.28	$3,381.15	$6,239,600
2017-18 **	4	710	6.62	$252.76	$1,674.44	$3,553,700
2017-18 **	TOTAL	790	7.53	$283.07	$2,132.04	$20,178,100

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

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

POV 185

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2014-15 *	1	151,620	3.34	$205.49	$685.53	$311,811,300
2014-15 *	2	123,940	3.15	$225.50	$710.62	$264,232,400
2014-15 *	3	135,170	3.06	$225.06	$688.06	$279,015,600
2014-15 *	4	115,620	2.96	$226.24	$669.80	$232,319,800
2014-15 *	TOTAL	131,590	3.14	$219.41	$688.63	$1,087,379,100
2015-16 *	1	131,050	3.21	$243.44	$780.26	$306,761,100
2015-16 *	2	129,740	2.91	$250.63	$730.57	$284,347,900
2015-16 *	3	121,260	2.86	$253.62	$725.25	$263,826,300
2015-16 *	4	124,360	2.82	$257.62	$727.01	$271,241,500
2015-16 *	TOTAL	126,600	2.95	$250.94	$741.28	$1,126,176,800
2016-17 *	1	140,710	2.94	$260.60	$766.98	$323,762,700
2016-17 *	2	126,600	2.84	$275.02	$780.56	$296,458,900
2016-17 **	3	136,960	2.89	$271.05	$784.35	$322,263,900
2016-17 **	4	120,890	2.69	$277.20	$747.00	$270,922,800
2016-17 **	TOTAL	131,290	2.85	$270.45	$770.18	$1,213,408,400
2017-18 **	1	145,550	2.98	$272.69	$812.70	$354,867,400
2017-18 **	2	129,210	2.81	$274.02	$770.41	$298,622,900
2017-18 **	3	139,140	2.90	$283.55	$822.40	$343,279,900
2017-18 **	4	123,840	2.70	$278.13	$751.65	$279,258,000
2017-18 **	TOTAL	134,430	2.86	$277.05	$790.99	$1,276,028,200

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

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

POV 133

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2014-15 *	1	27,730	1.96	$147.80	$289.51	$24,086,200
2014-15 *	2	32,390	1.88	$133.61	$251.36	$24,425,300
2014-15 *	3	42,540	1.87	$152.60	$285.95	$36,488,400
2014-15 *	4	44,560	1.86	$145.89	$270.83	$36,203,500
2014-15 *	TOTAL	36,800	1.89	$145.50	$274.43	$121,203,300
2015-16 *	1	56,590	2.09	$150.37	$314.14	$53,326,600
2015-16 *	2	65,040	1.90	$152.25	$288.85	$56,356,300
2015-16 *	3	64,000	1.86	$144.67	$269.51	$51,745,900
2015-16 *	4	68,970	1.97	$154.84	$305.36	$63,184,000
2015-16 *	TOTAL	63,650	1.95	$150.69	$294.08	$224,612,700
2016-17 *	1	76,280	1.95	$169.62	$331.42	$75,840,900
2016-17 *	2	77,570	1.77	$175.82	$310.91	$72,354,700
2016-17 **	3	77,720	1.85	$174.87	$323.99	$75,545,300
2016-17 **	4	74,290	1.80	$174.05	$313.96	$69,975,500
2016-17 **	TOTAL	76,470	1.84	$173.52	$320.09	$293,716,400
2017-18 **	1	80,220	1.85	$187.53	$346.48	$83,385,700
2017-18 **	2	82,520	1.79	$176.50	$316.48	$78,348,300
2017-18 **	3	79,380	1.90	$177.11	$337.27	$80,319,900
2017-18 **	4	75,340	1.81	$177.60	$321.65	$72,699,400
2017-18 **	TOTAL	79,370	1.84	$179.71	$330.49	$314,753,300

* 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 MAY 2017 BASE ESTIMATES)

POV 100

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2014-15 *	1	22,600	2.30	$167.80	$385.96	$26,164,700
2014-15 *	2	24,120	2.09	$156.77	$327.43	$23,694,900
2014-15 *	3	27,240	2.05	$152.03	$311.43	$25,448,500
2014-15 *	4	25,480	2.09	$152.94	$318.94	$24,384,200
2014-15 *	TOTAL	24,860	2.12	$157.27	$334.17	$99,692,200
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	36,200	1.93	$180.77	$349.07	$37,910,300
2016-17 **	4	33,110	2.00	$177.04	$353.55	$35,119,300
2016-17 **	TOTAL	35,920	1.95	$182.85	$357.07	$153,914,100
2017-18 **	1	38,250	2.07	$196.55	$406.13	$46,606,000
2017-18 **	2	39,580	1.92	$188.18	$361.67	$42,947,600
2017-18 **	3	38,210	2.01	$189.63	$381.39	$43,724,500
2017-18 **	4	34,900	2.02	$184.33	$372.02	$38,951,800
2017-18 **	TOTAL	37,740	2.00	$189.84	$380.32	$172,229,800

* 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 2016-17

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	ELIGIBILITY				
4	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	$65,767,000	$52,355,000	$0	$13,412,000
7	COUNTY HEALTH INITIATIVE MATCHING (CHIM)	$7,058,000	$6,211,040	$846,960	$0
8	MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL	$2,752,000	$2,421,760	$330,240	$0
	ELIGIBILITY SUBTOTAL	**$75,577,000**	**$60,987,800**	**$1,177,200**	**$13,412,000**
	DRUG MEDI-CAL				
63	NARCOTIC TREATMENT PROGRAM	$148,543,000	$146,563,400	$1,979,600	$0
65	OUTPATIENT DRUG FREE TREATMENT SERVICES	$22,516,000	$22,228,200	$287,800	$0
66	INTENSIVE OUTPATIENT TREATMENT SERVICES	$8,377,000	$7,158,250	$1,218,750	$0
68	RESIDENTIAL TREATMENT SERVICES	$1,481,000	$1,462,850	$18,150	$0
	DRUG MEDI-CAL SUBTOTAL	**$180,917,000**	**$177,412,700**	**$3,504,300**	**$0**
	MENTAL HEALTH				
70	SMHS FOR ADULTS	$1,285,401,000	$1,203,435,850	$16,006,150	$65,959,000
71	SMHS FOR CHILDREN	$1,058,354,000	$1,023,578,050	$887,950	$33,888,000
	MENTAL HEALTH SUBTOTAL	**$2,343,755,000**	**$2,227,013,900**	**$16,894,100**	**$99,847,000**
	MANAGED CARE				
96	TWO PLAN MODEL	$19,603,938,000	$14,163,492,370	$5,440,445,630	$0
97	COUNTY ORGANIZED HEALTH SYSTEMS	$7,891,527,000	$5,715,753,330	$2,175,773,670	$0
99	GEOGRAPHIC MANAGED CARE	$3,677,114,000	$2,719,928,270	$957,185,730	$0
102	REGIONAL MODEL	$1,201,454,000	$887,429,290	$314,024,710	$0
104	PACE (Other M/C)	$418,255,000	$209,127,500	$209,127,500	$0
106	DENTAL MANAGED CARE (Other M/C)	$126,718,000	$84,050,950	$42,667,050	$0
107	SENIOR CARE ACTION NETWORK (Other M/C)	$70,571,000	$35,285,500	$35,285,500	$0
108	AIDS HEALTHCARE CENTERS (Other M/C)	$9,628,000	$4,814,000	$4,814,000	$0
	MANAGED CARE SUBTOTAL	**$32,999,205,000**	**$23,819,881,210**	**$9,179,323,790**	**$0**
	OTHER				
167	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$3,080,719,000	$1,431,565,500	$1,649,153,500	$0
168	MEDICARE PAYMENTS - PART D PHASED-DOWN	$1,915,760,000	$0	$1,915,760,000	$0
169	HOME & COMMUNITY-BASED SVCS.- CDDS (Misc.)	$1,603,877,000	$1,603,877,000	$0	$0
170	PERSONAL CARE SERVICES (Misc. Svcs.)	$1,119,545,000	$1,119,545,000	$0	$0
171	DENTAL SERVICES	$975,699,000	$672,926,680	$302,772,320	$0
173	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$207,330,000	$207,330,000	$0	$0
175	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$215,538,000	$215,538,000	$0	$0

SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2016-17

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER				
177	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$44,055,000	$22,027,500	$22,027,500	$0
178	MEDI-CAL TCM PROGRAM	$35,392,000	$35,392,000	$0	$0
179	EPSDT SCREENS	$35,413,000	$18,460,040	$16,952,960	$0
186	LAWSUITS/CLAIMS	$5,358,000	$3,154,500	$2,203,500	$0
187	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$1,313,000	$656,500	$656,500	$0
188	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	$1,291,000	$1,291,000	$0	$0
203	BASE RECOVERIES	($321,820,000)	($167,165,000)	($154,655,000)	$0
	OTHER SUBTOTAL	**$8,919,470,000**	**$5,164,598,720**	**$3,754,871,280**	**$0**
	GRAND TOTAL	**$44,518,924,000**	**$31,449,894,330**	**$12,955,770,670**	**$113,259,000**

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	$29,170,000	$22,977,000	$0	$6,193,000
7	COUNTY HEALTH INITIATIVE MATCHING (CHIM)	$7,144,000	$6,286,720	$857,280	$0
8	MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL	$2,755,000	$2,424,400	$330,600	$0
	ELIGIBILITY SUBTOTAL	**$39,069,000**	**$31,688,120**	**$1,187,880**	**$6,193,000**
	DRUG MEDI-CAL				
63	NARCOTIC TREATMENT PROGRAM	$158,571,000	$153,244,850	$5,326,150	$0
65	OUTPATIENT DRUG FREE TREATMENT SERVICES	$24,330,000	$23,557,490	$772,510	$0
66	INTENSIVE OUTPATIENT TREATMENT SERVICES	$9,458,000	$8,038,630	$1,419,370	$0
68	RESIDENTIAL TREATMENT SERVICES	$1,505,000	$1,456,000	$49,000	$0
	DRUG MEDI-CAL SUBTOTAL	**$193,864,000**	**$186,296,970**	**$7,567,030**	**$0**
	MENTAL HEALTH				
70	SMHS FOR ADULTS	$1,425,027,000	$1,315,369,980	$17,359,020	$92,298,000
71	SMHS FOR CHILDREN	$1,127,659,000	$1,090,024,340	$2,266,660	$35,368,000
	MENTAL HEALTH SUBTOTAL	**$2,552,686,000**	**$2,405,394,320**	**$19,625,680**	**$127,666,000**
	MANAGED CARE				
96	TWO PLAN MODEL	$20,478,370,000	$14,361,860,360	$5,582,639,640	$533,870,000
97	COUNTY ORGANIZED HEALTH SYSTEMS	$7,985,671,000	$5,600,517,200	$2,261,243,800	$123,910,000
99	GEOGRAPHIC MANAGED CARE	$3,798,337,000	$2,743,082,570	$985,124,430	$70,130,000
102	REGIONAL MODEL	$1,219,782,000	$878,492,050	$338,889,950	$2,400,000
104	PACE (Other M/C)	$421,796,000	$210,898,000	$177,118,000	$33,780,000
106	DENTAL MANAGED CARE (Other M/C)	$133,170,000	$86,210,830	$46,959,170	$0
107	SENIOR CARE ACTION NETWORK (Other M/C)	$65,050,000	$32,525,000	$32,525,000	$0
108	AIDS HEALTHCARE CENTERS (Other M/C)	$19,750,000	$9,875,000	$9,875,000	$0
110	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	$3,117,000	$1,558,500	$1,558,500	$0
	MANAGED CARE SUBTOTAL	**$34,125,043,000**	**$23,925,019,510**	**$9,435,933,490**	**$764,090,000**
	OTHER				
167	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$3,270,379,000	$1,518,742,500	$1,733,276,500	$18,360,000
168	MEDICARE PAYMENTS - PART D PHASED-DOWN	$2,125,280,000	$0	$1,917,310,000	$207,970,000
169	HOME & COMMUNITY-BASED SVCS.- CDDS (Misc.)	$1,736,805,000	$1,736,805,000	$0	$0
170	PERSONAL CARE SERVICES (Misc. Svcs.)	$1,464,250,000	$1,464,250,000	$0	$0
171	DENTAL SERVICES	$1,171,505,000	$769,683,660	$357,651,340	$44,170,000
173	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				
175	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$194,996,000	$194,996,000	$0	$0
177	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$46,068,000	$23,034,000	$23,034,000	$0
178	MEDI-CAL TCM PROGRAM	$30,063,000	$30,063,000	$0	$0
179	EPSDT SCREENS	$34,832,000	$18,157,000	$16,675,000	$0
186	LAWSUITS/CLAIMS	$2,013,000	$932,500	$1,080,500	$0
187	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$1,307,000	$653,500	$653,500	$0
188	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	$1,028,000	$1,028,000	$0	$0
203	BASE RECOVERIES	($352,303,000)	($182,998,000)	($169,305,000)	$0
	OTHER SUBTOTAL	**$9,933,553,000**	**$5,782,677,160**	**$3,880,375,840**	**$270,500,000**
	GRAND TOTAL	**$46,844,215,000**	**$32,331,076,080**	**$13,344,689,920**	**$1,168,449,000**

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
MAY 2017 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2016 ESTIMATE
FISCAL YEAR 2016-17

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	2016-17 APPROPRIATION TOTAL FUNDS	2016-17 APPROPRIATION GENERAL FUNDS	NOV. 2016 EST. FOR 2016-17 TOTAL FUNDS	NOV. 2016 EST. FOR 2016-17 GENERAL FUNDS	MAY 2017 EST. FOR 2016-17 TOTAL FUNDS	MAY 2017 EST. FOR 2016-17 GENERAL FUNDS	DIFF. MAY TO APPROPRIATION TOTAL FUNDS	DIFF. MAY TO APPROPRIATION GENERAL FUNDS	DIFFERENCE MAY TO NOVEMBER TOTAL FUNDS	DIFFERENCE MAY TO NOVEMBER GENERAL FUNDS
		ELIGIBILITY										
4	4	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	$65,561,000	$0	$91,732,000	$0	$65,767,000	$0	$206,000	$0	($25,965,000)	$0
--	7	COUNTY HEALTH INITIATIVE MATCHING (CHIM)	$0	$0	$0	$0	$7,058,000	$846,960	$7,058,000	$846,960	$7,058,000	$846,960
8	8	MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL	$4,785,000	$574,200	$1,746,000	$209,520	$2,752,000	$330,240	($2,033,000)	($243,960)	$1,006,000	$120,720
		ELIGIBILITY SUBTOTAL	**$70,346,000**	**$574,200**	**$93,478,000**	**$209,520**	**$75,577,000**	**$1,177,200**	**$5,231,000**	**$603,000**	**($17,901,000)**	**$967,680**
		DRUG MEDI-CAL										
63	63	NARCOTIC TREATMENT PROGRAM	$116,267,000	$1,204,400	$131,983,000	$1,522,200	$148,543,000	$1,979,600	$32,276,000	$775,200	$16,560,000	$457,400
65	65	OUTPATIENT DRUG FREE TREATMENT SERVICES	$16,710,000	$131,550	$17,264,000	$149,750	$22,516,000	$287,800	$5,806,000	$156,250	$5,252,000	$138,050
66	66	INTENSIVE OUTPATIENT TREATMENT SERVICES	$4,952,000	$979,100	$6,217,000	$1,349,920	$8,377,000	$1,218,750	$3,425,000	$239,650	$2,160,000	($131,170)
68	68	RESIDENTIAL TREATMENT SERVICES	$868,000	$4,450	$1,120,000	$6,900	$1,481,000	$18,150	$613,000	$13,700	$361,000	$11,250
		DRUG MEDI-CAL SUBTOTAL	**$138,797,000**	**$2,319,500**	**$156,584,000**	**$3,028,770**	**$180,917,000**	**$3,504,300**	**$42,120,000**	**$1,184,800**	**$24,333,000**	**$475,530**
		MENTAL HEALTH										
70	70	SMHS FOR ADULTS	$1,410,630,000	$17,359,300	$1,287,426,000	$16,110,050	$1,285,401,000	$16,006,150	($125,229,000)	($1,353,150)	($2,025,000)	($103,900)
71	71	SMHS FOR CHILDREN	$1,091,389,000	$0	$1,059,399,000	$873,850	$1,058,354,000	$887,950	($33,035,000)	$887,950	($1,045,000)	$14,100
		MENTAL HEALTH SUBTOTAL	**$2,502,019,000**	**$17,359,300**	**$2,346,825,000**	**$16,983,900**	**$2,343,755,000**	**$16,894,100**	**($158,264,000)**	**($465,200)**	**($3,070,000)**	**($89,800)**
		MANAGED CARE										
96	96	TWO PLAN MODEL	$19,024,105,000	$5,582,634,920	$19,859,742,000	$5,572,405,790	$19,603,938,000	$5,440,445,630	$579,833,000	($142,189,290)	($255,804,000)	($131,960,160)
97	97	COUNTY ORGANIZED HEALTH SYSTEMS	$7,839,965,000	$2,261,244,470	$8,038,535,000	$2,251,455,440	$7,891,527,000	$2,175,773,670	$51,562,000	($85,470,800)	($147,008,000)	($75,681,770)
99	99	GEOGRAPHIC MANAGED CARE	$3,590,254,000	$985,126,420	$3,671,239,000	$968,419,600	$3,677,114,000	$957,185,730	$86,860,000	($27,940,690)	$5,875,000	($11,233,870)
102	102	REGIONAL MODEL	$1,152,969,000	$338,890,040	$1,242,284,000	$333,419,090	$1,201,454,000	$314,024,710	$48,485,000	($24,865,330)	($40,830,000)	($19,394,380)
104	104	PACE (Other M/C)	$354,239,000	$177,119,500	$414,524,000	$207,262,000	$418,255,000	$209,127,500	$64,016,000	$32,008,000	$3,731,000	$1,865,500
106	106	DENTAL MANAGED CARE (Other M/C)	$166,851,000	$65,765,570	$132,519,000	$49,754,390	$126,718,000	$42,667,050	($40,133,000)	($23,098,520)	($5,801,000)	($7,087,340)
107	107	SENIOR CARE ACTION NETWORK (Other M/C)	$68,065,000	$34,032,500	$70,604,000	$35,412,000	$70,571,000	$35,285,500	$2,506,000	$1,253,000	($33,000)	($126,500)
108	108	AIDS HEALTHCARE CENTERS (Other M/C)	$10,980,000	$5,490,000	$10,980,000	$5,490,000	$9,628,000	$4,814,000	($1,352,000)	($676,000)	($1,352,000)	($676,000)
110	--	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	$1,826,000	$913,000	$1,826,000	$913,000	$0	$0	($1,826,000)	($913,000)	($1,826,000)	($913,000)

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
MAY 2017 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2016 ESTIMATE
FISCAL YEAR 2016-17

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	2016-17 APPROPRIATION TOTAL FUNDS	2016-17 APPROPRIATION GENERAL FUNDS	NOV. 2016 EST. FOR 2016-17 TOTAL FUNDS	NOV. 2016 EST. FOR 2016-17 GENERAL FUNDS	MAY 2017 EST. FOR 2016-17 TOTAL FUNDS	MAY 2017 EST. FOR 2016-17 GENERAL FUNDS	DIFF. MAY TO APPROPRIATION TOTAL FUNDS	DIFF. MAY TO APPROPRIATION GENERAL FUNDS	DIFFERENCE MAY TO NOVEMBER TOTAL FUNDS	DIFFERENCE MAY TO NOVEMBER GENERAL FUNDS
		MANAGED CARE SUBTOTAL	**$32,209,254,000**	**$9,451,216,420**	**$33,442,253,000**	**$9,424,531,310**	**$32,999,205,000**	**$9,179,323,790**	**$789,951,000**	**($271,892,630)**	**($443,048,000)**	**($245,207,520)**
		OTHER										
167	167	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$2,994,034,000	$1,617,825,500	$3,002,163,000	$1,619,150,500	$3,080,719,000	$1,649,153,500	$86,685,000	$31,328,000	$78,556,000	$30,003,000
168	168	MEDICARE PAYMENTS - PART D PHASED-DOWN	$1,917,313,000	$1,917,313,000	$1,921,599,000	$1,921,599,000	$1,915,760,000	$1,915,760,000	($1,553,000)	($1,553,000)	($5,839,000)	($5,839,000)
169	169	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	$1,535,667,000	$0	$1,948,185,000	$0	$1,603,877,000	$0	$68,210,000	$0	($344,308,000)	$0
170	170	PERSONAL CARE SERVICES (Misc. Svcs.)	$1,518,950,000	$0	$1,299,545,000	$0	$1,119,545,000	$0	($399,405,000)	$0	($180,000,000)	$0
171	171	DENTAL SERVICES	$1,057,219,000	$357,650,190	$992,234,000	$310,636,300	$975,699,000	$302,772,320	($81,520,000)	($54,877,870)	($16,535,000)	($7,863,980)
173	173	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$207,330,000	$0	$207,330,000	$0	$207,330,000	$0	$0	$0	$0	$0
175	175	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$161,949,000	$0	$226,117,000	$0	$215,538,000	$0	$53,589,000	$0	($10,579,000)	$0
177	177	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$43,975,000	$21,987,500	$41,563,000	$20,781,500	$44,055,000	$22,027,500	$80,000	$40,000	$2,492,000	$1,246,000
178	178	MEDI-CAL TCM PROGRAM	$51,147,000	$0	$37,245,000	$0	$35,392,000	$0	($15,755,000)	$0	($1,853,000)	$0
179	179	EPSDT SCREENS	$42,193,000	$19,952,700	$36,894,000	$17,540,320	$35,413,000	$16,952,960	($6,780,000)	($2,999,740)	($1,481,000)	($587,360)
186	186	LAWSUITS/CLAIMS	$1,913,000	$956,500	$3,537,000	$1,292,500	$5,358,000	$2,203,500	$3,445,000	$1,247,000	$1,821,000	$911,000
187	187	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$1,626,000	$813,000	$1,476,000	$738,000	$1,313,000	$656,500	($313,000)	($156,500)	($163,000)	($81,500)
188	188	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	$1,028,000	$0	$1,291,000	$0	$1,291,000	$0	$263,000	$0	$0	$0
203	203	BASE RECOVERIES	($294,693,000)	($154,158,000)	($333,599,000)	($160,316,000)	($321,820,000)	($154,655,000)	($27,127,000)	($497,000)	$11,779,000	$5,661,000
		OTHER SUBTOTAL	**$9,239,651,000**	**$3,782,340,390**	**$9,385,580,000**	**$3,731,422,120**	**$8,919,470,000**	**$3,754,871,280**	**($320,181,000)**	**($27,469,110)**	**($466,110,000)**	**$23,449,160**
		GRAND TOTAL	**$44,160,067,000**	**$13,253,809,810**	**$45,424,720,000**	**$13,176,175,620**	**$44,518,924,000**	**$12,955,770,670**	**$358,857,000**	**($298,039,140)**	**($905,796,000)**	**($220,404,950)**

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
MAY 2017 ESTIMATE COMPARED TO NOVEMBER 2016 ESTIMATE
FISCAL YEAR 2017-18

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2016 EST. FOR 2017-18		MAY 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	$36,471,000	$0	$29,170,000	$0	($7,301,000)	$0
--	7	COUNTY HEALTH INITIATIVE MATCHING (CHIM)	$0	$0	$7,144,000	$857,280	$7,144,000	$857,280
8	8	MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL	$1,362,000	$163,440	$2,755,000	$330,600	$1,393,000	$167,160
		ELIGIBILITY SUBTOTAL	**$37,833,000**	**$163,440**	**$39,069,000**	**$1,187,880**	**$1,236,000**	**$1,024,440**
		DRUG MEDI-CAL						
63	63	NARCOTIC TREATMENT PROGRAM	$135,724,000	$3,916,520	$158,571,000	$5,326,150	$22,847,000	$1,409,630
65	65	OUTPATIENT DRUG FREE TREATMENT SERVICES	$17,377,000	$379,290	$24,330,000	$772,510	$6,953,000	$393,220
66	66	INTENSIVE OUTPATIENT TREATMENT SERVICES	$6,282,000	$1,388,580	$9,458,000	$1,419,370	$3,176,000	$30,790
68	68	RESIDENTIAL TREATMENT SERVICES	$1,057,000	$17,420	$1,505,000	$49,000	$448,000	$31,580
		DRUG MEDI-CAL SUBTOTAL	**$160,440,000**	**$5,701,810**	**$193,864,000**	**$7,567,030**	**$33,424,000**	**$1,865,220**
		MENTAL HEALTH						
70	70	SMHS FOR ADULTS	$1,430,236,000	$41,444,700	$1,425,027,000	$17,359,020	($5,209,000)	($24,085,680)
71	71	SMHS FOR CHILDREN	$1,131,616,000	$2,241,690	$1,127,659,000	$2,266,660	($3,957,000)	$24,970
		MENTAL HEALTH SUBTOTAL	**$2,561,852,000**	**$43,686,390**	**$2,552,686,000**	**$19,625,680**	**($9,166,000)**	**($24,060,710)**
		MANAGED CARE						
96	96	TWO PLAN MODEL	$20,194,590,000	$5,582,634,910	$20,478,370,000	$5,582,639,640	$283,780,000	$4,730
97	97	COUNTY ORGANIZED HEALTH SYSTEMS	$8,135,638,000	$2,261,244,540	$7,985,671,000	$2,261,243,800	($149,967,000)	($740)
99	99	GEOGRAPHIC MANAGED CARE	$3,759,068,000	$985,126,590	$3,798,337,000	$985,124,430	$39,269,000	($2,160)
102	102	REGIONAL MODEL	$1,249,041,000	$338,889,560	$1,219,782,000	$338,889,950	($29,259,000)	$390
104	104	PACE (Other M/C)	$425,845,000	$177,119,500	$421,796,000	$177,118,000	($4,049,000)	($1,500)
106	106	DENTAL MANAGED CARE (Other M/C)	$147,598,000	$56,443,760	$133,170,000	$46,959,170	($14,428,000)	($9,484,590)

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
MAY 2017 ESTIMATE COMPARED TO NOVEMBER 2016 ESTIMATE
FISCAL YEAR 2017-18

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2016 EST. FOR 2017-18		MAY 2017 EST. FOR 2017-18		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		MANAGED CARE						
107	107	SENIOR CARE ACTION NETWORK (Other M/C)	$67,060,000	$33,530,000	$65,050,000	$32,525,000	($2,010,000)	($1,005,000)
108	108	AIDS HEALTHCARE CENTERS (Other M/C)	$10,980,000	$5,490,000	$19,750,000	$9,875,000	$8,770,000	$4,385,000
110	110	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	$913,000	$456,500	$3,117,000	$1,558,500	$2,204,000	$1,102,000
		MANAGED CARE SUBTOTAL	**$33,990,733,000**	**$9,440,935,360**	**$34,125,043,000**	**$9,435,933,490**	**$134,310,000**	**($5,001,870)**
		OTHER						
167	167	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$3,088,491,000	$1,626,768,500	$3,270,379,000	$1,733,276,500	$181,888,000	$106,508,000
168	168	MEDICARE PAYMENTS - PART D PHASED-DOWN	$2,202,798,000	$1,917,313,000	$2,125,280,000	$1,917,310,000	($77,518,000)	($3,000)
169	169	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	$1,741,214,000	$0	$1,736,805,000	$0	($4,409,000)	$0
170	170	PERSONAL CARE SERVICES (Misc. Svcs.)	$2,120,950,000	$0	$1,464,250,000	$0	($656,700,000)	$0
171	171	DENTAL SERVICES	$1,247,550,000	$430,696,140	$1,171,505,000	$357,651,340	($76,045,000)	($73,044,800)
173	173	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$207,330,000	$0	$207,330,000	$0	$0	$0
175	175	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$192,287,000	$0	$194,996,000	$0	$2,709,000	$0
177	177	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$43,686,000	$21,843,000	$46,068,000	$23,034,000	$2,382,000	$1,191,000
178	178	MEDI-CAL TCM PROGRAM	$32,676,000	$0	$30,063,000	$0	($2,613,000)	$0
179	179	EPSDT SCREENS	$36,835,000	$17,512,340	$34,832,000	$16,675,000	($2,003,000)	($837,340)
186	186	LAWSUITS/CLAIMS	$1,865,000	$932,500	$2,013,000	$1,080,500	$148,000	$148,000
187	187	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$1,469,000	$734,500	$1,307,000	$653,500	($162,000)	($81,000)
188	188	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	$1,028,000	$0	$1,028,000	$0	$0	$0

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
MAY 2017 ESTIMATE COMPARED TO NOVEMBER 2016 ESTIMATE
FISCAL YEAR 2017-18

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2016 EST. FOR 2017-18		MAY 2017 EST. FOR 2017-18		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER						
203	203	BASE RECOVERIES	($337,345,000)	($162,116,000)	($352,303,000)	($169,305,000)	($14,958,000)	($7,189,000)
		OTHER SUBTOTAL	**$10,580,834,000**	**$3,853,683,980**	**$9,933,553,000**	**$3,880,375,840**	**($647,281,000)**	**$26,691,860**
		GRAND TOTAL	**$47,331,692,000**	**$13,344,170,980**	**$46,844,215,000**	**$13,344,689,920**	**($487,477,000)**	**$518,940**

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2016-17 AND 2017-18

NO.	POLICY CHANGE TITLE	MAY 2017 EST. FOR 2016-17		MAY 2017 EST. FOR 2017-18		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	ELIGIBILITY						
4	MEDI-CAL ACCESS PROGRAM MOTHERS 213 -322% FPL	$65,767,000	$0	$29,170,000	$0	($36,597,000)	$0
7	COUNTY HEALTH INITIATIVE MATCHING (CHIM)	$7,058,000	$846,960	$7,144,000	$857,280	$86,000	$10,320
8	MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL	$2,752,000	$330,240	$2,755,000	$330,600	$3,000	$360
	ELIGIBILITY SUBTOTAL	**$75,577,000**	**$1,177,200**	**$39,069,000**	**$1,187,880**	**($36,508,000)**	**$10,680**
	DRUG MEDI-CAL						
63	NARCOTIC TREATMENT PROGRAM	$148,543,000	$1,979,600	$158,571,000	$5,326,150	$10,028,000	$3,346,550
65	OUTPATIENT DRUG FREE TREATMENT SERVICES	$22,516,000	$287,800	$24,330,000	$772,510	$1,814,000	$484,710
66	INTENSIVE OUTPATIENT TREATMENT SERVICES	$8,377,000	$1,218,750	$9,458,000	$1,419,370	$1,081,000	$200,620
68	RESIDENTIAL TREATMENT SERVICES	$1,481,000	$18,150	$1,505,000	$49,000	$24,000	$30,850
	DRUG MEDI-CAL SUBTOTAL	**$180,917,000**	**$3,504,300**	**$193,864,000**	**$7,567,030**	**$12,947,000**	**$4,062,730**
	MENTAL HEALTH						
70	SMHS FOR ADULTS	$1,285,401,000	$16,006,150	$1,425,027,000	$17,359,020	$139,626,000	$1,352,870
71	SMHS FOR CHILDREN	$1,058,354,000	$887,950	$1,127,659,000	$2,266,660	$69,305,000	$1,378,710
	MENTAL HEALTH SUBTOTAL	**$2,343,755,000**	**$16,894,100**	**$2,552,686,000**	**$19,625,680**	**$208,931,000**	**$2,731,580**
	MANAGED CARE						
96	TWO PLAN MODEL	$19,603,938,000	$5,440,445,630	$20,478,370,000	$5,582,639,640	$874,432,000	$142,194,010
97	COUNTY ORGANIZED HEALTH SYSTEMS	$7,891,527,000	$2,175,773,670	$7,985,671,000	$2,261,243,800	$94,144,000	$85,470,130
99	GEOGRAPHIC MANAGED CARE	$3,677,114,000	$957,185,730	$3,798,337,000	$985,124,430	$121,223,000	$27,938,700
102	REGIONAL MODEL	$1,201,454,000	$314,024,710	$1,219,782,000	$338,889,950	$18,328,000	$24,865,240
104	PACE (Other M/C)	$418,255,000	$209,127,500	$421,796,000	$177,118,000	$3,541,000	($32,009,500)
106	DENTAL MANAGED CARE (Other M/C)	$126,718,000	$42,667,050	$133,170,000	$46,959,170	$6,452,000	$4,292,120
107	SENIOR CARE ACTION NETWORK (Other M/C)	$70,571,000	$35,285,500	$65,050,000	$32,525,000	($5,521,000)	($2,760,500)

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2016-17 AND 2017-18

NO.	POLICY CHANGE TITLE	MAY 2017 EST. FOR 2016-17		MAY 2017 EST. FOR 2017-18		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	MANAGED CARE						
108	AIDS HEALTHCARE CENTERS (Other M/C)	$9,628,000	$4,814,000	$19,750,000	$9,875,000	$10,122,000	$5,061,000
110	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	$0	$0	$3,117,000	$1,558,500	$3,117,000	$1,558,500
	MANAGED CARE SUBTOTAL	**$32,999,205,000**	**$9,179,323,790**	**$34,125,043,000**	**$9,435,933,490**	**$1,125,838,000**	**$256,609,700**
	OTHER						
167	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$3,080,719,000	$1,649,153,500	$3,270,379,000	$1,733,276,500	$189,660,000	$84,123,000
168	MEDICARE PAYMENTS - PART D PHASED-DOWN	$1,915,760,000	$1,915,760,000	$2,125,280,000	$1,917,310,000	$209,520,000	$1,550,000
169	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	$1,603,877,000	$0	$1,736,805,000	$0	$132,928,000	$0
170	PERSONAL CARE SERVICES (Misc. Svcs.)	$1,119,545,000	$0	$1,464,250,000	$0	$344,705,000	$0
171	DENTAL SERVICES	$975,699,000	$302,772,320	$1,171,505,000	$357,651,340	$195,806,000	$54,879,020
173	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$207,330,000	$0	$207,330,000	$0	$0	$0
175	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$215,538,000	$0	$194,996,000	$0	($20,542,000)	$0
177	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$44,055,000	$22,027,500	$46,068,000	$23,034,000	$2,013,000	$1,006,500
178	MEDI-CAL TCM PROGRAM	$35,392,000	$0	$30,063,000	$0	($5,329,000)	$0
179	EPSDT SCREENS	$35,413,000	$16,952,960	$34,832,000	$16,675,000	($581,000)	($277,960)
186	LAWSUITS/CLAIMS	$5,358,000	$2,203,500	$2,013,000	$1,080,500	($3,345,000)	($1,123,000)
187	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$1,313,000	$656,500	$1,307,000	$653,500	($6,000)	($3,000)
188	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	$1,291,000	$0	$1,028,000	$0	($263,000)	$0
203	BASE RECOVERIES	($321,820,000)	($154,655,000)	($352,303,000)	($169,305,000)	($30,483,000)	($14,650,000)
	OTHER SUBTOTAL	**$8,919,470,000**	**$3,754,871,280**	**$9,933,553,000**	**$3,880,375,840**	**$1,014,083,000**	**$125,504,560**
	GRAND TOTAL	**$44,518,924,000**	**$12,955,770,670**	**$46,844,215,000**	**$13,344,689,920**	**$2,325,291,000**	**$388,919,250**

MEDI-CAL PROGRAM BASE
POLICY CHANGE INDEX

MEDI-CAL PROGRAM BASE
POLICY CHANGE INDEX

MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL

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

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$65,767,000	$29,170,000
- STATE FUNDS	$13,412,000	$6,193,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$65,767,000	$29,170,000
STATE FUNDS	$13,412,000	$6,193,000
FEDERAL FUNDS	$52,355,000	$22,977,000

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. 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 will enroll in the Fee-for-Service (FFS) delivery system. Pending Centers for Medicare and Medicaid Services (CMS) approval of a State Plan Amendment, new MCAP beneficiaries will enroll into the Medi-Cal Managed Care (MMC) plans beginning in July, 2017. 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 decrease from the prior estimate, for FY 2016-17, is due to the following:

- The Department anticipates paying retroactive capitation payments for October 2015 through June 2016 totaling $30.2M in February through June of 2017. The Department assumed $65.6M in the prior estimate.
- Enrollment projections decreased based on updated actual enrollment.
- Premium payment projections decreased based on updated actual payments in FY 2016-17.

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

- Enrollment projections decreased based on updated actual enrollment.
- Premium payment projections decreased based on updated actual payments in FY 2016-17.

The change from FY 2016-17 to FY 2017-18, in the current estimate, resulted from the following:

- The enrollment shift from run-out enrollment under the MCAP plan delivery system and the FFS delivery system to new and continued enrollment into the MMC plan delivery system.
  - The MMC plan Per Member Per Month (PMPM) rates are estimated to be a 51% savings over the MCAP plan rates.
  - The Per Member Per Delivery (PMPD) rate savings are estimated to be 38%.
- FY 2016-17 includes FY 2015-16 retroactive capitation costs.

Methodology:

1. Based on actual enrollment data from September 2012 through December 2016, the Department estimates the following:

FY 2016-17	Average Monthly Caseload	Monthly Deliveries
MCAP Plan Delivery System	2,116	289
FFS	1,391	233
Medi-Cal Managed Care	-	-
Total	**3,507**	**522**

FY 2017-18	Average Monthly Caseload	Monthly Deliveries
MCAP Plan Delivery System	191	9
FFS	1,515	252
Medi-Cal Managed Care	2,523	267
Total	**4,229**	**528**

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

FY 2016-17	PMPM	PMPD
MCAP Plan Delivery System	$ 506	$ 11,748
FFS	$ 439	$ -
Weighted Average	**$ 479**	**$ 11,748**

MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL

BASE POLICY CHANGE NUMBER: 4

FY 2017-18	PMPM	PMPD
MCAP Plan Delivery System	$ 506	$ 11,748
FFS	$ 439	$ -
Medi-Cal Managed Care	$ 251	$ 7,292
Weighted Average	**$ 330**	**$ 3,888**

3. Medi-Cal Access Program subscribers are subject to premiums fixed at 1.5% of their adjusted annual income. Premiums are estimated to total $9,097,000 in FY 2016-17 with the October – June 2015 premiums also included in FY 2016-17, and $5,250,000 in FY 2017-18.

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

5. The total estimated costs for MCAP mothers in FY 2016-17 and FY 2017-18 are:

(Dollars in Thousands)

FY 2016-17	TF	SF	FF
88% Title XXI FFP/12% Perinatal Insurance Fund	$ 67,226	$ 8,067	$ 59,159
100% Perinatal Insurance Fund	$ 7,638	$ 7,638	$ -
Premiums	$ (9,097)	$ (2,293)	$ (6,804)
TOTAL	**$ 65,767**	**$ 13,412**	**$ 52,355**

FY 2017-18	TF	SF	FF
88% Title XXI FFP/12% Perinatal Insurance Fund	$ 30,835	$ 3,700	$ 27,135
100% Perinatal Insurance Fund	$ 3,585	$ 3,585	$ -
Premiums	$ (5,250)	$ (1,092)	$ (4,158)
TOTAL	**$ 29,170**	**$ 6,193**	**$ 22,977**

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

COUNTY HEALTH INITIATIVE MATCHING (CHIM)

BASE POLICY CHANGE NUMBER:	7
IMPLEMENTATION DATE:	7/2014
ANALYST:	Jason Moody
FISCAL REFERENCE NUMBER:	1823

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$7,058,000	$7,144,000
- STATE FUNDS	$846,960	$857,280
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$7,058,000	$7,144,000
STATE FUNDS	$846,960	$857,280
FEDERAL FUNDS	$6,211,040	$6,286,720

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 of 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: 7

Reason for Change:
The change from the prior estimate, for FY 2016-17, is an increase due to a continuous increase in enrollment following the CCHIP integration into CalHEERS. The change from the prior estimate, for FY 2017-18, is an increase due to an increase in the projected total monthly enrollment averages following the CCHIP integration into CalHEERS. The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to an increase in the projected total monthly enrollment averages following the CCHIP integration into CalHEERS in FY 2017-18.

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 2016-17	TF	GF	FF
Benefits			
88% Title XXI FF / 12% GF	$6,352,000	$762,000	$5,590,000
Admin			
88% Title XXI FF / 12% GF	$706,000	$85,000	$621,000
Total	**$7,058,000**	**$847,000**	**$6,211,000**

FY 2017-18	TF	GF	FF
Benefits			
88% Title XXI FF / 12% GF	$6,430,000	$772,000	$5,658,000
Admin			
88% Title XXI FF / 12% GF	$714,000	$86,000	$628,000
Total	**$7,144,000**	**$858,000**	**$6,286,000**

*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:	8
IMPLEMENTATION DATE:	11/2013
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1797

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$2,752,000	$2,755,000
- STATE FUNDS	$330,240	$330,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,752,000	$2,755,000
STATE FUNDS	$330,240	$330,600
FEDERAL FUNDS	$2,421,760	$2,424,400

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 2016-17 and FY 2017-18, resulted from the addition of Medi-Cal Managed Care capitation costs previously reported to be included in the Managed Care base. Additionally, the Fee-for-Services (FFS) per member per month (PMPM) rate increased. The increase for FY 2017-18 also resulted from caseload stabilization instead of the previously predicted continued downward trend. The change from FY 2016-17 to FY2017-18 in the current estimate reflects caseload stabilization slightly increasing monthly enrollment in FY 2017-18.

MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL

BASE POLICY CHANGE NUMBER: 8

Methodology:

1. The Department estimates the following average monthly infants with family income between 266% and 322% FPL will enroll in FY 2016-17 and FY 2017-18:

Delivery System	FY 2016-17	FY 2017-18
FFS	206	206
Medi-Cal Managed Care	646	647
Total Monthly Enrollment	**852**	**853**

2. The Department estimates the weighted average monthly per-member-per-month (PMPM) cost in FY 2016-17 and FY 2017-18 is $704.17 for FFS infants and $147.97 for Medi-Cal Managed Care infants.

3. MCAP subscribers are subject to monthly premiums. Premiums are estimated to total $133,000 in FY 2016-17 and FY 2017-18.

4. The total estimated costs for MCAP infants in FY 2016-17 and FY 2017-18 are:

(Dollars in Thousands)

FY 2016-17	TF	GF	FF
Benefits	$ 2,884	$ 346	$ 2,538
Premiums	$ (133)	$ (15)	$ (118)
Net	**$ 2,752**	**$ 331**	**$ 2,421**

FY 2017-18	TF	GF	FF
Benefits	$ 2,888	$ 346	$ 2,542
Premiums	$ (133)	$ (16)	$ (117)
Net	**$ 2,755**	**$ 330**	**$ 2,424**

Funding:

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

NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER:	63
IMPLEMENTATION DATE:	7/2012
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1728

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$148,543,000	$158,571,000
- STATE FUNDS	$1,979,600	$5,326,150
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$148,543,000	$158,571,000
STATE FUNDS	$1,979,600	$5,326,150
FEDERAL FUNDS	$146,563,400	$153,244,850

DESCRIPTION

Purpose:
This policy change estimates the federal 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 64 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 65% and 88%. Funding for the ACA Optional beneficiaries is 100% FF until December 31, 2016, 95% FF / 5% GF beginning January 2017, and 94% FF / 6% GF beginning January 2018.

NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER: 63

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 (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 2016-17 and FY 2017-18, is due to the following:

- Significant increase in caseload projections for ACA Optional population.
- Increased the units of services (UOS) for regular and perinatal ACA clients based on updated FY 2015-16 claims data.

The change in the current estimate, from FY 2016-17 to FY 2017-18, is due to an increase in ACA Optional caseload projection for FY 2017-18.

Methodology:

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

2. Except for NTP perinatal ACA Optional caseload, the caseload projections are based on complete caseload data from January 2010 through June 2016. The NTP perinatal ACA Optional population caseload is based on data 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 2016-17 and FY 2017-18 budgeted amounts are based on the FY 2016-17 rates.

NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER: 63

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

			FY 2016-17		FY 2017-18	
	UOS	Rates	Caseload	Total	Caseload	Total
Regular - Current						
Dosing	290.6	$11.95	17,828	$61,911,000	17,828	$61,911,000
Individual	125.1	$13.90	17,828	$31,001,000	17,828	$31,001,000
Group	0.8	$3.05	17,828	$44,000	17,828	$44,000
Regular - EPSDT						
Dosing	116.1	$11.95	384	$533,000	384	$533,000
Individual	55.4	$13.90	384	$296,000	384	$296,000
Group	0.0	$3.05	384	$0	384	$0
Regular - ACA Optional						
Dosing	198.3	$11.95	29,078	$68,906,000	31,155	$73,828,000
Individual	89.8	$13.90	29,078	$36,296,000	31,155	$38,888,000
Group	0.5	$3.05	29,078	$44,000	31,155	$48,000
Regular Total				$199,031,000		$206,549,000
Perinatal - Current						
Dosing	135.2	$13.80	90	$168,000	90	$168,000
Individual	49.2	$18.43	90	$82,000	90	$82,000
Group	0.9	$6.07	90	$0	90	$0
Perinatal - ACA Optional						
Dosing	80.6	$13.80	197	$219,000	212	$236,000
Individual	31.4	$18.43	197	$114,000	212	$123,000
Group	0.3	$6.07	197	$0	212	$0
Perinatal Total				$583,000		$609,000
Grand Total				$199,614,000		$207,158,000

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 2016-17*	FY 2017-18*
Regular	$182,423,000	$45,606,000	$0
Perinatal	$571,000	$143,000	$0
Total for FY 2015-16	$182,994,000	$45,749,000	$0
Regular	$199,031,000	$149,274,000	$49,758,000
Perinatal	$583,000	$438,000	$146,000
Total for FY 2016-17	$199,614,000	$149,712,000	$49,904,000
Regular	$206,549,000	$0	$154,912,000
Perinatal	$609,000	$0	$457,000
Total for FY 2017-18	$207,158,000	$0	$155,369,000
Total		$195,461,000	$205,273,000

*Totals may differ due to rounding

NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER: 63

7. Total estimated reimbursements for NTP services are:

FY 2016-17	TF	GF	FF (Title XIX)	FF (Title XXI)	County
Regular					
Current	$94,190,000	$0	$46,681,000	$716,000	$46,793,000
ACA Optional	$100,690,000	$1,973,000	$98,717,000	$0	$0
Perinatal					
Current	$253,000	$0	$124,000	$4,000	$125,000
ACA Optional	$328,000	$6,000	$322,000	$0	$0
Total	$195,461,000	**$1,979,000**	**$145,844,000**	**$720,000**	$46,918,000

FY 2017-18	TF	GF	FF (Title XIX)	FF (Title XXI)	County
Regular					
Current	$93,785,000	$0	$46,478,000	$729,000	$46,578,000
ACA Optional	$110,885,000	$5,309,000	$105,576,000	$0	$0
Perinatal					
Current	$251,000	$0	$123,000	$4,000	$124,000
ACA Optional	$352,000	$17,000	$335,000	$0	$0
Total	$205,273,000	**$5,326,000**	**$152,512,000**	**$733,000**	$46,702,000

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)

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER:	65
IMPLEMENTATION DATE:	7/2012
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1727

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$22,516,000	$24,330,000
- STATE FUNDS	$287,800	$772,510
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$22,516,000	$24,330,000
STATE FUNDS	$287,800	$772,510
FEDERAL FUNDS	$22,228,200	$23,557,490

DESCRIPTION

Purpose:
This policy change estimates the federal 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 64 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: 65

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, and 94% FF / 6% GF beginning January 2018.

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 2016-17 and FY 2017-18, is due to the following:

- Increased caseload projections for the ACA Optional population based on actuals through June 2016.
- Increased units of services (UOS) for regular, EPSDT and perinatal clients based on updated FY 2015-16 claims data.

The change in the current estimate, from FY 2016-17 to FY 2017-18, is due to an increase in ACA Optional caseload projection for FY 2017-18.

Methodology:

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

2. The caseload projections are based on complete caseload data from January 2010 through June 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 2016-17 and FY 2017-18 budgeted amounts are based on the FY 2016-17 required rates.

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 65

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

			FY 2016-17		FY 2017-18	
	UOS	Rates	Caseload	Total	Caseload	Total
Regular						
Current						
Individual	3.30	$69.50	6,795	$1,558,000	6,795	$1,558,000
Group	23.70	$27.46	6,795	$4,422,000	6,795	$4,422,000
EPSDT						
Individual	4.00	$69.50	6,255	$1,739,000	6,602	$1,835,000
Group	22.30	$27.46	6,255	$3,830,000	6,602	$4,043,000
Minor Consent						
Individual	4.20	$69.50	624	$182,000	624	$182,000
Group	17.10	$27.46	624	$293,000	624	$293,000
ACA Optional						
Individual	2.80	$69.50	21,366	$4,158,000	22,833	$4,443,000
Group	18.70	$27.46	21,366	$10,971,000	22,833	$11,725,000
Perinatal						
Current						
Individual	2.70	$92.13	145	$36,000	145	$36,000
Group	19.60	$54.63	145	$155,000	145	$155,000
ACA Optional						
Individual	3.00	$92.13	191	$53,000	204	$56,000
Group	16.00	$54.63	191	$167,000	204	$178,000
Total				$27,564,000		$28,926,000

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 2016-17	FY 2017-18
Regular			
Current	$6,120,000	$1,530,000	$0
EPSDT	$5,011,000	$1,253,000	$0
Minor Consent	$625,000	$156,000	$0
ACA Optional	$12,516,000	$3,129,000	$0
Perinatal			
Current	$189,000	$47,000	$0
ACA Optional	$177,000	$44,000	$0
FY 2015-16	$24,638,000	$6,159,000	$0

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 65

	Accrual	FY 2016-17	FY 2017-18
Regular			
Current	$5,980,000	$4,485,000	$1,495,000
EPSDT	$5,569,000	$4,177,000	$1,392,000
Minor Consent	$475,000	$356,000	$119,000
ACA Optional	$15,129,000	$11,347,000	$3,782,000
Perinatal			
Current	$191,000	$143,000	$48,000
ACA Optional	$220,000	$165,000	$55,000
FY 2016-17	$27,564,000	$20,673,000	$6,891,000
Regular			
Current	$5,980,000	$0	$4,485,000
EPSDT	$5,878,000	$0	$4,409,000
Minor Consent	$475,000	$0	$356,000
ACA Optional	$16,168,000	$0	$12,126,000
Perinatal			
Current	$191,000	$0	$143,000
ACA Optional	$234,000	$0	$176,000
FY 2017-18	$28,926,000	$0	$21,695,000
Total		$26,832,000	$28,586,000

8. Total estimated reimbursements for ODF treatment services are:

FY 2016-17	TF	GF	FF (Title XIX)	FF (Title XXI)	County
Regular					
Current	$11,956,000	$0	$3,007,000	$4,706,000	$4,243,000
ACA Optional	$14,476,000	$284,000	$14,192,000	$0	$0
Perinatal					
Current	$191,000	$0	$115,000	$3,000	$73,000
ACA Optional	$209,000	$4,000	$205,000	$0	$0
Total	$26,832,000	**$288,000**	**$17,519,000**	**$4,709,000**	$4,316,000

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 65

FY 2017-18	TF	GF	FF (Title XIX)	FF (Title XXI)	County
Regular					
Current	$12,255,000	$0	$2,989,000	$5,104,000	$4,162,000
ACA Optional	$15,909,000	$762,000	$15,147,000	$0	$0
Perinatal					
Current	$191,000	$0	$94,000	$3,000	$94,000
ACA Optional	$231,000	$11,000	$220,000	$0	$0
Total	$28,586,000	**$773,000**	**$18,450,000**	**$5,107,000**	$4,256,000

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)

INTENSIVE OUTPATIENT TREATMENT SERVICES

BASE POLICY CHANGE NUMBER:	66
IMPLEMENTATION DATE:	7/2012
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1726

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$8,377,000	$9,458,000
- STATE FUNDS	$1,218,750	$1,419,370
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$8,377,000	$9,458,000
STATE FUNDS	$1,218,750	$1,419,370
FEDERAL FUNDS	$7,158,250	$8,038,630

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 64 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: 66

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 65% and 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, and 94% FF / 6% GF beginning January 2018.

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 2016-17 and FY 2017-18, is due to the following:

- Increased caseload projections for the ACA Optional population.
- Increased the units of services (UOS) for regular clients based on updated FY 2015-16 claims data.
- Caseload data was updated with data through December 2016 for IOT Regular and IOT Regular ACA. The IOT EPSDT, IOT Perinatal, and IOT Perinatal ACA caseload were projected using data through June 2016.

The change in the current estimate, from FY 2016-17 to FY 2017-18, is due to an increase in the ACA Optional caseload projection for FY 2017-18.

Methodology:

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

2. The caseload projections for IOT EPSDT, IOT Perinatal, and IOT Perinatal ACA are based on complete caseload data from January 2010 through June 2016. The caseload projections for IOT Regular and IOT Regular ACA are based on caseload data through December 2016.

3. The 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 2016-17 and FY 2017-18 budgeted amounts are based on the FY 2016-17 rates.

INTENSIVE OUTPATIENT TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 66

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

			FY 2016-17		FY 2017-18	
	UOS	Rates	Caseload	Total	Caseload	Total
Regular						
Current	27.0	$59.13	1,140	$1,820,000	1,143	$1,825,000
EPSDT	37.0	$59.13	946	$2,070,000	946	$2,070,000
ACA Optional	24.6	$59.13	3,309	$4,813,000	3,525	$5,127,000
Subtotal			5,395	$8,703,000	5,614	$9,022,000
Perinatal						
Current	26.5	$82.54	138	$302,000	138	$302,000
ACA Optional	20.1	$82.54	207	$343,000	222	$368,000
Subtotal			345	$645,000	360	$670,000
Total				$9,348,000		$9,692,000

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 2016-17	FY 2017-18
FY 2015-16			
Regular	$5,487,000	$1,372,000	$0
Perinatal	$568,000	$142,000	$0
Subtotal	$6,055,000	$1,514,000	$0
FY 2016-17			
Regular	$8,703,000	$6,528,000	$2,176,000
Perinatal	$645,000	$484,000	$162,000
Subtotal	$9,348,000	$7,012,000	$2,338,000
FY 2017-18			
Regular	$9,022,000	$0	$6,767,000
Perinatal	$670,000	$0	$503,000
Subtotal	$9,692,000	$0	$7,270,000
Total		$8,526,000	$9,608,000

7. Total estimated reimbursements for IOT services are:

FY 2016-17	TF	GF	FF Title XIX	FF Title XXI	County
Regular					
Current	$3,711,000	$1,123,000	$858,000	$1,730,000	$0
ACA Optional	$4,189,000	$90,000	$4,099,000	$0	$0
Perinatal					
Current	$301,000	$0	$148,000	$4,000	$149,000
ACA Optional	$325,000	$6,000	$319,000	$0	$0
Total	$8,526,000	**$1,219,000**	**$5,424,000**	**$1,734,000**	$149,000

INTENSIVE OUTPATIENT TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 66

FY 2017-18	TF	GF	FF Title XIX	FF Title XXI	County
Regular					
Current	$3,895,000	$1,161,000	$912,000	$1,822,000	$0
ACA Optional	$5,047,000	$241,000	$4,806,000	$0	$0
Perinatal					
Current	$304,000	$0	$149,000	$5,000	$150,000
ACA Optional	$362,000	$17,000	$345,000	$0	$0
Total	$9,608,000	**$1,419,000**	**$6,212,000**	**$1,827,000**	$150,000

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
100% Title XIX FF (4260-101-0890)
100% Title XXI FF (4260-113-0890)
65% Title XXI FF / 35% GF (4260-113-0001/0890)
88% Title XXI FF / 12% GF (4260-113-0001/0890)
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)

RESIDENTIAL TREATMENT SERVICES

BASE POLICY CHANGE NUMBER:	68
IMPLEMENTATION DATE:	7/2012
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1725

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$1,481,000	$1,505,000
- STATE FUNDS	$18,150	$49,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,481,000	$1,505,000
STATE FUNDS	$18,150	$49,000
FEDERAL FUNDS	$1,462,850	$1,456,000

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 64 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 drug 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.

RESIDENTIAL TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 68

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 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), 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 2016-17 and FY 2017-18, is due to the following:

- Increased caseload projections for the ACA Optional population based on actuals through June 2016.
- Increased the units of services (UOS) for perinatal clients based on updated FY 2015-16 claims data.

The change in the current estimate, from FY 2016-17 to FY 2017-18, is due to an increase in the ACA Optional caseload projection in FY 2017-18.

Methodology:

1. The caseload projections are based on complete caseload data from January 2010 through June 2016.

2. The UOS is based on the most recent complete data, July 2015 through June 2016 to calculate an average UOS for existing caseload.

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 2016-17 and FY 2017-18 budgeted amounts are based on the FY 2016-17 rates.

RESIDENTIAL TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 68

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

	Caseload	UOS	Rates	Total
Current Perinatal	152	77.5	$99.97	$1,179,000
ACA Optional	221	44.2	$99.97	$977,000
FY 2015-16				$2,156,000
Current Perinatal	152	77.5	$80.92	$952,000
ACA Optional	271	44.2	$80.92	$969,000
FY 2016-17				$1,921,000
Current Perinatal	152	77.5	$80.92	$952,000
ACA Optional	291	44.2	$80.92	$1,041,000
FY 2017-18				$1,993,000

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 2016-17	FY 2017-18
Current Perinatal	$1,179,000	$295,000	$0
ACA Optional	$977,000	$244,000	$0
FY 2015-16	$2,156,000	$539,000	$0
Current Perinatal	$952,000	$714,000	$238,000
ACA Optional	$969,000	$727,000	$242,000
FY 2016-17	$1,921,000	$1,441,000	$480,000
Current Perinatal	$952,000	$0	$714,000
ACA Optional	$1,041,000	$0	$781,000
FY 2017-18	$1,993,000	$0	$1,495,000
Total		$1,980,000	$1,975,000

6. Total estimated reimbursements for RTS are:

FY 2016-17	TF	GF	FF Title XIX	FF Title XXI	County
Perinatal					
Current	$1,009,000	$0	$496,000	$14,000	$499,000
ACA Optional	$971,000	$18,000	$953,000	$0	$0
Total	$1,980,000	**$18,000**	**$1,449,000**	**$14,000**	$499,000

RESIDENTIAL TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 68

FY 2017-18	TF	GF	FF Title XIX	FF Title XXI	County
Perinatal					
Current	$952,000	$0	$468,000	$14,000	$470,000
ACA Optional	$1,023,000	$49,000	$974,000	$0	$0
Total	$1,975,000	**$49,000**	**$1,442,000**	**$14,000**	$470,000

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)

SMHS FOR ADULTS

BASE POLICY CHANGE NUMBER:	70
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1780

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$1,285,401,000	$1,425,027,000
- STATE FUNDS	$81,965,150	$109,657,020
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,285,401,000	$1,425,027,000
STATE FUNDS	$81,965,150	$109,657,020
FEDERAL FUNDS	$1,203,435,850	$1,315,369,980

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 federal reimbursement through claims to the State. MHPs are responsible for 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: 70

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 2016-17, for Short-Doyle Medi-Cal (SD/MC) and Fee-For-Service (FFS) Inpatient, is a net decrease due to updated estimated utilization and costs, based on additional claims data through September 2016 for SD/MC and claims through July 2016 for FFS Inpatient.

The change from the prior estimate, for FY 2017-18, for SD/MC, is a net decrease based on updated estimated utilization. The change from the prior estimate, for FY 2017-18, for FFS Inpatient, is a decrease due to updated utilization and cost projections.

The change between FY 2016-17 and FY 2017-18, in the current estimate, is due to an increase of SD/MC, FFS Inpatient, and ACA utilization for FY 2017-18, based on projections.

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. The costs and clients are developed using 70 months of SD/MC and 70 months FFS/MC approved claims data, excluding disallowed claims. The SD/MC data is current as of December 31, 2016, with dates of service from December 2010 through September 2016. The FFS data is current as of December 31, 2016, with dates of service from October 2010 through July 2016.

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.

SMHS FOR ADULTS

BASE POLICY CHANGE NUMBER: 70

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

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 2016-17 Utilization	FY 2017-18 Utilization
SD/MC	232,869	233,810
SD/MC ACA	155,115	181,101
FFS	13,501	13,529
FFS ACA	14,866	16,770
Total	416,351	445,210

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 2014-15	$1,629,308	$1,427,633	$201,675
FY 2015-16	$1,740,890	$1,513,122	$227,768
FY 2016-17	$1,905,499	$1,657,479	$248,020
FY 2017-18	$2,075,331	$1,809,099	$266,232

6. On a cash basis for FY 2016-17, the Department will be paying 1% of FY 2014-15 claims, 62% of FY 2015-16 claims, and 37% of FY 2016-17 claims for SD/MC claims. For FFS Inpatient adult claims, the Department will be paying 1% of FY 2014-15 claims, 69% of FY 2015-16 claims, and 30% of FY 2016-17 claims. The cash amounts (rounded) for Adult's SMHS are:

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2014-15	$16,293	$14,276	$2,017
FY 2015-16	$1,101,827	$944,749	$157,078
FY 2016-17	$680,518	$606,023	$74,495
Total FY 2016-17	$1,798,638	$1,565,048	$233,590

SMHS FOR ADULTS

BASE POLICY CHANGE NUMBER: 70

7. On a cash basis for FY 2017-18, the Department will be paying 1% of FY 2015-16 claims, 62% of FY 2016-17 claims, and 37% of FY 2017-18 claims for SD/MC claims. For FFS Inpatient adult claims, the Department will be paying 1% of FY 2015-16 claims, 69% of FY 2016-17 claims, and 30% 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	$17,409	$15,131	$2,278
FY 2016-17	$1,205,925	$1,034,881	$171,044
FY 2017-18	$741,427	$661,462	$79,965
Total FY 2017-18	$1,964,761	$1,711,474	$253,287

8. Of the nonfederal share for this policy change in 2017-18, $23.797 million in new growth as compared to the 2016 Budget Act will be funded with Proposition 56 revenue.

9. The chart below shows the FY 2016-17 and FY 2017-18 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
   - 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	*SF	County	GF Reimbursement
2016-17	$1,798,638	**$579,197**	**$624,239**	**$16,006**	$0	$513,237	**$65,959**
2017-18	$1,964,761	**$608,235**	**$707,135**	**$17,359**	**$23,797**	$539,734	**$68,501**

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)
*Healthcare Treatment Fund (4260-101-3305)

SMHS FOR CHILDREN

BASE POLICY CHANGE NUMBER:	71
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1779

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$1,058,354,000	$1,127,659,000
- STATE FUNDS	$34,775,950	$37,634,660
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,058,354,000	$1,127,659,000
STATE FUNDS	$34,775,950	$37,634,660
FEDERAL FUNDS	$1,023,578,050	$1,090,024,340

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 federal reimbursement through claims to the State. MHPs are responsible for the non-federal share of Medi-Cal SMHS. Mental health services for Medi-Cal beneficiaries who do not meet the criteria for SMHS are provided under the broader Medi-Cal program either through Medi-Cal managed care (MC) plans or the fee-for-service Medi-Cal (FFS/MC) program for beneficiaries not enrolled in a MC plan.

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

SMHS FOR CHILDREN

BASE POLICY CHANGE NUMBER: 71

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 2016-17, for Short-Doyle Medi-Cal (SD/MC) is a net increase due to updated estimated utilization and costs for SD/MC clients, based on paid claims data through September 2016. The change from the prior estimate, for FY 2016-17, for Fee-For-Service (FFS) Inpatient, is a net decrease due to updated estimated utilization and costs, based on additional claims data through July 2016.

The change from the prior estimate, for FY 2017-18, for SD/MC, is a decrease based on updated estimated utilization. The change from the prior estimate, for FY 2017-18, for FFS Inpatient, is a decrease due to updated utilization and cost projections.

The change between FY 2016-17 and FY 2017-18, in the current estimate, is due to an increase of SD/MC, FFS Inpatient, and ACA utilization for FY 2017-18, based on projections.

Methodology:
1. The costs and clients are developed using 70 months of SD/MC and 70 months FFS/MC approved claims data, excluding disallowed claims. The SD/MC data is current as of December 31, 2016, with dates of service from December 2010 through September 2016. The FFS data is current as of December 31, 2016, with dates of service from October 2010 through July 2016.

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

SMHS FOR CHILDREN

BASE POLICY CHANGE NUMBER: 71

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 2016-17 Utilization	FY 2017-18 Utilization
SD/MC	276,420	286,836
SD/MC ACA	6,644	7,388
FFS	12,992	13,370
FFS ACA	861	952
Total	296,917	308,546

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 2014-15	$1,686,795	$1,605,435	$81,360
FY 2015-16	$1,766,809	$1,678,785	$88,024
FY 2016-17	$1,864,043	$1,770,896	$93,147
FY 2017-18	$1,959,851	$1,861,126	$98,725

5. On a cash basis for FY 2016-17, the Department will be paying 1% of FY 2014-15 claims, 62% of FY 2015-16 claims, and 37% of FY 2016-17 claims for SD/MC claims. For FFS Inpatient children's claims, the Department will be paying 1% of FY 2014-15 claims, 69% of FY 2015-16 claims, and 30% of FY 2016-17 claims. The cash amounts (rounded) for Children's SMHS are:

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2014-15	$16,868	$16,054	$814
FY 2015-16	$1,108,904	$1,048,184	$60,720
FY 2016-17	$675,454	$647,492	$27,962
Total FY 2016-17	$1,801,226	$1,711,730	$89,496

6. On a cash basis for FY 2017-18, the Department will be paying 1% of FY 2015-16 claims, 62% 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, 69% of FY 2016-17 claims, and 30% 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	$17,668	$16,788	$880
FY 2016-17	$1,169,948	$1,105,695	$64,253
FY 2017-18	$710,121	$680,484	$29,637
Total FY 2017-18	$1,897,737	$1,802,967	$94,770

SMHS FOR CHILDREN

BASE POLICY CHANGE NUMBER: 71

7. The chart below shows the FY 2016-17 and FY 2017-18 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 and 6% GF until December 31, 2018, 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	County	GF Reimbursement
2016-17	$1,801,226	**$777,649**	**$211,299**	**$34,630**	**$888**	$742,872	**$33,888**
2017-18	$1,897,737	**$807,714**	**$243,365**	**$38,945**	**$2,267**	$770,078	**$35,368**

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)

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER:	96
IMPLEMENTATION DATE:	7/2000
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	56

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$19,603,938,000	$20,478,370,000
- STATE FUNDS	$5,440,445,630	$6,116,509,640
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$19,603,938,000	$20,478,370,000
STATE FUNDS	$5,440,445,630	$6,116,509,640
FEDERAL FUNDS	$14,163,492,370	$14,361,860,360

DESCRIPTION

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

Authority:
Welfare & Institutions Code 14087.3

Interdependent Policy Changes:
PC 112 Capitated Rate Adjustment for FY 2017-18

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 from Prior Estimate:
The change from the prior estimate, for FY 2016-17, is a decrease due to:

- Final rates for FY 2016-17 replaces draft rates used in the prior estimate,
- Lower Hepatitis C costs due to lower than previously expected average monthly utilizers, and
- Lower POV 250 costs due to lower rates and eligible months.

The change from the prior estimate, for FY 2017-18, is an increase due to:

- FY 2017-18 draft rates replaces FY 2016-17 draft rates used in the prior estimate, and
- Higher than previously expected ACA eligible months.

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER: 96

The change from FY 2016-17 to FY 2017-18, is an increase in the current estimate due to:

- Higher eligible months,
- Higher Hepatitis C costs due to higher utilization in FY 2017-18, and
- Higher ACA costs due to higher ACA eligible months in FY 2017-18.

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. All rates are set by the Department at the lower bound of the rate range. For those plans participating in an intergovernmental transfer (IGT), the lower bound rates plus the total funds of the IGT increase cannot exceed the upper bound of the rate range. IGT increases are budgeted in the Managed Care Rate Range IGTs policy change. The base IGT capitation payments for Alameda County are budgeted in this policy change.

3. Rates have been updated for FY 2016-17 from draft FY 2016-17 rates in the prior estimate to final FY 2016-17 rates in the current estimate. FY 2017-18 rates have been updated from draft FY 2016-17 rates in the previous estimate, to draft FY 2017-18 rates in the current estimate.

4. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of $433,796,000 for FY 2016-17 and $438,675,000 for FY 2017-18 were included in the rates.

5. The savings from AB 97 are included in the rates. Savings of $260,899,000 for FY 2016-17 and $265,306,000 for FY 2017-18 were included in the rates. Rates include the savings for application to primary care physicians effective January 1, 2015.

6. Services provided through the LA Mobile Vision Pilot Project are included in the FY 2016-17 rates, but have been removed for FY 2017-18.

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

8. 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.

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

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER: 96

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 of 88/12 was budgeted for OTLICP.

11. Of the nonfederal share for this policy change in 2017-18, $533.9 million in new growth as compared to the 2016 Budget Act will be funded with Proposition 56 revenue.

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

(Dollars in Thousands)

FY 2016-17	Eligible Months	Total
Alameda	3,877,235	$994,359
Contra Costa	2,551,696	$650,957
Kern	3,835,666	$828,645
Los Angeles	35,699,652	$8,405,584
Riverside	8,331,783	$1,785,818
San Bernardino	8,432,229	$1,802,194
San Francisco	1,884,288	$569,432
San Joaquin	2,930,069	$565,583
Santa Clara	4,152,757	$924,855
Stanislaus	2,384,166	$585,029
Tulare	2,498,729	$476,941
Fresno	4,946,332	$1,158,962
Kings	552,610	$107,447
Madera	659,754	$134,458
Total	82,736,969	$18,990,264
Hepatitis C Adjustment		$491,684
Total FY 2016-17		**$19,481,948**

(Dollars in Thousands)

Included in the Above Dollars	FY 2016-17
Mental Health	$433,795
AB 97	($260,898)

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER: 96

(Dollars in Thousands)

FY 2017-18	Eligible Months	Total
Alameda	3,924,681	$1,026,649
Contra Costa	2,571,771	$673,204
Kern	3,889,005	$840,873
Los Angeles	36,002,436	$8,904,418
Riverside	8,463,785	$1,898,861
San Bernardino	8,583,903	$1,929,615
San Francisco	1,925,863	$586,747
San Joaquin	2,960,640	$596,955
Santa Clara	4,163,461	$945,538
Stanislaus	2,420,523	$607,958
Tulare	2,523,866	$475,818
Fresno	5,001,637	$1,174,303
Kings	559,926	$112,469
Madera	666,396	$138,787
Total	83,657,894	$19,912,195
Hepatitis C Adjustment		$572,377
Total FY 2017-18		**$20,484,572**

(Dollars in Thousands)

Included in the Above Dollars	FY 2017-18
Mental Health	$438,674
AB 97	($265,306)

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

(Dollars in Thousands)

FY 2016-17	TF	GF	FF
Title XIX 50/50	$10,287,422	$5,143,711	$5,143,711
State GF	$31,692	$31,692	$0
ACA 100% FFP	$5,025,468	$0	$5,025,468
ACA 95/5 GF	$3,474,327	$173,716	$3,300,611
Family Planning 90/10 GF	$143,860	$14,385	$129,475
Title XXI 88/12 GF	$641,169	$76,940	$564,229
Total	**$19,603,938**	**$5,440,444**	**$14,163,494**

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER: 96

(Dollars in Thousands)

FY 2017-18	TF	GF	FF	SF
Title XIX 50/50	$9,983,957	$4,991,978	$4,991,979	$0
State GF	$32,061	$32,061	$0	$0
ACA 95/5 GF	$5,003,502	$250,175	$4,753,327	$0
ACA 94/6 GF	$3,590,531	$215,432	$3,375,099	$0
Family Planning 90/10 GF	$153,815	$15,382	$138,433	$0
Title XXI 88/12 GF	$646,764	$77,612	$569,152	$0
Healthcare Treatment Fund	$533,870	$0	$0	$533,870
Title XIX 100%	$533,870	$0	$533,870	$0
Total	**$20,478,370**	**$5,582,641**	**$14,361,860**	**$533,870**

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER:	97
IMPLEMENTATION DATE:	12/1987
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	57

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$7,891,527,000	$7,985,671,000
- STATE FUNDS	$2,175,773,670	$2,385,153,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$7,891,527,000	$7,985,671,000
STATE FUNDS	$2,175,773,670	$2,385,153,800
FEDERAL FUNDS	$5,715,753,330	$5,600,517,200

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

Interdependent Policy Changes:
PC 112 Capitated Rate Adjustment for FY 2017-18

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 2016-17, is a decrease due to the following:

- Final rates for FY 2016-17 replaces draft rates used in the prior estimate,
- Lower Hepatitis C costs due to lower than previously estimated average monthly utilizers, and
- Higher AB 97 savings due to updated enrollments (included in base rates).

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

- FY 2017-18 draft rates replaces FY 2016-17 draft rates used for FY 2017-18 in the prior estimate,
- Lower Hepatitis C costs due to lower than previously estimated average monthly utilizers, and
- Higher AB 97 savings due to updated enrollments (included in base rates).

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 97

The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to:

- Higher eligible months,
- Higher Hepatitis C costs due to higher utilization in FY 2017-18 than in FY 2016-17, and
- Inclusion of Medi-Cal Access Program (MCAP) service costs into the base rate as of July 1, 2017.

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. All rates are set by the Department at the lower bound of the rate range. For those plans participating in an intergovernmental transfer (IGT), the lower bound rates plus the total funds of the IGT increase cannot exceed the upper bound of the rate range. IGT increases are budgeted in the Managed Care Rate Range IGTs PC. The base IGT capitation payments for San Mateo County are budgeted in this policy change.

3. 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).

4. Rates have been updated for FY 2016-17 from draft FY 2016-17 rates in the prior estimate to final FY 2016-17 rates in the current estimate. FY 2017-18 rates have been updated from draft FY 2016-17 rates in the previous estimate, to draft FY 2017-18 rates in the current estimate.

5. 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.

6. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of $155,724,000 for FY 2016-17 and $157,546,000 for FY 2017-18 were included in the rates.

7. The savings from AB 97 are included in the rates. Savings of $91,939,000 for FY 2016-17 and $93,921,000 for FY 2017-18 were included in the rates. Rates include the savings for application to primary care providers effective January 1, 2015.

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

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

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 97

10. The Department receives 90% federal reimbursement 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 split of 88/12 was budgeted for OTLICP.

12. Of the nonfederal share for this policy change in 2017-18, $123.9 million in new growth as compared to the 2016 Budget Act will be funded with Proposition 56 revenue.

13. COHS dollars on an accrual basis are:

(Dollars in Thousands)

FY 2016-17	Eligible Months	Total
501- San Luis Obispo	669,306	$191,984
502- Santa Barbara	1,478,442	$431,046
503- San Mateo	1,360,178	$400,909
504- Solano	1,362,710	$446,616
505- Santa Cruz	839,567	$235,518
506-Orange	9,353,192	$2,654,974
507- Napa	349,391	$123,777
508-Monterey	1,865,307	$468,306
509- Yolo	644,434	$202,566
513- Sonoma	1,356,620	$429,383
514- Merced	1,525,367	$337,978
510 - Marin	458,729	$174,353
512 - Mendocino	446,703	$139,107
515 - Ventura	2,497,108	$649,566
523 - Del Norte	136,799	$42,645
517 - Humboldt	630,145	$199,913
511 - Lake	359,957	$110,845
518 - Lassen	87,746	$27,440
519 - Modoc	36,435	$13,025
520 - Shasta	727,280	$243,307
521 - Siskiyou	211,990	$62,374
522 - Trinity	55,007	$17,824
Total FY 2016-17	26,452,416	$7,603,456
Hepatitis C Adjustment		$199,017
Total with Adjustments		**$7,802,473**

(Dollars in Thousands)

Included in Above Dollars	FY 2016-17
Mental Health	$155,724
AB 97	($91,939)

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 97

(Dollars in Thousands)

FY 2017-18	Eligible Months	Total
501- San Luis Obispo	668,966	$195,104
502- Santa Barbara	1,484,539	$432,934
503- San Mateo	1,360,696	$383,306
504- Solano	1,361,608	$449,774
505- Santa Cruz	835,376	$239,739
506-Orange	9,505,685	$2,679,266
507- Napa	357,128	$127,845
508-Monterey	1,886,948	$483,355
509- Yolo	644,769	$210,439
513- Sonoma	1,372,745	$444,441
514- Merced	1,547,620	$351,284
510 - Marin	471,859	$180,843
512 - Mendocino	456,038	$141,092
515 - Ventura	2,493,743	$667,089
523 - Del Norte	138,299	$44,570
517 - Humboldt	643,567	$210,576
511 - Lake	366,918	$117,160
518 - Lassen	89,385	$28,974
519 - Modoc	36,835	$13,622
520 - Shasta	733,489	$254,174
521 - Siskiyou	216,573	$66,134
522 - Trinity	55,770	$18,725
Total FY 2017-18	26,728,555	$7,740,446
Hepatitis C Adjustment		$231,678
Total with Adjustments		**$7,972,124**

(Dollars in Thousands)

Included in Above Dollars	FY 2017-18
Mental Health	$157,546
AB 97	($93,921)

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 97

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

(Dollars in Thousands)

FY 2016-17	TF	GF	FF
Title XIX 50/50	$4,094,573	$2,047,286	$2,047,287
State GF	$12,885	$12,885	$0
Family Planning 90/10 GF	$48,803	$4,880	$43,923
Title XXI 88/12 GF	$347,596	$41,712	$305,884
ACA Optional Expansion 100% FFP	$2,007,463	$0	$2,007,463
ACA Optional Expansion 95/5 GF	$1,380,207	$69,011	$1,311,196
Total	**$7,891,527**	**$2,175,774**	**$5,715,753**

(Dollars in Thousands)

FY 2017-18	TF	GF	FF	SF
Title XIX 50/50	$4,049,836	$2,024,918	$2,024,918	$0
State GF	$12,818	$12,818	$0	$0
Family Planning 90/10 GF	$48,643	$4,865	$43,778	$0
Title XXI 88/12 GF	$337,428	$40,492	$296,936	$0
ACA Optional Expansion 95/5	$1,919,542	$95,977	$1,823,565	$0
ACA Optional Expansion 94/6	$1,369,584	$82,175	$1,287,409	$0
Healthcare Treatment Fund	$123,910	$0	$0	$123,910
Title XIX 100% FFP	$123,910	$0	$123,910	$0
Total	**$7,985,671**	**$2,261,245**	**$5,600,516**	**$123,910**

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER:	99
IMPLEMENTATION DATE:	4/1994
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	58

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$3,677,114,000	$3,798,337,000
- STATE FUNDS	$957,185,730	$1,055,254,430
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,677,114,000	$3,798,337,000
STATE FUNDS	$957,185,730	$1,055,254,430
FEDERAL FUNDS	$2,719,928,270	$2,743,082,570

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

Interdependent Policy Changes:
PC 112 Capitated Rate Adjustment for FY 2017-18

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 July 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 2016-17, is an increase due to:

- Final rates for FY 2016-17 replaces draft rates used in the prior estimate,
- Higher than previously estimated eligible months, and
- Mental Health costs based on higher enrollments (included in base rates).

The change from the prior estimate, for FY 2017-18, is an increase due to:

- FY 2017-18 draft rates replaces FY 2016-17 draft rates used for FY 2017-18 in the prior estimate, and
- Mental Health costs based on higher enrollments (included in base rates).

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 99

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to:

- Higher eligible months in FY 2017-18, and
- Higher Hepatitis C costs due to higher utilization in FY 2017-18.

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. All rates are set by the Department at the lower bound of the rate range. For those plans participating in an intergovernmental transfer (IGT), the lower bound rates plus the total funds of the IGT increase cannot exceed the upper bound of the rate range. IGT increases are budgeted in the Managed Care Rate Range IGTs policy change.

3. Rates have been updated for FY 2016-17 from draft FY 2016-17 rates in the prior estimate to final FY 2016-17 rates in the current estimate. FY 2017-18 rates have been updated from draft FY 2016-17 rates in the previous estimate, to draft FY 2017-18 rates in the current estimate.

4. 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.

5. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of $74,009,000 for FY 2016-17 and $75,006,000 for FY 2017-18 were included in the rates.

6. The savings from AB 97 are included in the rates. Savings of $46,415,000 for FY 2016-17 and $47,405,000 for FY 2017-18 were included in the rates. Rates include the savings for application to primary care providers effective January 1, 2015.

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

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

9. Costs for the Optional Targeted Low Income Children Program (OTLICP) are budgeted in the managed care model policy changes. Beginning October 1, 2015, a FMAP split of 88/12 was budgeted for OTLICP.

10. Of the nonfederal share for this policy change in 2017-18, $70.1 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: 99

11. GMC dollars on an accrual basis are:
(Dollars in Thousands)

FY 2016-17	Eligible Months	Total
Sacramento	5,346,953	$1,276,855
San Diego	8,656,838	$2,309,538
Total	14,003,791	$3,586,393
Hepatitis C Adjustment		$90,892
Total FY 2016-17		**$3,677,285**

(Dollars in Thousands)

Included in Dollars Above	FY 2016-17
Mental Health	$74,009
AB 97	($46,415)

(Dollars in Thousands)

FY 2017-18	Eligible Months	Total
Sacramento	5,396,708	$1,317,790
San Diego	8,792,493	$2,370,989
Total	14,189,201	$3,688,779
Hepatitis C Adjustment		$105,809
Total FY 2017-18		**$3,794,588**

(Dollars in Thousands)

Included in Dollars Above	FY 2017-18
Mental Health	$75,006
AB 97	($47,405)

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 99

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

(Dollars in Thousands)

FY 2016-17	TF	GF	FF
Title XIX 50/50	$1,790,328	$895,164	$895,164
State GF	$5,695	$5,695	$0
Family Planning 90/10 GF	$27,190	$2,719	$24,471
Title XXI 88/12 GF	$152,719	$18,326	$134,393
ACA Optional Expansion 100% FF	$995,553	$0	$995,553
ACA Optional Expansion 95/5 GF	$705,629	$35,282	$670,347
Total	**$3,677,114**	**$957,186**	**$2,719,928**

(Dollars in Thousands)

FY 2017-18	TF	GF	FF	SF
Title XIX 50/50	$1,728,170	$864,085	$864,085	$0
State GF	$5,794	$5,794	$0	$0
Family Planning 90/10 GF	$27,805	$2,781	$25,024	$0
Title XXI 88/12 GF	$147,758	$17,731	$130,026	$0
ACA Optional Expansion 95/5 GF	$1,017,903	$50,895	$967,008	$0
ACA Optional Expansion 94/6 GF	$730,647	$43,839	$686,808	$0
Healthcare Treatment Fund	$70,130	$0	$0	$70,130
Title XIX 100% FFP	$70,130	$0	$70,130	$0
Total	**$3,798,337**	**$985,125**	**$2,743,081**	**$70,130**

REGIONAL MODEL

BASE POLICY CHANGE NUMBER:	102
IMPLEMENTATION DATE:	11/2013
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1842

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$1,201,454,000	$1,219,782,000
- STATE FUNDS	$314,024,710	$341,289,950
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,201,454,000	$1,219,782,000
STATE FUNDS	$314,024,710	$341,289,950
FEDERAL FUNDS	$887,429,290	$878,492,050

DESCRIPTION

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

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

Interdependent Policy Changes:
PC 112 Capitated Rate Adjustment for FY 2017-18

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 2016-17, is a decrease due to:

- Lower than previously expected Hepatitis C average monthly utilizers, and
- Updated FY 2016-17 rates from draft rates to final rates.

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

- Updated FY 2017-18 rates from draft FY 2016-17 rates to draft FY 2017-18 rates, and
- Lower Hepatitis C rates and lower than previously expected average monthly utilizers.

REGIONAL MODEL

BASE POLICY CHANGE NUMBER: 102

The change from FY 2016-17 to FY 2017-18, is an increase in the current estimate due to:

- Higher expected eligible months,
- Higher ACA dollars due to higher ACA eligible months, and
- Higher Hepatitis C utilization in FY 2017-18.

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. All rates are set by the Department at the lower bound of the rate range. For those plans participating in an intergovernmental transfer (IGT), the lower bound rates plus the total funds of the IGT increase cannot exceed the upper bound of the rate range. IGT increases are budgeted in the Managed Care Rate Range IGTs policy change.

4. Rates have been updated for FY 2016-17 from draft FY 2016-17 rates in the prior estimate to final FY 2016-17 rates in the current estimate. FY 2017-18 rates have been updated from draft FY 2016-17 rates in the previous estimate, to draft FY 2017-18 rates in the current estimate.

5. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of $27,215,000 for FY 2016-17 and $27,324,000 for FY 2017-18 were included in the rates.

6. The savings from AB 97 are included in the rates. Savings of $11,493,000 for FY 2016-17 and $11,564,000 for FY 2017-18 were included in the rates. Rates include the savings for application to the primary care providers effective January 1, 2015.

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

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

9. Costs for the Optional Targeted Low Income Children Program (OTLICP) are budgeted in the managed care model policy changes. Beginning October 1, 2015, a FMAP split of 88/12 was budgeted for OTLICP.

10. Of the nonfederal share for this policy change in 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: 102

11. Regional Model dollars on an accrual basis are:

(Dollars in Thousands)

FY 2016-17	Eligible Months	Total
Alpine	2,816	$816
Amador	78,909	$20,290
Butte	789,521	$224,264
Calaveras	117,525	$31,174
Colusa	85,840	$17,050
El Dorado	360,478	$94,173
Glenn	118,260	$26,956
Inyo	47,216	$11,506
Mariposa	46,263	$12,410
Mono	33,361	$7,760
Nevada	245,009	$63,422
Placer	567,852	$139,692
Plumas	58,074	$16,208
Sierra	6,808	$1,953
Sutter	396,290	$91,994
Tehama	246,889	$63,316
Tuolumne	133,501	$36,101
Yuba	302,599	$75,980
Imperial	907,345	$206,255
San Benito	97,649	$16,873
Total FY 2016-17	4,642,205	$1,158,193
Hepatitis C Adjustment		$30,756
Total with Adjustments		**$1,188,949**

(Dollars in Thousands)

Included in Dollars Above	FY 2016-17
Mental Health	$27,215
AB 97	($11,493)

REGIONAL MODEL

BASE POLICY CHANGE NUMBER: 102

(Dollars in Thousands)

FY 2017-18	Eligible Months	Total
Alpine	2,786	$826
Amador	79,735	$20,659
Butte	789,387	$227,846
Calaveras	118,798	$31,998
Colusa	86,948	$17,675
El Dorado	360,951	$95,551
Glenn	119,338	$27,554
Inyo	47,249	$11,551
Mariposa	46,693	$12,688
Mono	34,397	$8,200
Nevada	243,348	$64,014
Placer	571,496	$143,107
Plumas	59,226	$16,828
Sierra	6,818	$1,976
Sutter	397,485	$93,799
Tehama	246,321	$64,196
Tuolumne	133,253	$36,558
Yuba	302,949	$77,411
Imperial	918,263	$213,913
San Benito	100,530	$17,376
Total FY 2017-18	4,665,972	$1,183,726
Hepatitis C Adjustment		$35,804
Total with Adjustments		**$1,219,530**

(Dollars in Thousands)

Included in Dollars Above	FY 2017-18
Mental Health	$27,324
AB 97	($11,564)

REGIONAL MODEL

BASE POLICY CHANGE NUMBER: 102

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

(Dollars in Thousands)

FY 2016-17		TF	GF	FF
Title XIX 50/50 FFP	4260-101-0001/0890	$589,267	$294,634	$294,634
State GF	4260-101-0001	$1,933	$1,933	$0
ACA 100% FFP	4260-101-0890	$329,368	$0	$329,368
ACA 95/5 GF	4260-101-0890	$229,307	$11,465	$217,842
Family Planning 90/10 GF	4260-101-0001/0890	$9,831	$983	$8,848
OTLICP 88/12 GF	4260-113-0001/0890	$41,748	$5,010	$36,738
Total		**$1,201,454**	**$314,025**	**$887,430**

(Dollars in Thousands)

FY 2017-18		TF	GF	FF	SF
Title XIX 50/50 FFP	4260-101-0001/0890	$601,639	$300,819	$300,820	$0
State GF	4260-101-0001	$1,755	$1,755	$0	$0
ACA 95/5 GF	4260-101-0890	$326,397	$16,320	$310,077	$0
ACA 94/6 FFP	4260-101-0890	$233,779	$14,027	$219,752	$0
Family Planning 90/10 GF	4260-101-0001/0890	$10,029	$1,002	$9,026	$0
OTLICP 88/12 GF	4260-113-0001/0890	$41,383	$4,966	$36,417	$0
Healthcare Treatment Fund	4260-101-3305	$2,400	$0	$0	$2,400
Title XIX 100% FFP	4260-101-0890	$2,400	$0	$2,400	$0
Total*		**$1,219,782**	**$338,890**	**$878,492**	**$2,400**

*Difference due to rounding.

PACE (Other M/C)

BASE POLICY CHANGE NUMBER:	104
IMPLEMENTATION DATE:	7/1992
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	62

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$418,255,000	$421,796,000
- STATE FUNDS	$209,127,500	$210,898,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$418,255,000	$421,796,000
STATE FUNDS	$209,127,500	$210,898,000
FEDERAL FUNDS	$209,127,500	$210,898,000

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 life-time 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: 104

methodology will be no sooner than July 1, 2017. PACE rates are set on a calendar year basis to coincide with the time period of the contracts.

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.

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

Reason for Change:
The change from the prior estimate, for FY 2016-17, is an overall increase due to the implementation of the 2016 PACE rates for all plans in April 2017 and 2017 PACE rates for all plans in September 2017. The change from the prior estimate, for FY 2017-18, is a decrease due to a slight drop in the projected overall enrollment. The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to actual eligible month trending at a 6% increase.

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

PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 104

2. FY 2016-17 and FY 2017-18 estimated funding is based on pending CMS approval of calendar year (CY) 2016 rates and projected CY 2017 and CY 2018 rates.

3. Assume enrollment will increase based on past enrollment to PACE organization by county and plan and 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.

5. The Department anticipates receiving CMS approval of contract amendments implementing 2016 rates in February 2017, retroactive to January 2016. This results in a repayment of $42,552,000 for the increase of Non-dual and Dual rates that were paid at 2016 PACE rates from January to March 2017. The repayment is expected to occur during the April 2017 capitation cycle.

6. The Department anticipates the submission of CY 2017 rates to CMS in May 2017 with a projected approval date by CMS in August 2017, retroactive to January 2017. This will result in a repayment of approximately $12,806,000 to the PACE plans. The repayment is expected to occur during the September 2017 capitation cycle.

7. Of the non-federal share for this policy change in 2017-18, $30 million in new growth as compared to the 2016 Budget Act will be funded with Proposition 56 revenue.

FY 2016-17	TF Cost (Rounded)	Eligible Months	Avg. Monthly Enrollment
Centers for Elders' Independence (Alameda and Contra Costa	$43,194,000	8,127	677
Sutter Senior Care	$14,761,000	3,148	262
AltaMed Senior BuenaCare	$120,235,000	25,217	2,101
OnLok (SF, Alameda and Santa Clara)	$96,195,000	17,122	1,427
St. Paul's PACE	$31,084,000	6,736	561
Los Angeles Jewish Homes	$9,506,000	2,160	180
CalOptima PACE	$10,531,000	2,148	179
InnovAge (San Bernardino and Riverside)	$17,764,000	3,595	300
Redwood Coast	$4,555,000	1,087	91
Central Valley Medical Services	$16,123,000	3,338	278
San Ysidro San Diego	$11,755,000	2,198	183
Total Capitation Payments	$375,703,000	74,876	6,239
2016 Rate Repayment	$42,552,000		
Total FY 2016-17	**$418,255,000**		

*Totals may differ due to rounding.

PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 104

FY 2017-18	TF Cost (Rounded)	Eligible Months	Avg. Monthly Enrollment
Centers for Elders' Independence (Alameda and Contra Costa)	$44,501,000	8,109	676
Sutter Senior Care	$15,335,000	3,160	263
AltaMed Senior BuenaCare	$134,949,000	27,383	2,282
OnLok (SF, Alameda and Santa Clara)	$99,436,000	17,130	1,428
St. Paul's PACE	$36,871,000	7,715	643
Los Angeles Jewish Homes	$9,863,000	2,168	181
CalOptima PACE	$10,832,000	2,153	179
InnovAge (San Bernardino and Riverside)	$18,759,000	3,660	305
Redwood Coast	$4,726,000	1,092	91
Central Valley Medical Services	$16,921,000	3,432	286
San Ysidro San Diego	$16,797,000	3,072	256
Total Capitation Payments	$408,990,000	79,074	6,590
2017 Rate Repayment	$12,806,000		
Total FY 2017-18	**$421,796,000**		

*Totals may differ due to rounding.

Funding:

FY 2016-17: 50% Title XIX / 50% GF (4260-101-0001/0890)

FY 2017-18: 50% Title XIX / 50% GF (4260-101-0001/0890) $361,796,000
Healthcare Treatment Fund (4260-101-3305) $ 30,000,000
Title XIX 100% FFP (4260-101-0890) $ 30,000,000

DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER:	106
IMPLEMENTATION DATE:	7/2004
ANALYST:	Nikaela Ratliff
FISCAL REFERENCE NUMBER:	1029

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$126,718,000	$133,170,000
- STATE FUNDS	$42,667,050	$46,959,170
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$126,718,000	$133,170,000
STATE FUNDS	$42,667,050	$46,959,170
FEDERAL FUNDS	$84,050,950	$86,210,830

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. The impact of the restoration of adult dental benefits is included in the capitation rates.

DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER: 106

Reason for Change:
The change from the prior estimate for FY 2016-17 consisted of an increase in Health Insurance Provider Fee (HIPF) costs, no change in rates, an increase in projected GMC eligibles, but a decrease in PHP eligibles which resulted in an overall decrease. The change from the prior estimate for FY 2017-18 consisted of an increase to HIPF costs, an increase to projected GMC eligibles, a decrease to projected PHP eligibles, and a decrease to rates which resulted in an overall decrease. The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to an increase in projected monthly eligibles as well as increase HIPF costs although there was no change to rates.

Methodology:
1. Effective July 1, 2009, separate dental managed care rates have been established for those enrollees under age 21. Beginning March 2011, these rates are paid on an ongoing basis.

2. The retroactive adjustments of the rates for FY 2014-15 and FY 2015-16 are shown in the Dental Retroactive Rate Changes policy change.

3. Proposed FY 2015-16 capitated rates have been used for FY 2016-17 and for FY 2017-18. FY 2015-16 rates include the exemption from AB 97.

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

(Dollars in Thousands)

FY 2016-17	Capitation Rate	Average Monthly Eligibles	Total Funds
GMC			
<21	$11.86	212,626	$30,261
21+	$8.71	101,718	$10,632
PHP			
<21	$13.50	242,669	$39,312
21+	$9.31	133,605	$14,926
DMC HIPF Add-on			$3,104
ACA Optional Dental			
GMC	$8.71	118,307	$12,365
PHP	$9.31	141,615	$15,821
HIPF Add-on			$297
		Total FY 2016-17	**$126,718**

DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER: 106

(Dollars in Thousands)

FY 2017-18	Capitation Rate	Average Monthly Eligibles	Total Funds
GMC			
<21	$11.86	219,047	$31,175
21+	$8.71	106,948	$11,178
PHP			
<21	$13.50	249,229	$40,375
21+	$9.31	154,054	$17,211
DMC HIPF Add-on			$3,466
ACA Optional Dental			
GMC	$8.71	121,856	$12,736
PHP	$9.31	150,746	$16,841
HIPF Add-on			$188
		Total FY 2017-18	**$133,170**

Funding:

FY 2016-17	TF	GF	FF
50% Title XIX / 50% GF 4260-101-0001/0890	$81,417,000	$40,708,500	$40,708,500
88% Title XIX / 12% GF 4260-101-0001/0890	$8,695,000	$1,043,400	$7,651,600
100% Title XIX ACA FF 4260-101-0890	$18,303,000	$0	$18,303,000
95% Title XIX ACA FF / 5% GF 4260-101-0001/0890	$18,303,000	$915,150	$17,387,850
Total	**$126,718,000**	**$42,667,050**	**$84,050,950**

FY 2017-18	TF	GF	FF
50% Title XIX / 50% GF 4260-101-0001/0890	$87,760,000	$43,880,000	$43,880,000
88% Title XIX / 12% GF 4260-101-0001/0890	$8,948,000	$1,073,760	$7,874,240
95% Title XIX ACA FF / 5% GF 4260-101-0001/0890	$18,231,000	$911,550	$17,319,450
94% Title XIX ACA FF / 6% GF 4260-101-0001/0890	$18,231,000	$1,093,860	$17,137,140
Total	**$133,170,000**	**$46,959,170**	**$86,210,830**

*Totals may differ due to rounding.

SENIOR CARE ACTION NETWORK (Other M/C)

BASE POLICY CHANGE NUMBER:	107
IMPLEMENTATION DATE:	2/1985
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	61

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$70,571,000	$65,050,000
- STATE FUNDS	$35,285,500	$32,525,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$70,571,000	$65,050,000
STATE FUNDS	$35,285,500	$32,525,000
FEDERAL FUNDS	$35,285,500	$32,525,000

DESCRIPTION

Purpose:
This policy change estimates the capitated payments associated with enrollment of dual eligible Medicare/Medi-Cal beneficiaries in the Senior Care Action Network (SCAN) health plan.

Authority:
Welfare & Institutions Code 14200

Interdependent Policy Changes:
PC 122 MCO Tax Mgd. Care Plans – Incr. Cap. Rates
PC 116 MCO Tax Mgd. Care Plans – Funding Adjustment
PC 117 MCO Tax Managed Care Plans

Background:
SCAN is a Medicare Advantage Special Needs Plan and 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. Effective January 1, 2019, SCAN will expand to provide coverage in San Joaquin County. 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:
There is no significant change from the prior estimate for FY 2016-17. The change from the prior estimate, for FY 2017-18, is a decrease due to the delay in implementation of coverage in San Joaquin County from January 1, 2018 to January 1, 2019. The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to enrollment growth, increase in rates, and elimination of prior year adjustments.

SENIOR CARE ACTION NETWORK (Other M/C)

BASE POLICY CHANGE NUMBER: 107

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.

2. Total enrollment is projected to be 14,123 in June 2017 and 15,632 by June 2018 based on Medi-Cal enrollment projections submitted by SCAN.

3. The CY 2016 rates for dually eligible enrollees were determined using SCAN provided costs for Medi-Cal services rendered to this population. The Department is finalizing CY 2016 rates using SCAN actuals. CY 2017 rates are projected by trending forward from preliminary CY 2016 rates. Rates in development will be based on SCAN plans' actual experience.

4. The Department received CMS approval of the contract amendments implementing 2015 SCAN rates, retroactive from January 1, 2015, in July 2016. This resulted in a repayment of approximately $8,304,000 for the increase in rates for SCAN health plans covering the period of January 2015 through September 2016. The repayment occurred during the September 2016 capitation cycle. This also resulted in an estimated recoupment of approximately $1,360,000 for the decrease to the rates set for SCAN health plans. The recoupment occurred during the September 2016 capitation cycle.

5. The Department anticipates receiving CMS approval of the contract amendment implementing the SCAN 2016 rates, retroactive to January 2016, in April 2017. This will result in a repayment to SCAN of approximately $3,971,000 for the increase in rates for SCAN health plan for the period of January 2016 through May 2017. The repayment is expected to occur during the June 2017 capitation cycle.

6. The Department anticipates the submission of CY 2017 rates to CMS in June 2017 with CMS approval projected to be in September 2017, retroactive to January 2017. The repayment is projected to occur in October 2017 capitation cycle for an estimate $2,250,000.

FY 2016-17	Costs	Eligible Months	Avg. Monthly Enrollment
Los Angeles	$38,977,000	106,125	8,844
Riverside	$12,731,000	30,877	2,573
San Bernardino	$7,948,000	20,291	1,691
Total	$59,656,000	157,293	13,108
2015 Rate Repayment	$8,304,000		
2015 Rate Recoupment	($1,360,000)		
2016 Rate Repayment	$3,971,000		
Total FY 2016-17	**$70,571,000**		

SENIOR CARE ACTION NETWORK (Other M/C)

BASE POLICY CHANGE NUMBER: 107

FY 2017-18	Costs	Eligible Months	Avg. Monthly Enrollment
Los Angeles	$40,701,000	105,891	8,824
Riverside	$13,507,000	32,068	2,672
San Bernardino	$8,592,000	21,311	1,776
Total	$62,800,000	159,271	13,272
2017 Rate Repayment	$2,250,000		
Total FY 2017-18	**$65,050,000**		

*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:	108
IMPLEMENTATION DATE:	5/1985
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	63

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	**$9,628,000**	$19,750,000
- STATE FUNDS	**$4,814,000**	**$9,875,000**
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	**$9,628,000**	$19,750,000
STATE FUNDS	**$4,814,000**	**$9,875,000**
FEDERAL FUNDS	**$4,814,000**	**$9,875,000**

DESCRIPTION

Purpose:
This policy change estimates the cost of capitation rates and the savings sharing for AIDS Healthcare centers.

Authority:
Welfare & Institutions Code 14088.85

Interdependent Policy Changes:
Not Applicable

Background:
The HIV/AIDS capitated case management project in Los Angeles became operational in April 1995 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 is in discussions with the plan regarding further extensions.

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

AIDS HEALTHCARE CENTERS (Other M/C)

BASE POLICY CHANGE NUMBER: 108

Reason for Change:
The change from the prior estimate, for FY 2016-17, is a decrease due to updated eligible member months.

The change from the prior estimate, for FY 2017-18, is an increase due to:
- A net rate increase between Medi-Cal Only and Dual rates, and
- Updated (decrease) eligible member months.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to:
- The addition of retro payments, and
- Paying updated FY 2017-18 rates in FY 2017-18.

Methodology:
1) Assume the following eligible months for FY 2016-17 and FY 2017-18:

Member Months	Dual	Medi-Cal Only
January to June 2016	2,278	2,506
July 2016 to June 2017	4,255	4,605
July 2017 to June 2018	4,255	4,605

2) Assume the following paid rates for FY 2016-17 and FY 2017-18:

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
July 2017 to June 2018	$272.23	$1,839.50

3) Assume the following revised rates for FY 2016-17 and 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 June 2018	$102.81	$3,501.58

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

FY 2016-17	Paid Rate	MM	**TF**
Dual	$272.23	4,255	$1,158,000
Medi-Cal Only	$1,839.50	4,605	$8,470,000
Total			**$9,628,000**

AIDS HEALTHCARE CENTERS (Other M/C)

BASE POLICY CHANGE NUMBER: 108

FY 2017-18	Year	Paid Rate	Revised Rate	Rate Difference	MM	TF
Dual (Retro)	Jan-June 2016	$272.23	$49.56	($222.67)	2,278	($507,000)
Medi-Cal Only (Retro)	Jan-June 2016	$1,839.50	$2,598.57	$759.07	2,506	$1,902,000
Dual (Retro)	FY 2016-17	$272.23	$51.62	($220.61)	4,255	($939,000)
Medi-Cal Only (Retro)	FY 2016-17	$1,839.50	$2,732.76	$893.26	4,605	$4,113,000
*Dual	FY 2017-18	$0.00	$102.81	$102.81	4,255	$401,000
*Medi-Cal Only	FY 2017-18	$0.00	$3,501.58	$3,501.58	4,605	$14,780,000
Total						**$19,750,000**

*Assumes 11 months of capitation payments.

FY 2016-17	TF	GF	FF
Dual	$1,158,000	$579,000	$579,000
Medi-Cal Only	$8,470,000	$4,235,000	$4,235,000
Total FY 2016-17	**$9,628,000**	**$4,814,000**	**$4,814,000**

FY 2017-18	TF	GF	FF
Dual	($1,045,000)	($522,500)	($522,500)
Medi-Cal Only	$20,795,000	$10,397,500	$10,397,500
Total FY 2017-18	**$19,750,000**	**$9,875,000**	**$9,875,000**

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

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

BASE POLICY CHANGE NUMBER:	110
IMPLEMENTATION DATE:	7/2017
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	66

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	**$3,117,000**
- STATE FUNDS	$0	**$1,558,500**
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	**$3,117,000**
STATE FUNDS	$0	**$1,558,500**
FEDERAL FUNDS	$0	**$1,558,500**

DESCRIPTION

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

Authority:
Welfare & Institutions Code 14087.3

Interdependent Policy Changes:
Not Applicable

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

Reason for Change:
The change from the prior estimate, for FY 2016-17, is a decrease due to a delay in FY 2015-16 and FY 2016-17 payments from current year to budget year.

The change from the prior estimate, for FY 2017-18, is an increase due to:

- Updated rates, and
- A delay in FY 2015-16 and FY 2016-17 payments from current year to budget year.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to scheduling payments for FY 2015-16, FY 2016-17, and FY 2017-18 in FY 2017-18.

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: 110

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

- $3,286.64 in FY 2015-16
- $3,361.41 in FY 2016-17
- $3,361.41 in FY 2017-18

3) FY 2015-16 and FY 2016-17 rates are anticipated to be submitted for CMS approval in May 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 = $1,019,000 TF

FY 2016-17: $3,361.41 x 312 = $1,049,000 TF

FY 2017-18: $3,361.41 x 312 = $1,049,000 TF

	TF	GF	FF
FY 2017-18	**$3,117,000**	**$1,558,500**	**$1,558,500**

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

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

BASE POLICY CHANGE NUMBER:	167
IMPLEMENTATION DATE:	7/1988
ANALYST:	Humei Wang
FISCAL REFERENCE NUMBER:	76

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$3,080,719,000	$3,270,379,000
- STATE FUNDS	$1,649,153,500	$1,751,636,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,080,719,000	$3,270,379,000
STATE FUNDS	$1,649,153,500	$1,751,636,500
FEDERAL FUNDS	$1,431,565,500	$1,518,742,500

DESCRIPTION

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

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

Interdependent Policy Changes:
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 2016-17 is due to:

1. The actual 2017 Medicare Part B premium is higher than estimated in the November 2016 Estimate; the 2017 Part B premium from the Medicare Part B Adjustment policy change is now included in this estimate.
2. The estimated change in both Medicare Part A and Part B eligibles. Since the November 2016 Estimate, both Part A and Part B eligibles exhibited a slower growth for FY 2016-17 than previously estimated.

The change from the prior estimate for FY2017-18 is due to:

1. Higher Part B premium rate estimate: the Part B premium from the Medicare Part B Adjustment policy change is now included in this estimate.
2. Slower growth estimate for both Part A and Part B eligibles.

The change from FY 2016-17 to FY 2017-18 is related to:

1. Projected growth in the premium for both Part A and Part B.
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: 167

3. 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.

	2016	2017		2018	
	Actual	November 2016 Estimate	May 2017 Actual	November 2016 Estimate	May 2017 Estimate
	Premiums				
Part A	$411.00	$413.00	$413.00	$425.00	$425.00
Part B	$121.80	$121.80	$134.00	$124.40	$134.00
	Average Estimated Monthly Eligibles				
Part A		178,400	176,800	182,100	179,700
Part B		1,382,500	1,377,800	1,414,000	1,411,400

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 2016 and 2017:

Calendar Year	Part A Premium	Part B Premium
2016	$ 411.00	$ 121.80
2017	$ 413.00	$ 134.00

3. For 2018, the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance, projected at 2.8% growth in the Medicare Part A premiums. Applying this growth to the 2017 Part A Premium ($413 x 1.028) = $425 (rounded)

4. The Medicare Part B premium is budgeted at $134.00 in this policy change and the projected 2018 premium change is budgeted in the Medicare Part B Adjustment policy change.

FY 2016-17	**Part A**	**Part B**
Average Monthly Eligibles	176,800	1,377,800
Rate 07/2016-12/2016	$411.00	$121.80
Rate 01/2017-06/2017	$413.00	$134.00

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

BASE POLICY CHANGE NUMBER: 167

FY 2017-18

Average Monthly Eligibles	179,700	1,411,400
Rate 07/2017-12/2017	$413.00	$134.00
Rate 01/2018-06/2018	$425.00	$134.00

5. Of the non-federal share for this policy change in 2017-18, $18.4 million in new growth as compared to the 2016 Budget Act will be funded with Proposition 56 revenue.

(Dollars in Thousands)

FY 2016-17	TF	GF	FF
Title XIX 50/50	$2,784,929	$1,392,464	$1,392,465
State GF 100%	$256,689	$256,689	$0
Title XIX 100% FFP	$39,101	$0	$39,101
Total	**$3,080,719**	**$1,649,153**	**$1,431,566**

(Dollars in Thousands)

FY 2017-18	TF	GF	FF	SF
Title XIX 50/50	$2,953,781	$1,476,890	$1,476,891	$0
State GF 100%	$256,386	$256,386	$0	$0
Healthcare Treatment Fund	$18,360	$0		$18,360
Title XIX 100% FFP	$41,852	$0	$41,852	$0
Total	**$3,270,379**	**$1,733,276**	**$1,518,743**	**$18,360**

MEDICARE PAYMENTS - PART D PHASED-DOWN

BASE POLICY CHANGE NUMBER:	168
IMPLEMENTATION DATE:	1/2006
ANALYST:	Joulia Dib
FISCAL REFERENCE NUMBER:	1019

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$1,915,760,000	$2,125,280,000
- STATE FUNDS	$1,915,760,000	$2,125,280,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,915,760,000	$2,125,280,000
STATE FUNDS	$1,915,760,000	$2,125,280,000
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
2014	$97.40
2015	$98.76
2016	$110.23
2017	$123.38
2018	$125.10 (estimated)

MEDICARE PAYMENTS - PART D PHASED-DOWN

BASE POLICY CHANGE NUMBER: 168

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 2013-14	$1,479,580,071	1,213,682
FY 2014-15	$1,522,511,847	1,296,510
FY 2015-16	$1,670,974,353	1,357,168

Reason for Change:
The change from the prior estimate for FY 2016-17 is due to a decrease in recent eligible counts of approximately 3,900 average monthly eligibles. The change from the prior estimate for FY 2017-18 is due to a decrease in the estimated 2018 PMPM from $137.92 to $125.10. The change between FY 2016-17 and FY 2017-18 is due to an estimated increase of $1.72 PMPM for 2018 and estimated historical growth in eligibles.

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. The 2016 growth increased 11.61% over 2015 amounts per *Centers for Medicare & Medicaid Services*. Medi-Cal's PMPM for 2016 is $110.23.

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

3. The 2018 growth is estimated to increase 1.38% based on the Part D 2017 annual percentage increase from *Centers for Medicare & Medicaid Services.* Medi-Cal's estimated PMPM for 2018 is $125.10.

4. Phase-down payments have a two-month lag (i.e., the invoice for January is received in February and due in March).

5. The average monthly eligible beneficiaries are estimated using the growth trend in the monthly Part D enrollment data from July 2011 to January 2017.

6. The Phased-down Contribution is funded 100% by State General Fund in FY 2016-17.

7. Of the nonfederal share for this policy change in 2017-18, $207.97 million in new growth as compared to the 2016 Budget Act, will be funded with Proposition 56 revenue.

MEDICARE PAYMENTS - PART D PHASED-DOWN

BASE POLICY CHANGE NUMBER: 168

	Payment Months	Est. Ave. Monthly Beneficiaries	Est. Ave. Monthly Cost	Total Cost
FY 2016-17	12	1,392,884	$159,646,700	**$1,915,760,000**
FY 2017-18	12	1,428,765	$177,106,700	**$2,125,280,000**

Funding:

FY 2016-17:	100% GF (4260-101-0001)	
FY 2017-18:	100% GF (4260-101-0001)	$1,917,310,000
	Health Treatment Fund (4260-101-3305)	$207,970,000

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

BASE POLICY CHANGE NUMBER:	169
IMPLEMENTATION DATE:	7/1990
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	23

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$1,603,877,000	$1,736,805,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,603,877,000	$1,736,805,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,603,877,000	$1,736,805,000

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 2016-17 and FY 2017-18, has been revised to reflect updated data. The change from FY 2016-17 to FY 2017-18, in the current estimate, is based on additional expenditures being budgeted in FY 2017-18.

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

BASE POLICY CHANGE NUMBER: 169

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

(Dollars in Thousands)

	Total Funds	CDDS GF	DHCS FFP
FY 2016-17	$3,207,755	$1,603,878	**$1,603,877**
FY 2017-18	$3,473,610	$1,736,805	**$1,736,805**

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

PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER:	170
IMPLEMENTATION DATE:	4/1993
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	22

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$1,119,545,000	$1,464,250,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,119,545,000	$1,464,250,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,119,545,000	$1,464,250,000

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: 170

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 2016-17	$2,239,090	**$1,119,545**	$1,119,545
FY 2017-18	$2,928,500	**$1,464,250**	$1,464,250

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

DENTAL SERVICES

BASE POLICY CHANGE NUMBER:	171
IMPLEMENTATION DATE:	7/1988
ANALYST:	Nikaela Ratliff
FISCAL REFERENCE NUMBER:	135

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$975,699,000	$1,171,505,000
- STATE FUNDS	$302,772,320	$401,821,340
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$975,699,000	$1,171,505,000
STATE FUNDS	$302,772,320	$401,821,340
FEDERAL FUNDS	$672,926,680	$769,683,660

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:
PC 40 Dental Children's Outreach Ages 0-3
PC 44 Beneficiary Outreach and Education Program
PC 46 Allied Dental Professionals Enrollment
PC 47 CHDP Program Dental Referral

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 has 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 is currently seeking approval on an additional contract extension amendment to extend through Assumption of Operations of the new contractors.

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

DENTAL SERVICES

BASE POLICY CHANGE NUMBER: 171

serves Medi-Cal beneficiaries, including Federally Qualified Health Clinics (FQHCs) and Rural Health Centers (RHCs), is limited to the adult optional benefits restored May 1, 2014, in addition to adult dental benefits which include services for pregnant women, emergency services, Federally Required Adult Dental Services (FRADs), services provided at an Intermediate Care Facility/Skilled Nursing Facility, and services for Department of Developmental Services consumers. The restoration of adult dental benefits is included in the capitation rates.

Reason for Change:
The change from the prior estimate, for FY 2016-17, is an overall decrease due to an increase in ACA optional average monthly eligibles, a decrease in regular average monthly eligibles, and a decrease in costs to be paid in FY 2016-17 for the Health Insurance Provider Fee (HIPF). The change from the prior estimate, for FY 2017-18, is an overall decrease due to an increase in ACA optional average monthly eligibles, a decrease in regular average monthly eligibles, a decrease in the rate, and a decrease in costs to be paid in FY 2017-18 for the HIPF. The change from FY 2016-17 to FY 2017-18, in the current estimate, is an overall increase due to the inclusion of the underwriting gain/loss in FY 2016-17, an increase in average monthly eligibles for the ACA optional and regular populations in FY 2017-18, and an increase in costs to be paid in FY 2017-18 for the HIPF.

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. The proposed FY 2015-16 capitation rate of $8.32 is used in both FY 2016-17 and FY 2017-18 for regular and refugee eligibles as there is a single rate for both populations. FY 2015-16 rates include the exemption from AB 97.

2. The contractor is required to have an annual independent audit which includes the determination of any underwriting gain or loss. The audit for the period ending June 30, 2015 resulted in an underwriting gain of $179.1 million. According to the contract distribution provisions, the Department will receive $174.5 million and Delta will retain $4.7 million in FY 2016-17.

3. The impact of the HIPF for the first six months of CY 2015 is $3,958,000 in FY 2016-17. The impact of the HIPF for the second six months of CY 2015 is $4,007,000 in FY 2017-18.

4. Of the nonfederal share for this policy change in 2017-18, $44,170,000 in new growth as compared to the 2016 Budget Act will be funded with Proposition 56 revenue.

DENTAL SERVICES

BASE POLICY CHANGE NUMBER: 171

(Dollars in Thousands)

FY 2016-17		Average Monthly Eligibles	
	Rate		Total Funds
Regular 7/15 – 6/16	$8.32	8,243,092	$822,990
Other FFS	Non-Capitated		$7,399
		Subtotal	$830,389
HIPF Add-on			$3,265
Underwriting Gain			($174,469)
		Total	$659,185
ACA			
ACA Optional Dental	$8.32	3,163,269	$315,821
HIPF Add-on			$693
ACA Subtotal			$316,514
		Total FY 2016-17	**$975,699**

(Dollars in Thousands)

FY 2017-18		Average Monthly Eligibles	
	Rate		Total Funds
Regular 7/15 – 6/16	$8.32	8,266,378	$825,315
Other FFS	Non-Capitated		$6,840
		Subtotal	$832,155
HIPF Add-on			$2,839
ACA			
ACA Optional Dental	$8.32	3,358,809	$335,343
HIPF Add-on			$1,168
ACA Subtotal			$336,511
		Total FY 2017-18	**$1,171,505**

DENTAL SERVICES

BASE POLICY CHANGE NUMBER: 171

Funding:

FY 2016-17	TF	GF	FF
88% Title XXI / 12% GF (4260-113-0001/0890)	$80,176,000	$9,621,120	$70,554,880
65% Title XIX / 35% GF (4260-101-0001/0890)	$477,000	$166,950	$310,050
100% GF (4260-101-0001)	$62,000	$62,000	$0
50% Title XIX / 50% GF (4260-101-0001/0890)	$569,574,000	$284,787,000	$284,787,000
100% Title XIX ACA (4260-101-0890)	$162,705,000	$0	$162,705,000
95% Title XIX ACA FF / 5% GF (4260-101-0001/0890)	$162,705,000	$8,135,250	$154,569,750
Total	**$975,699,000**	**$302,772,320**	**$672,926,680**

FY 2017-18	TF	GF	FF
88% Title XXI / 12% GF (4260-113-0001/0890)	$80,310,000	$9,637,200	$70,672,800
65% Title XIX / 35% GF (4260-101-0001/0890)	$477,000	$166,950	$310,050
100% GF (4260-101-0001)	$62,000	$62,000	$0
50% Title XIX / 50% GF (4260-101-0001/0890)	$657,658,000	$328,829,000	$328,829,000
95% Title XIX ACA FF / 5% GF (4260-101-0001/0890)	$172,329,000	$8,616,450	$163,712,550
94% Title XIX ACA FF / 6% GF (4260-101-0001/0890)	$172,329,000	$10,339,740	$161,989,260
100% Title XIX FFP (4260-101-0890)	$44,170,000		$44,170,000
Healthcare Treatment Fund	$44,170,000	$44,170,000	
Total	**$1,171,505,000**	**$401,821,340**	**$769,683,660**

*Totals may differ due to rounding.

DEVELOPMENTAL CENTERS/STATE OP SMALL FAC

BASE POLICY CHANGE NUMBER:	**173**
IMPLEMENTATION DATE:	**7/1997**
ANALYST:	**Jedidiah Warren**
FISCAL REFERENCE NUMBER:	**77**

	FY 2016-17	FY 2017-18
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 2016-17 and FY 2017-18. There is no change from FY 2016-17 to FY 2017-18 in the current estimate.

Methodology:
1. The following estimates have been provided by CDDS.

DEVELOPMENTAL CENTERS/STATE OP SMALL FAC

BASE POLICY CHANGE NUMBER: 173

(Dollars in Thousands)

Cash Basis	Total Funds	CDDS GF	FFP Regular
FY 2016-17	$414,660	$207,330	**$207,330**
FY 2017-18	$414,660	$207,330	**$207,330**

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

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

BASE POLICY CHANGE NUMBER:	175
IMPLEMENTATION DATE:	7/1991
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	26

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$215,538,000	$194,996,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$215,538,000	$194,996,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$215,538,000	$194,996,000

DESCRIPTION

Purpose:
This policy change estimates the federal match for the California Department of Developmental Services (CDDS) for regional center targeted case management services provided to eligible developmentally disabled clients.

Authority:
Interagency Agreement (IA) 03-75284

Interdependent Policy Changes:
Not Applicable

Background:
Authorized by the Lanterman Act, the Department entered into an IA with CDDS to reimburse the Title XIX federal financial participation (FFP) for targeted case management services for Medi-Cal eligible clients. There are 21 CDDS Regional Centers statewide that provide these services. CDDS conducts a time study every three years and an annual administrative cost survey to determine each regional center's actual cost to provide Targeted Case Management (TCM). A unit of service reimbursement rate for each regional center is established annually. To obtain FFP, the federal government requires that the TCM rate be based on the regional center's cost of providing case management services to all of its consumers with developmental disabilities, regardless of whether the consumer is TCM eligible.

The General Fund is in the CDDS budget on an accrual basis. The federal funds in the Department's budget are on a cash basis.

Reason for Change:
The change for FY 2016-17 and FY 2017-18 from the prior estimate and the change from FY 2016-17 to FY 2017-18 in the current estimate is due to updated caseload.

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

BASE POLICY CHANGE NUMBER: 175

Methodology:

1. The following estimates have been provided by CDDS:

(Dollars in Thousands)

CASH BASIS	Total Funds	CDDS GF	DHCS FFP
FY 2016-17	$431,076	$215,538	**$215,538**
FY 2017-18	$389,991	$194,995	**$194,996**

Funding:

100% Title XIX (4260-101-0890)

WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER:	177
IMPLEMENTATION DATE:	4/2000
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	32

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$44,055,000	$46,068,000
- STATE FUNDS	$22,027,500	$23,034,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$44,055,000	$46,068,000
STATE FUNDS	$22,027,500	$23,034,000
FEDERAL FUNDS	$22,027,500	$23,034,000

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 35 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: 177

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.

Reason for Change from Prior Estimate:
The change from the prior estimate, for FY 2016-17 and FY 2017-18, is an increase due to a higher cost per hour rate. The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to anticipated minimum wage increases each year through 2022.

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 2016-17 and FY 2017-18.

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 2016-17 and FY 2017-18.

3. The Department's CCT Demonstration Project transferred 520 beneficiaries in FY 2015-16. The CCT Demonstration Project expects to transition 542 beneficiaries out of inpatient extended health care facilities in FY 2016-17 and 498 in FY 2017-18. Based on actual data from July 2015 through June 2016, the Department assumes 3% of CCT beneficiaries will use WPCS for FY 2016-17 and FY 2017-18.

4. The average cost/hour is $11.09 for FY 2016-17 and $11.27 FY 2017-18.

5. The chart below displays the estimate on an accrual basis.

FY 2016-17	Total Hours	Cost/Hour	TF	GF	FF
NF/AH Waiver					
NF A/B	2,523,255	$11.09	$27,983,000	$13,992,000	$13,991,000
NF S/A	1,340,535	$11.09	$14,867,000	$7,434,000	$7,433,000
IHO Waiver					
NF A/B	141,132	$11.09	$1,565,000	$782,000	$783,000
NF S/A	19,850	$11.09	$220,000	$110,000	$110,000
Total			**$44,635,000**	**$22,318,000**	**$22,317,000**

FY 2017-18	Total Hours	Cost/Hour	TF	GF	FF
NF/AH Waiver					
NF A/B	2,565,570	$11.27	$28,914,000	$14,457,000	$14,457,000
NF S/A	1,386,401	$11.27	$15,625,000	$7,813,000	$7,812,000
IHO Waiver					
NF A/B	141,132	$11.27	$1,591,000	$795,000	$796,000
NF S/A	19,850	$11.27	$224,000	$112,000	$112,000
Total			**$46,354,000**	**$23,177,000**	**$23,177,000**

WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 177

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

(Dollars in Thousands)	TF	GF	FF
FY 2016-17	**$44,055**	**$22,028**	**$22,027**
FY 2017-18	**$46,068**	**$23,034**	**$23,034**

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

MEDI-CAL TCM PROGRAM

BASE POLICY CHANGE NUMBER:	178
IMPLEMENTATION DATE:	6/1995
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	27

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$35,392,000	$30,063,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$35,392,000	$30,063,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$35,392,000	$30,063,000

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 from the prior estimate, for FY 2016-17 and FY 2017-18, is a net decrease due to:

- Updated reconciliation periods and payments that resulted in net recoupments in FY 2016-17 and FY 2017-18,
- Increased ACA payments,
- Removal of the 1% program growth factor,
- Updated LGA turnover and probation caseload, and
- Decreased FY 2016-17 and FY 2017-18 base payment based on the average expenditure of three fiscal years compared to two fiscal years in the prior estimate.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is a decrease due to increased reconciliation recoupments in FY 2017-18.

MEDI-CAL TCM PROGRAM

BASE POLICY CHANGE NUMBER: 178

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 $33,437,000 for FY 2016-17 and FY 2017-18 is based on average expenditures from FY 2013-14 through FY 2015-16.

3. In FY 2016-17, $2,993,000 will be paid for ACA optional encounters retro to January 1, 2014. In FY 2017-18, ACA optional encounters are estimated to be $2,682,000.

4. The following reconciliations will occur in FY 2016-17:
   - The Department will recoup a net of $1,335,000 to complete the FY 2010-11 final reconciliations.
   - The Department will pay out a net of $374,000 to begin the FY 2011-12 final reconciliations.
   - The Department will recoup $217,000 for the FY 2013-14 interim reconciliations.

5. LGAs may choose to participate or withdraw from the program. In 2016-17, it is expected the net impact of these shifts will be $140,000.

6. In FY 2017-18, additional SPA cap removal claims will be paid for FY 2010-11 and FY 2012-13.

7. Assume that in FY 2017-18 the Department will complete final reconciliations for FY 2011-12 and will complete interim reconciliations for FY 2014-15.

8. Assume that in FY 2017-18 the Department will experience an increase in probation claims of 15% from the estimated FY 2016-17 probation claims.

FY 2016-17	**TF**	**FF**
FY 2016-17 Base (Average Expenditures)	$33,437,000	$33,437,000
ACA encounters		
FY 2013-14	$24,000	$24,000
FY 2014-15	$464,000	$464,000
FY 2015-16	$1,630,000	$1,630,000
FY 2016-17	$875,000	$875,000
Reconciliations		
FY 2010-11(Final)	($1,335,000)	($1,335,000)
FY 2011-12 (Final)	$374,000	$374,000
FY 2013-14 (Interim)	($217,000)	($217,000)
LGA Turnover/Additions & Probation	$140,000	$140,000
Total FY 2016-17	**$35,392,000**	**$35,392,000**

MEDI-CAL TCM PROGRAM

BASE POLICY CHANGE NUMBER: 178

FY 2017-18	TF	FF
FY 2017-18 Base (Average Expenditures)	$33,437,000	$33,437,000
SPA#10-010 increase (CAP removal)		
FY 2010-11	$270,000	$270,000
FY 2012-13	$29,000	$29,000
ACA encounters		
FY 2015-16	$857,000	$857,000
FY 2016-17	$925,000	$925,000
FY 2017-18	$900,000	$900,000
Reconciliations		
FY 2011-12 (Final)	($5,534,000)	($5,534,000)
FY 2014-15 (Interim)	($5,160,000)	($5,160,000)
LGA Probation Increase	$4,339,000	$4,339,000
Total FY 2017-18	**$30,063,000**	**$30,063,000**

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

EPSDT SCREENS

BASE POLICY CHANGE NUMBER:	179
IMPLEMENTATION DATE:	7/2001
ANALYST:	Sasha Jetton
FISCAL REFERENCE NUMBER:	136

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$35,413,000	$34,832,000
- STATE FUNDS	$16,952,960	$16,675,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$35,413,000	$34,832,000
STATE FUNDS	$16,952,960	$16,675,000
FEDERAL FUNDS	$18,460,040	$18,157,000

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.

EPSDT claims are converting to meet the Health Insurance Portability and Accountability Act (HIPPA) requirements by transitioning to the standard Fee-For-Service paid claims process. Claims for clinical laboratories transitioned starting January 1, 2017. All other claims will begin transitioning on or after 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 and cost per screen decreased from the prior estimate for both FY 2016-17 (17,204 and $0.77) and FY 2017-18 (28,512 and $0.53). This decrease is due to the decline in Fee-For-Service beneficiaries and a possible shift of beneficiaries to Managed Care. There is a slight decrease between FY 2016-17 and FY 2017-18 which is based on the historical trend.

EPSDT SCREENS

BASE POLICY CHANGE NUMBER: 179

Methodology:
Costs are determined by multiplying the number of screens by the estimated average cost per screen for FY 2016-17 and FY 2017-18, based on historical trends from July 2011 to September 2016.

FY 2016-17
Screens 606,158 x $58.42 (weighted average) **= $35,413,000** (rounded)

FY 2017-18
Screens 594,031 x $58.64 (weighted average) **= $34,832,000** (rounded)

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
88% Title XXI / 12% GF (4260-113-0001/0890)

LAWSUITS/CLAIMS

BASE POLICY CHANGE NUMBER:	186
IMPLEMENTATION DATE:	7/1989
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	93

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	**$5,358,000**	**$2,013,000**
- STATE FUNDS	**$2,203,500**	**$1,080,500**
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	**$5,358,000**	**$2,013,000**
STATE FUNDS	**$2,203,500**	**$1,080,500**
FEDERAL FUNDS	**$3,154,500**	**$932,500**

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 2016-17, is an increase due to updated lawsuit information. There is no change from the prior estimate for FY 2017-18. The change from FY 2016-17 to FY 2017-18, 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

1. E.M. v. Lightbourne, et al.	$3,000
2. Hanna, Yousif v. Kent, Jennifer, et al.	$4,000
3. Douglas v. CA Office of Administrative Hearings	$300
Total for FY 2016-17	**$7,300**

LAWSUITS/CLAIMS

BASE POLICY CHANGE NUMBER: 186

2. Provider Settlements of $75,000 or Less Payments	
1. CPH Hospital Management v. DHCS	$4,100
Total for FY 2016-17	**$4,100**
3. Beneficiary Settlements of $2,000 or Less Payments	
1. Douglas v. CA Office of Administrative Hearings	$900
Total for FY 2016-17	**$900**
4. Other Attorney Fees Payments	
1. McLaurin v. Tuolumne County CCS	$32,000
2. Freeman v. Kent, Director of DHCS	$52,500
3. In the Matter of: Ridgecrest Regional Hospital	$315,000
4. Kathem and Tluang v. Lightbourne, DDS; Kent, DHCS	$45,000
Total for FY 2016-17	**$444,500**
1. Douglas v. CA Office of Administrative Hearings	$122,800
Total for FY 2017-18	**$122,800**
5. Other Provider Settlements	
1. City & County of SF v. Shewry, Director of DHCS (100% FF)	$951,700
2. In the Matter of: Children's Hospital at Mission	$220,000
3. In the Matter of: Community Hospital of Monterey Peninsula	$77,900
4. In the Matter of: Enloe Medical Center	$1,776,000
Total for FY 2016-17	**$3,025,600**
6. Other Beneficiary Settlements	
1. Shurtleff v. Medi-Cal, State of California	$15,600
2. California Victim Compensation/Government Claims Board	$7,000
Total for FY 2016-17	**$22,600**
1. Douglas v. CA Office of Administrative Hearings	$25,600
Total for FY 2017-18	**$25,600**

	Committed	Balance	Budgeted	Budgeted
	2016-17	2016-17	2016-17	2017-18
Attorney Fees <$5,000	$7,300	$42,700	$50,000 *	$50,000 *
Provider Settlements <$75,000	$4,100	$1,595,900	$1,600,000 *	$1,600,000 *
Beneficiary Settlements <$2,000	$900	$14,100	$15,000 *	$15,000 *
Small Claims Court	$0	$200,000	$200,000 *	$200,000 *
Other Attorney Fees	$444,500	N/A	$444,500	$122,800
Other Provider Settlements	$3,025,600	N/A	$3,025,600	$0
Other Beneficiary Settlements	$22,600	N/A	$22,600	$25,600
	$3,505,000	$1,852,700	**$5,358,000**	**$2,013,000**

* Represents potential totals.

LAWSUITS/CLAIMS

BASE POLICY CHANGE NUMBER: 186

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

HIPP PREMIUM PAYOUTS (Misc. Svcs.)

BASE POLICY CHANGE NUMBER:	187
IMPLEMENTATION DATE:	1/1993
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	91

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$1,313,000	$1,307,000
- STATE FUNDS	$656,500	$653,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,313,000	$1,307,000
STATE FUNDS	$656,500	$653,500
FEDERAL FUNDS	$656,500	$653,500

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 from the prior estimate, for FY 2016-17 and FY 2017-18, is due to lower than previously projected enrollment and premium costs. The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to the anticipated increase in premium costs, but an estimated reduction in enrollment causing a net decrease in overall forecasted expenditures in FY 2017-18.

HIPP PREMIUM PAYOUTS (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 187

Methodology:

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

2. In FY 2016-17 and FY 2017-18, based on actual data through December 2016, it is estimated that there will be a decrease in premium costs and enrollment compared to the prior estimate.

3. The average monthly premium cost including ancillary costs is estimated to be $576.00 in FY 2016-17 and $605.00 in FY 2017-18.

4. The average monthly HIPP enrollment is estimated to be 190 in FY 2016-17 and 180 in FY 2017-18.

5. Costs for FY 2016-17 and FY 2017-18 are estimated to be:

   FY 2016-17: $576.00 x 190 x 12 Months **= $1,313,000 TF ($656,500 GF)**

   FY 2017-18: $605.00 x 180 x 12 Months **= $1,307,000 TF ($653,500 GF)**

Funding:

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

CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER:	188
IMPLEMENTATION DATE:	7/1997
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1083

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	**$1,291,000**	**$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	**$1,291,000**	**$1,028,000**
STATE FUNDS	$0	$0
FEDERAL FUNDS	**$1,291,000**	**$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:
There is no change from the prior estimate. The change in the current estimate, from FY 2016-17 to FY 2017-18, is due to all delayed invoicing being paid in FY 2016-17.

Methodology:
1. Annual expenditures on the accrual basis are $2,056,000 TF. 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: 188

2. The estimates are provided by CDPH on a cash basis.

FY 2016-17	DHCS FFP	CDPH CLPP Fee Funds
FY 2015-16 - Benefits Costs	$520,000	$520,000
FY 2016-17 - Benefits Costs	$771,000	$771,000
Total	**$1,291,000**	$1,291,000

FY 2017-18	DHCS FFP	CDPH CLPP Fee Funds
FY 2016-17 - Benefits Costs	$257,000	$257,000
FY 2017-18 - Benefits Costs	$771,000	$771,000
Total	**$1,028,000**	$1,028,000

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

BASE RECOVERIES

BASE POLICY CHANGE NUMBER:	203
IMPLEMENTATION DATE:	7/1987
ANALYST:	Stephanie Hockman
FISCAL REFERENCE NUMBER:	127

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	-$321,820,000	-$352,303,000
- STATE FUNDS	-$154,655,000	-$169,305,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$321,820,000	-$352,303,000
STATE FUNDS	-$154,655,000	-$169,305,000
FEDERAL FUNDS	-$167,165,000	-$182,998,000

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, 14124.88, 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 182 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 will cease 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. Hence, during this transition, 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.

Reason for Change from Prior Estimate:
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,

BASE RECOVERIES

BASE POLICY CHANGE NUMBER: 203

judgements, and awards. The decrease from the prior estimate for FY 2016-17 is due to lower than average provider general collections and the Department temporarily suspending all recovery activities for Health Insurance (H.I.) while revising H.I. correspondence. The change between fiscal years is due to the suspended H.I. recovery activity shifting the timing of collections from FY 2016-17 to FY 2017-18.

(Dollars in Thousands)

Recovery Type	FY 2016-17	FY 2017-18
Personal Injury Collections	($97,776)	($97,721)
Workers' Comp. Collections	($1,688)	($2,300)
Health Insurance Contingency Contract	($87,676)	($116,255)
General Collections	($134,680)	($136,027)
TOTAL	**($321,820)**	**($352,303)**

Methodology:

1. The recoveries estimate uses the trend in monthly recoveries for July 2013 – December 2016.

2. The General Fund ratio for collections is estimated to be 48.06% in FY 2016-17 and FY 2017-18.

Funding:

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

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FAMILY PACT PROGRAM

REGULAR POLICY CHANGE NUMBER:	1
IMPLEMENTATION DATE:	1/1997
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$316,502,000	$310,264,000
- STATE FUNDS	$76,127,800	$74,627,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$316,502,000	$310,264,000
STATE FUNDS	$76,127,800	$74,627,800
FEDERAL FUNDS	$240,374,200	$235,636,200

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 more persons in need of such services with incomes under 200% of the Federal Poverty Level. The Centers for Medicare & Medicaid Services (CMS) approved a Section 1115 demonstration project waiver, effective December 1, 1999.

On March 24, 2011, CMS approved a State Plan Amendment (SPA), in accordance with the Affordable Care Act (ACA), to transition the current Family PACT waiver into the State Plan. Under the SPA, eligible family planning services and supplies formerly reimbursed exclusively with 100% State General Fund receive a 90% federal financial participation (FFP), and family planning-related services receive reimbursement at Title XIX 50/50 FFP.

Drug rebates for Family PACT drugs are included in the Family PACT Drug Rebates policy change.

Reason for Change:
The decrease from the prior estimate, for FY 2016-17 and FY 2017-18, is due to a decrease in users in the Other Medical service category. The decrease in the current estimate, from FY 2016-17 to FY 2017-18, is due to the predicted trend of decreased users.

FAMILY PACT PROGRAM

REGULAR POLICY CHANGE NUMBER: 1

Methodology:

1. Linear regressions on actual data from September 2011 to December 2016 were used 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 2016-17		FY 2017-18	
	TF	GF	TF	GF
Physicians	$ 66,157	$ 15,913	$ 66,029	$ 15,882
Other Medical	$ 197,608	$ 47,530	$ 190,261	$ 45,763
Co. & Comm. Outpatient	$ 2,239	$ 539	$ 2,384	$ 573
Pharmacy	$ 50,498	$ 12,146	$ 51,590	$ 12,409
Total	**$ 316,502**	**$ 76,128**	**$ 310,264**	**$ 74,627**

Funding:

(Dollars in Thousands)

FY 2016-17	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$ 11,852	$ 5,926	$ 5,926
100% GF (4260-101-0001)	$ 44,152	$ 44,152	$ -
90% Family Planning / 10% GF (4260-101-0001/0890)	$ 260,498	$ 26,050	$ 234,448
Total	**$ 316,502**	**$ 76,128**	**$ 240,374**

FY 2017-18	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$ 11,619	$ 5,809	$ 5,810
100% GF (4260-101-0001)	$ 43,282	$ 43,282	$ -
90% Family Planning / 10% GF (4260-101-0001/0890)	$ 255,363	$ 25,536	$ 229,827
Total	**$ 310,264**	**$ 74,627**	**$ 235,637**

MEDI-CAL STATE INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER:	3
IMPLEMENTATION DATE:	12/2016
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1569

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$77,936,000	$117,057,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$77,936,000	$117,057,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$77,936,000	$117,057,000

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, counties, and the CDCR to:

- Claim FFP for inpatient hospital services to Medi-Cal or Low Income Health Program (LIHP) eligible adult inmates in State and county correctional facilities when these services are provided off the grounds of the facility. Previously these services were paid by CDCR or the county. 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: 3

SB 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 by CDCR or the county.

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 prior estimate, for FY 2016-17, is an overall decrease due to the following reasons:

- County adults and compassionate release costs are now budgeted in the Medi-Cal County Inmate Programs policy change and State juvenile costs are budgeted in this policy change, and
- An adjustment decreasing the retroactive claim amounts for adults and juveniles.

The change from prior estimate, for FY 2017-18, is an overall decrease due to the following reasons:

- County adults and compassionate release costs are now budgeted in the Medi-Cal County Inmate Programs policy change and State juvenile costs are budgeted in this policy change,
- The average annual cost for inpatient admission for a juvenile inmate increased from $10,206 TF to $11,314 TF,
- State juvenile costs increase from $663,000 TF to $709,000 TF, and
- An adjustment increased the retroactive claim amounts for State adults, but removal of County adults and associated retroactive payments decreased the estimate.

The change from FY 2016-17 to FY 2017-18 is an increase due to an adjustment in retroactive claim amounts expected to be paid in each FY.

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. Based on actual claims data, the average cost for an adult inpatient admission is estimated to be $11,180 TF for State inmates.

4. Assume the Department will process 320 applications per month for State inmates with verified citizenship.

5. Assume 90% of the monthly applicants will become eligible for Medi-Cal.

MEDI-CAL STATE INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 3

6. Of the eligible Medi-Cal applicants, assume 10% are for Non-ACA Medi-Cal and 90% for the ACA Optional Expansion in FY 2016-17 and FY 2017-18.
   - Adults Non-ACA: 320 x 90% x 10% = 29 monthly Non-ACA State inmates
   - Adults ACA Optional Expansion: 320 x 90% x 90% = 259 monthly ACA State inmates

7. State adult Non-ACA inmate inpatient costs are estimated to be $3,891,000 TF annually. State adult ACA inmate inpatient costs are estimated to be $34,747,000 TF annually.

8. Based on FFS cost data, the average cost for a general acute care inpatient admission for a juvenile inmate is estimated at $11,314 TF annually, which accounts for two-thirds of admits.

9. The Department estimates that the average inpatient psychiatric cost per juvenile inmate for those less than 21 years of age is $6,903 TF annually which accounts for one-third of admits.

10. Assume the Department will process 6 applications monthly for juvenile inmates.

11. State juvenile costs are estimated to be $709,000 TF annually.

12. Assume the Department will process 25 applications annually for State Medical Parolees with verified citizenship. Assume these eligibles will receive long-term care (LTC) services for 20 months of continuous coverage. Estimated monthly eligibles are phased-in for an annual total of 500.

13. Based on actual claims data, the average monthly LTC cost for inmates in the State Medical Parole program are estimated to be $9,099 TF.

14. State Medical Parole estimated costs are $4,550,000 TF annually.

15. Total estimated Medi-Cal Inpatient Hospital Costs for all eligible (Medi-Cal and ACA) adult and juvenile inmates in FY 2016-17 and FY 2017-18, including retroactive payments are:

	FY 2016-17		FY 2017-18	
State Adults	**TF**	**FF**	**TF**	**FF**
State - Non ACA	$3,891,000	$1,946,000	$3,891,000	$1,946,000
State - ACA	$34,747,000	$34,313,000	$34,747,000	$32,923,000
Medical Parole	$4,550,000	$2,275,000	$4,550,000	$2,275,000
Total Retroactive Payments	$52,416,000	$38,980,000	$98,895,000	$79,159,000
Retro ACA	$25,544,000	$25,544,000	$60,291,000	$59,857,000
Retro Non-ACA	$26,872,000	$13,436,000	$38,604,000	$19,302,000
State Adults Total	$95,604,000	**$77,514,000**	$142,083,000	**$116,303,000**
State Juveniles	**TF**	**FF**	**TF**	**FF**
State Juveniles	$709,000	$355,000	$709,000	$355,000
Retroactive Payments	$134,000	$67,000	$798,000	$399,000
State Juveniles Total	$843,000	**$422,000**	$1,507,000	**$754,000**
Grand Total	$96,447,000	**$77,936,000**	$143,590,000	**$117,057,000**

*Totals may differ due to rounding.

MEDI-CAL STATE INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 3

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:	5
IMPLEMENTATION DATE:	1/2002
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	3

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$67,000,000	$69,000,000
- STATE FUNDS	$36,100,000	$36,800,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$67,000,000	$69,000,000
STATE FUNDS	$36,100,000	$36,800,000
FEDERAL FUNDS	$30,900,000	$32,200,000

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 women 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 women 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 persons' 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 decrease from the prior estimate for FY 2016-17 and FY 2017-18, is due to a 4% decrease in eligibles. The increase in the current estimate from FY 2016-17 to FY 2017-18, is due to updated

BREAST AND CERVICAL CANCER TREATMENT

REGULAR POLICY CHANGE NUMBER: 5

expenditures data from July 2016 through October 2016, predicting a slight increase in expenditures.

Methodology:

1. There were 4,992 FFS and 2,055 managed care eligibles as of October 2016 (total of 7,047). 1,907 of the FFS eligibles were eligible for State-Only services.
2. 123 of the FFS eligibles were in accelerated enrollment as of October 2016.
3. Assume the State will pay Medicare and other health coverage premiums for an average of 469 beneficiaries monthly in FY 2016-17 and FY 2017-18. Assume an average monthly premium cost per beneficiary of $133.43.

   FY 2016-17: 469 x $133.43 x 12 months = $751,000 TF ($751,000 GF)
   FY 2017-18: 469 x $133.43 x 12 months = $751,000 TF ($751,000 GF)

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

FFS Costs	FY 2016-17 TF	FY 2016-17 GF	FY 2017-18 TF	FY 2017-18 GF
Full Scope Costs	$ 48,113	$ 17,120	$ 49,622	$ 17,655
State-Only Services	$ 18,282	$ 18,282	$ 18,530	$ 18,530
State-Only Premiums	$ 751	$ 751	$ 751	$ 751
Total	**$ 67,146**	**$ 36,153**	**$ 68,903**	**$ 36,936**

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 2016-17	TF	GF	FF
General Fund 4260-101-001	$ 19,000	$ 19,000	$ -
50 Title XIX FFP / 50 GF (4260-101-0001/0890)	$ 2,000	$ 1,000	$ 1,000
Title XIX 65/35 FFP4260-101-0001/0890	$ 46,000	$ 16,000	$ 30,000
Total	**$ 67,000**	**$ 36,000**	**$ 31,000**

FY 2017-18	TF	GF	FF
General Fund 4260-101-001	$ 19,000	$ 19,000	$ -
50 Title XIX FFP / 50 GF (4260-101-0001/0890)	$ 2,000	$ 1,000	$ 1,000
Title XIX 65/35 FFP4260-101-0001/0890	$ 48,000	$ 17,000	$ 31,000
Total	**$ 69,000**	**$ 37,000**	**$ 32,000**

MEDI-CAL COUNTY INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER:	6
IMPLEMENTATION DATE:	4/2017
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1755

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$27,385,000	$301,867,000
- STATE FUNDS	$9,345,500	$37,477,550
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$27,385,000	$301,867,000
STATE FUNDS	$9,345,500	$37,477,550
FEDERAL FUNDS	$18,039,500	$264,389,450

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, counties, and the California Department of Corrections and Rehabilitation (CDCR) to:

- Claim FFP for inpatient hospital services to Medi-Cal or Low Income Health Program (LIHP) eligible adult inmates in State and county correctional facilities when these services are provided off the grounds of the facility. Previously these services were paid by CDCR or the county. 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.

MEDI-CAL COUNTY INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 6

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

- Claim Federal Financial Participation (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 by CDCR or 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 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 2016-17 and FY 2017-18, is due to the following reasons:

- County adults and compassionate release costs are now budgeted in this policy change and state juvenile costs are budgeted in the Medi-Cal State Inmate Programs policy change,
- Adjustments in processing retroactive claim amounts and the delay in implementation of the FI processing claims. All claims from July 1, 2016 to March 31, 2017 will be part of the retroactive payments in FY 2017-18,
- The average annual cost for inpatient admission for a juvenile inmate increased from $10,206 TF to $11,314 TF, and
- The inpatient cost for adult county inmates decreased from $17,327 to $11,180.

The change from FY 2016-17 to FY 2017-18 is an increase due to the delay in the processing of retroactive claims to FY 2017-18 and the implementation of the FI processing claims.

Methodology:

1. The adult county inmate program began in November 2010. The juvenile county inmate program began in January 2012.

MEDI-CAL COUNTY INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 6

2. Applications for county inmates will be completed by the county welfare departments.

3. County inmate claims with dates of services beginning April 1, 2017 will be processed by the fiscal intermediary.

4. 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 2017-18. Currently, counties are paying for these services. The retroactive claiming for services prior to April 1, 2017 will be processed manually and not by the fiscal intermediary to reimburse the counties with federal funds.

5. Based on actual claims data, the average cost for an adult inpatient admission is estimated to be $11,180 TF for county inmates.

6. Assume there are 80,000 monthly county adult inmates. Assume that 2% will utilize inpatient services on a monthly basis and, of these, 20% will be eligible for Medi-Cal.

7. Assume the county application split will be 10% for Non-ACA Medi-Cal and 90% for ACA Optional Expansion in FY 2016-17 and FY 2017-18.
   - County Non-ACA: 80,000 x 2% x 20% x 10% = 32 monthly Non-ACA county inmates
   - County ACA: 80,000 x 2% x 20% x 90% = 288 monthly ACA county inmates

8. County adult Non-ACA inmate inpatient costs are estimated to be $4,293,000 TF annually. County adult ACA inmate inpatient costs are estimated to be $38,638,000 TF annually.

9. Based on fee-for-service (FFS) cost data, the average cost for a general acute care inpatient admission for juveniles is estimated at $11,314 TF annually.

10. The Department estimates that the average inpatient psychiatric cost per client for those less than 21 years of age is $6,903 TF annually.

11. Assume the county welfare departments will process an estimated 495 applications per month for county juveniles with verified citizenship in FY 2016-17 and FY 2017-18. Of the estimated monthly State and county applications, it is assumed 30% are for psychiatric services and 70% for other inpatient services.

12. County juvenile costs are estimated to be $59,320,000 TF annually.

13. Assume 100 county inmates will be granted Compassionate Release each year. Assume these eligibles will receive LTC services for 9 months of continuous coverage. Estimated monthly eligibles are phased-in for an annual total of 900 annually.

14. Based on actual claims data, the average monthly long-term care cost for inmates in the Compassionate Release program are estimated to be $8,095 TF.

15. County Compassionate Release program estimated costs are $7,286,000 TF annually.

MEDI-CAL COUNTY INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 6

16. Claims processed by the fiscal intermediary will be 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.

17. Retroactive processing of the claims for county inmates in FY 2017-18 are estimated to be $296,450,000 TF.

18. Total estimated costs for Medi-Cal inpatient hospital and psychiatric services for County adult and juvenile inmates in FY 2016-17and FY 2017-18 are:

(Dollars in Thousands)	FY 2016-17			FY 2017-18		
County Adult	**TF**	**GF**	**FF**	**TF**	**GF**	**FF**
County - Non ACA	$1,073	$537	$537	$4,293	$2,147	$2,147
County - ACA	$9,660	$483	$9,177	$38,638	$2,028	$36,610
Compassionate Release	$1,822	$911	$911	$7,286	$3,643	$3,643
Total Retroactive Payments*	$0	$0	$0	$170,366	$0	$129,288
Retro ACA	$0	$0	$0	$88,210	$0	$88,210
Retro Non-ACA	$0	$0	$0	$82,156	$0	$41,078
County Adult Total	$12,555	$1,931	**$10,625**	$220,583	**$7,818**	**$171,688**
County Juveniles	**TF**	**GF**	**FF**	**TF**	**GF**	**FF**
County Juveniles	$14,830	$7,415	$7,415	$59,320	$29,660	$29,660
Retroactive Payments*	$0	$0	$0	$126,084	$0	$63,042
County Juvenile Total	$14,830	**$7,415**	**$7,415**	$185,404	**$29,660**	**$92,702**
Grand Total	$27,385	**$9,346**	**$18,040**	$405,987	**$37,478**	**$264,390**

*Total Funds include County Funds not shown above.

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)

STATE-ONLY BCCTP COVERAGE EXTENSION

REGULAR POLICY CHANGE NUMBER:	9
IMPLEMENTATION DATE:	1/2017
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	2005

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$551,000	$1,696,000
- STATE FUNDS	$551,000	$1,696,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	5.21 %	3.09 %
APPLIED TO BASE		
TOTAL FUNDS	$522,300	$1,643,600
STATE FUNDS	$522,290	$1,643,590
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 women 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 women 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 persons' 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: 9

Reason for Change:
The increase from the previous estimate for FY 2016-17 and FY 2017-18, resulted from an increase in the per member per month (PMPM) rates from $941 for both fiscal years to $957.38 for FY 2016-17 and $961.25 for FY 2017-18 based on an increased managed care PMPM. Additionally, beneficiaries increased by 1% with aid codes 0L and 0Y added this 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 2,377 beneficiaries in October 2016. Approximately half are in their first year of treatment (1,189) and half are in their second year of treatment.

6. The weighted average per member per month rate is $957.38 for FY 2016-17 and $961.25 for FY 2017-18.

7. Anticipated recurrences for year 1 are estimated as follows:
   - Breast Cancer Recurrences
     (1,189 x 95%) x 8.1% = 91.49
   - Cervical Cancer Recurrences
     (1,189 x 5%) x 8% = 4.76
   - Combined anticipated recurrences = 96.25 (round to 96)
   - FY 2016-17 has six months of implementation, for a recurrence rate of 48

8. Anticipated recurrences for year 2 are estimated as follows:
   - Breast Cancer Recurrences (6 months coverage)
     (1,189 x 95%) x 8.1% x 50% = 45.75
   - Cervical Cancer Recurrences (12 months coverage)
     (1,189 x 5%) x 8% = 4.76
   - Combined anticipated recurrences = 50.5 (round to 51)

9. AB 1795 provides a new coverage period only and does not affect the previously estimated 18 or 24

STATE-ONLY BCCTP COVERAGE EXTENSION

REGULAR POLICY CHANGE NUMBER: 9

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	1,189	48	96	-
2017	1,189	1,189	51	96
2018	-	1,189	1,189	51
2019	-	-	1,189	1,189
2020	-	-	-	1,189
Additional	-	48	147	147
Total	**2,378**	**2,474**	**2,672**	**2,672**

10. Using the PMPM and yearly members, additional costs are estimated to be:
    Year 2: (48 x 12 months) x $957.38 = $551,451 GF
    Year 3: (147 x 12 months) x $961.25 = $1,695,645 GF
    Year 4: (147 x 12 months) x $961.25 = $1,695,645 GF

The annual ongoing cost to for AB 1795: $1,696,645 GF.

FY 2016-17:$551,000 GF (rounded)
FY 2017-18: $1,696,000 GF (rounded)

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

NON-OTLICP CHIP

REGULAR POLICY CHANGE NUMBER:	10
IMPLEMENTATION DATE:	12/1998
ANALYST:	Jason Moody
FISCAL REFERENCE NUMBER:	13

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$53,229,010	-$479,752,490
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$53,229,010	-$479,752,490
FEDERAL FUNDS	-$53,229,010	$479,752,490

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: 10

- 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 2016-17 and FY 2017-18 is a decrease in GF savings due to prior year CS3-Proxy adjustments. The GF savings decrease is slightly offset in both FYs by an increase in Medicaid Expansion expenditures, based on the addition of fee for service data through January 2017 and managed care data through September 2016, which results in additional adjustments to enhanced FFP. The change from FY 2016-17 to FY 2017-18 in the current estimate is an increase in GF savings mostly due to the CS3-Proxy adjustment, but slightly offset by a decrease in estimated expenditures for 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 $471,388,000 TF in FY 2016-17 and $465,028,000 TF in FY 2017-18.

(Dollars in Thousands)

FY 2016-17	TF	GF
Resource Disregard	$32,015	($12,166)
HPE	$4,763	($1,810)
Medicaid Expansion	$434,610	($165,152)
Total Cost	**$471,388**	**($179,127)**

FY 2017-18	TF	GF
Resource Disregard	$30,067	($11,425)
HPE	$4,595	($1,746)
Medicaid Expansion	$430,366	($163,539)
Total Cost	**$465,028**	**($176,710)**

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 has starting 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 2016-17 and FY 2017-18 (Ongoing Adjustment).

NON-OTLICP CHIP

REGULAR POLICY CHANGE NUMBER: 10

4. The 2014 and the January – March 2015 adjustments overdrew CHIP funding by $454 million. In FY 2016-17, the Department will repay the CHIP Title 21 federal funds and corresponding General Fund (Fund 4260-113-0001) using General Fund (4260-101-0001).

5. The Department anticipates to draw the appropriate Title 19 federal funds in FY 2017-18.

(Dollars in Thousands)

FY 2016-17	GF (101)	FF (T19)	GF (113)	FF (T21)
Ongoing Adjustment				
FFS	($67,798)	($67,798)	$47,459	$88,138
Dental	($32,986)	($32,986)	$23,090	$42,881
SMHS	$45,522	($45,522)	($60,651)	$60,651
Managed Care	($200,753)	($200,753)	$140,527	$260,978
Subtotal	($256,015)	($347,058)	$150,425	$452,648
Repayment	$454,476	$0	($116,530)	($337,946)
Total	**$198,461**	**($347,058)**	**$33,895**	**$114,702**

FY 2017-18	GF (101)	FF (T19)	GF (113)	FF (T21)
Ongoing Adjustment				
FFS	($18,847)	($18,847)	$13,193	$24,501
Dental	($8,695)	($8,695)	$6,086	$11,303
SMHS	$18,230	($18,230)	($23,699)	$23,699
Managed Care	($97,838)	($97,838)	$68,486	$127,189
Subtotal	($107,150)	($143,609)	$64,067	$186,692
Repayment	($259,959)	$259,959	$0	$0
Total	**($367,108)**	**$116,349**	**$64,067**	**$186,692**

Funding:

(Dollars in Thousands)

FY 2016-17		TF	GF	FF
50 % Title XIX /50 % GF	4260-101-0001/0890	($1,074,461)	($537,230)	($537,230)
Title XIX FF	4260-101-0890	($45,522)	$0	($45,522)
Title XIX GF	4260-101-0001	$499,998	$499,998	$0
65% Title XXI / 35% GF	4260-113-0001/0890	$148,597	$52,009	$96,588
Title XXI FF	4260-113-0890	$18,114	$0	$18,114
Title XXI GF	4260-113-0001	($18,114)	($18,114)	$0
88 % Title XXI /12 % GF	4260-113-0001/0890	$471,388	$56,567	$414,821
Net Impact (rounded)		**$0**	**$53,229**	**($53,229)**

NON-OTLICP CHIP

REGULAR POLICY CHANGE NUMBER: 10

FY 2017-18		TF	GF	FF
50 % Title XIX /50 % GF	4260-101-0001/0890	($261,311)	($130,655)	($130,655)
Title XIX FF	4260-101-0890	$14,491	$0	$14,491
Title XIX GF	4260-101-0001	($468,967)	($468,967)	$0
65% Title XXI / 35% GF	4260-113-0001/0890	$250,759	$87,766	$162,993
Title XXI FF	4260-113-0890	($23,699)	($23,699)	$0
Title XXI GF	4260-113-0001	$23,699	$0	$23,699
88 % Title XXI /12 % GF	4260-113-0001/0890	$465,028	$55,803	$409,225
Net Impact (rounded)		**$0**	**($479,752)**	**$479,752**

*Difference in totals is due to rounding

NON-EMERGENCY FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER:	11
IMPLEMENTATION DATE:	12/1997
ANALYST:	Jason Moody
FISCAL REFERENCE NUMBER:	15

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$985,633,000	$899,150,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$985,633,000	$899,150,000
FEDERAL FUNDS	-$985,633,000	-$899,150,000

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 New Qualified Immigrants (NQI), 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 since their date of entry. 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: 11

Reason for Change:
The increase from the prior estimate, for FY 2016-17 and FY 2017-18, is due to the addition of FFS and managed care expenditure data from July 2016 through December 2016 that includes costs for SB 75 undocumented children (previously identified in PC 2 Undocumented Children Full Scope Expansion), which began transitioning to full-scope Medi-Cal in May 2016. There was also a technical adjustment to include enhanced funding categories, which had previously not been included. The increase is slightly offset by the exclusion of the Children's Health Insurance Program Reauthorization Act (CHIPRA) population in updated FFS expenditure reports.

The decrease from FY 2016-17 to FY 2017-18 in the current estimate, is due to updated estimated expenditure projections. This is mostly driven by a reduction in estimated costs for the managed care ACA population.

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. Based on updated July through December 2016 FFS expenditure reports of non-emergency services provided to this population, the Department estimates non-emergency FFS costs will be $299,647,000 TF in FY 2016-17 and $291,447,000 TF in FY 2017-18.

2. Based on July 2016 through December 2016 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 $583,241,000 TF in FY 2016-17 and $537,735,000 TF in FY 2017-18. The repayment for this group will be 100% FFP for FY 2016-17 until January, 2017 when FFP changes to 95%. For FY 2017-18, the repayment for this group will be 94% from January 2018 to December 2018.

3. Based on January 2016 through December 2016 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 $515,092,000 TF in FY 2016-17 and $473,336,000 in FY 2017-18. 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 March 2, 2017, 61,917 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 182,531.

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.

NON-EMERGENCY FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 11

7. Of the nonfederal share for this policy change in FY 2017-18, $77 million in new growth as compared to the 2016 Budget Act will be funded with Proposition 56 revenue.

8. The estimated FFP Repayment in FY 2016-17 and FY 2017-18:

(Dollars in Thousands)

	FY 2016-17		FY 2017-18	
FFS and MC costs	**TF**	**FF Repayment**	**TF**	**FF Repayment**
All Others (50% FF / 50% GF)	785,593	$392,796	$738,202	$369,101
All Others (65% FF / 35% GF)	$8,035	$5,223	$7,683	$4,994
All Others (88% FF / 12% GF)	$17,155	$15,097	$14,801	$13,025
ACA	$587,197	$572,517	$541,831	$512,030
Total	$1,397,980	**$985,633**	$1,302,517	**$899,150**

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)
Healthcare Treatment Fund (4260-101-3305)

SCHIP FUNDING FOR PRENATAL CARE

REGULAR POLICY CHANGE NUMBER:	12
IMPLEMENTATION DATE:	7/2005
ANALYST:	Jason Moody
FISCAL REFERENCE NUMBER:	1007

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$63,757,760	-$68,261,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$63,757,760	-$68,261,600
FEDERAL FUNDS	$63,757,760	$68,261,600

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 decrease from the prior estimate for FY 2016-17 is due to updated expenditure reports reflecting lower prenatal costs for undocumented women. The increase from the prior estimate for FY 2017-18 is due to an increase in estimated prenatal costs for both, undocumented women and legal immigrant women. The increase from FY 2016-17 to FY 2017-18 in the current estimate is due to an increase in estimated prenatal costs for undocumented women.

Methodology:
1. The cost of prenatal care for undocumented women is estimated to be $59,831,000 TF in FY 2016-17 and $65,395,000 TF in FY 2017-18.

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: 12

(Dollars in Thousands)

FY 2016-17:	$59,831 TF x .88 =	**$52,651 FFP**
FY 2017-18:	$65,395 TF x .88 =	**$57,548 FFP**

3. The cost of prenatal care for legal immigrant women is estimated to be $12,621,000 TF in FY 2016-17 and $12,175,000 in FY 2017-18.

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 2016-17:	$12,621 x .88 =	**$11,106 FFP**
FY 2017-18:	$12,175 x .88 =	**$10,714 FFP**

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

(Dollars in Thousands)

FY		GF Savings
FY 2016-17:	$52,561 + $11,106 =	**$63,757**
FY 2017-18:	$57,548 + $10,714 =	**$68,262**

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:	13
IMPLEMENTATION DATE:	12/2016
ANALYST:	Jason Moody
FISCAL REFERENCE NUMBER:	1371

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	**$5,313,000**	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	**$5,313,000**	$0
FEDERAL FUNDS	**-$5,313,000**	$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 immigrants who have not yet met the federal 5-year bar, and other specified lawfully present children and pregnant women who are eligible for full scope Medi-Cal with federal financial participation.

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 federal financial participation (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:
This PC now only includes the cost of the remaining retroactive adjustments from July 2011 to March 2016. 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.

CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN

REGULAR POLICY CHANGE NUMBER: 13

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 19 and 20 year olds and pregnant women.

2. Assume that the retroactive claims from July 2011 through March 2016 will be paid in FY 2016-17.

3. An OIG audit found additional claims that did not meet the CHIPRA requirements. System corrections were implemented in June 2016 and are reflected in the costs below.

FY 2016-17	GF	FF
Total	$5,313,000	($5,313,000)

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:	14
IMPLEMENTATION DATE:	8/2011
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1632

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	-$11,933,000	-$15,838,000
- STATE FUNDS	-$5,966,500	-$7,919,000
PAYMENT LAG	0.9654	0.9711
% REFLECTED IN BASE	77.64 %	75.34 %
APPLIED TO BASE		
TOTAL FUNDS	-$2,575,900	-$3,792,800
STATE FUNDS	-$1,287,950	-$1,896,390
FEDERAL FUNDS	-$1,287,950	-$1,896,390

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 2016-17.

PARIS-VETERANS

REGULAR POLICY CHANGE NUMBER: 14

Reason for Change:
The reason for change from prior estimate, for FY 2016-17 and FY 2017-18, is an increase in savings due to updated managed care (MC) rates and fee-for-service (FFS) per member per month (PMPM) costs, as well as updated discontinued eligibles. Discontinuances were increased from 311 to 328 in FY 2016-17 and FY 2017-18. The estimated average PMPM savings increased from $187.69 to $248.03 in FY 2016-17 and FY 2017-18. The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to updated payment lag, percent in base, and dollars in base data for FY 2017-18.

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 328 veterans in FY 2016-17 and FY 2017-18, of which 220 will be MC and 108 will be FFS. 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 $248.03 in FY 2016-17 and FY 2017-18. These savings are not captured in the base trends.

5. In FY 2016-17, it is estimated that 77.64% of the MC and FFS savings is captured in the base trends. In FY 2017-18, it is estimated that 75.34% of the MC and FFS savings is captured in the base trends.

(Dollars in Thousands)

FY 2016-17	Total Savings	% in Base	Savings in Base
Managed Care Savings	($3,268)	77.64%	($2,537)
FFS Savings	($8,665)	77.64%	($6,728)
Total	**($11,933)**		**($9,265)**
FY 2017-18	**Total Savings**	**% in Base**	**Savings in Base**
Managed Care Savings	($4,338)	75.34%	($3,268)
FFS Savings	($11,500)	75.34%	($8,665)
Total	**($15,838)**		**($11,933)**

PARIS-VETERANS

REGULAR POLICY CHANGE NUMBER: 14

6. Total estimated savings not in the base trends:

FY 2016-17	Savings Not In Base	Weighted Payment Lag	TF	GF
Managed Care Savings	($731,000)	0.9654	($706,000)	($353,000)
FFS Savings	($1,937,000)	0.9654	($1,870,000)	($935,000)
Total	**($2,668,000)**		**($2,576,000)**	**($1,288,000)**
FY 2017-18	**Savings Not In Base**	**Weighted Payment Lag**	**TF**	**GF**
Managed Care Savings	($1,070,000)	0.9711	($1,040,000)	($520,000)
FFS Savings	($2,835,000)	0.9711	($2,753,000)	($1,376,000)
Total	**($3,905,000)**		**($3,793,000)**	**($1,896,000)**

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

MINIMUM WAGE INCREASE - CASELOAD SAVINGS

REGULAR POLICY CHANGE NUMBER:	15
IMPLEMENTATION DATE:	4/2017
ANALYST:	Jason Moody
FISCAL REFERENCE NUMBER:	1979

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	-$7,714,000	-$144,192,000
- STATE FUNDS	-$1,508,000	-$29,866,020
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$7,714,000	-$144,192,000
STATE FUNDS	-$1,508,000	-$29,866,020
FEDERAL FUNDS	-$6,206,000	-$114,325,980

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 from the prior estimate, for FY 2016-17 and FY 2017-18, is due to updated caseload and payment lag data. The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to an increase in incremental savings as a result of the minimum wage increase to $11 per hour, caseload growth, increase in per-member month costs, as well as the FY 2016-17 savings only impacting a 6 month period.

Methodology:
1. The implementation date for the increase to $10.50 is January 1, 2017.

2. Assume savings will not materialize in the first quarter of 2017 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 100% FFP for FY 2016-17 until January 2017 when FFP changes to 95%. Effective January 2018, FFP changes to 94%.

6. Assume the FFS population is 27% 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 2016-17	TF	GF	FF
Title XIX 50% GF / 50% FF	($2,494,000)	($1,247,000)	($1,247,000)
Title XIX ACA 95% FF / 5% GF	($5,220,000)	($261,000)	($4,959,000)
Total Savings	**($7,714,000)**	**($1,508,000)**	**($6,206,000)**

FY 2017-18	TF	GF	FF
Title XIX 50% GF / 50% FF	($49,390,000)	($24,695,000)	($24,695,000)
Title XIX ACA 95% FF / 5% GF	($51,710,000)	($2,585,000)	($49,125,000)
Title XIX ACA 94% FF / 6% GF	($43,092,000)	($2,586,000)	($40,506,000)
Total Savings	**($144,192,000)**	**($29,866,000)**	**($114,326,000)**

*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)

OTLICP PREMIUMS

REGULAR POLICY CHANGE NUMBER:	16
IMPLEMENTATION DATE:	7/2014
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1879

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	-$67,447,000	-$66,749,000
- STATE FUNDS	-$8,093,640	-$8,009,880
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$67,447,000	-$66,749,000
STATE FUNDS	-$8,093,640	-$8,009,880
FEDERAL FUNDS	-$59,353,360	-$58,739,120

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 decrease from the prior estimate, is due to a decrease in estimated average monthly eligibles for both FY 2016-17 and FY 2017-18. The decrease from FY 2016-17 to FY 2017-18, in the current estimate, is due to a decrease in average monthly eligibles.

Methodology:
1. The Department estimates in FY 2016-17 there will be 940,454 average monthly OTLICP eligibles and 930,898 in FY 2017-18. Based on FY 2015-16 data, 60.87% of the OTLICP population has family incomes over 160% of the FPL.

2. In FY 2016-17, the Department estimates there are 6,869,452 member months subject to monthly premiums and 6,799,663 in FY 2017-18.
   FY 2016-17: 940,454 x 12 months x 60.87% **= 6,869,452** member months
   FY 2017-18: 930,898 x 12 months x 60.87% **= 6,799,663** member months

OTLICP PREMIUMS

REGULAR POLICY CHANGE NUMBER: 16

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 2016-17	FY 2017-18
Total Exempt Member Months	101,233	101,233

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 2016-17	FY 2017-18
Discount Program	893,029	883,956
Delinquent Premiums	686,946	679,966
Total Loss of Premium Member Months	**1,579,975**	**1,563,922**

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

Member Months	FY 2016-17	FY 2017-18
Eligible Member Months	6,869,456	6,799,663
Exempt Member Months	(101,233)	(101,233)
Loss Member Months	(1,579,975)	(1,563,922)
Net Member Months	**5,188,248**	**5,134,507**

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 2016-17	**$ 67,447**	**$ 8,094**	**$ 59,353**
FY 2017-18	**$ 66,749**	**$ 8,010**	**$ 58,739**

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

COMMUNITY FIRST CHOICE OPTION

REGULAR POLICY CHANGE NUMBER:	17
IMPLEMENTATION DATE:	12/2012
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1595

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$2,045,900,000	$2,535,500,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,045,900,000	$2,535,500,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$2,045,900,000	$2,535,500,000

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:	19
IMPLEMENTATION DATE:	4/2015
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1831

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$220,166,000	$502,274,000
- STATE FUNDS	$74,748,810	$169,642,060
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$220,166,000	$502,274,000
STATE FUNDS	$74,748,810	$169,642,060
FEDERAL FUNDS	$145,417,190	$332,631,940

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: 19

Reason for Change:
The change from the prior estimate, for FY 2016-17, nets a decrease due to:

- CY 2015 actuals being lower than previously estimated, and
- A portion of CY 2015 payments shifting from FY 2016-17 to FY 2017-18.

The change from the prior estimate, for FY 2017-18, nets an increase due to:

- A portion of CY 2015 payments shifting from FY 2016-17 to FY 2017-18,
- Basing CY 2017 payments on CY 2015 payments plus a 5 percent growth factor, and
- Accounting for Hospital Quality Assurance Fee, AB 85/SB 208, Coordinated Care Initiative, and Intergovernmental Transfers in the CY 2015 payment scheduled for FY 2017-18.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to:

- A portion of CY 2015 payments shifting from FY 2016-17 to FY 2017-18,
- CY 2017 and CY 2018 (January-June 2018) are expected to be made in FY 2017-18, and
- An estimated 5% growth factor from CY 2015 to determine CY 2017. No growth factor applied to CY 2017 to determine the CY 2018 HIPF payment.

Methodology:

1. This fee will apply to Medi-Cal premiums for existing Medi-Cal beneficiaries and the ACA expansion population.

2. Effective January 1, 2014, fees were assessed to the plans by the federal government and are ongoing. The payments for fees assessed on CY 2014 actual revenues were made in FY 2015-16. However, due to processing delays and retro payments, $22,395,000 of the HIPF payments were made in December 2016.

3. CY 2015 fee payments will be made in FY 2016-17 and FY 2017-18. Estimated payments for CY 2016 have been suspended due to federal budget legislation. Due to ongoing efforts to move to a prospective rate setting, CY 2017 and CY 2018 (January-June 2018) estimated payments are expected to be made in FY 2017-18.

4. Assume the following amounts:

(Dollars in Thousands)

	FY 2016-17	FY 2017-18
CY 2014 Payments	$22,395	$0
CY 2015 Payments	$197,771	$70,590
CY 2017 Payments	$0	$287,789
CY 2018 Payments	$0	$143,895
Total	**$220,166**	**$502,274**

5. 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: 19

Funding:
(Dollars in Thousands)

FY 2016-17	TF	GF	FF
50% Title XIX FF/ 50% GF (4260-101-0001/0890)	$139,569	$69,784	$69,785
100% Title XIX ACA (4260-101-0890)	$63,625	$0	$63,625
88% Title XXI FF/ 12% GF (4260-101-0001/0890)	$4,243	$509	$3,734
65% Title XXI FF / 35% GF (4260-113-0001/0890)	$12,729	$4,455	$8,274
Total	**$220,166**	**$74,749**	**$145,417**

FY 2017-18	TF	GF	FF
50% Title XIX FF/ 50% GF (4260-101-0001/0890)	$316,665	$158,333	$158,333
94% Title XIX ACA / 6% GF (4260-101-0890)	$42,352	$2,541	$39,811
95% Title XIX ACA / 5% GF (4260-101-0890)	$84,704	$4,235	$80,469
100% Title XIX ACA (4260-101-0890)	$20,776	$0	$20,776
88% Title XXI FF/ 12% GF (4260-101-0001/0890)	$37,777	$4,533	$33,244
Total	**$502,274**	**$169,642**	**$332,632**

HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS

REGULAR POLICY CHANGE NUMBER:	20
IMPLEMENTATION DATE:	2/2016
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1967

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$101,925,000	$19,463,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$101,925,000	$19,463,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$101,925,000	$19,463,000

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 2016-17, is due to updated actual retroactive payment amounts. The decrease from the prior estimate for FY 2017-18, is due to updated estimated payment amounts, based on updated actual payments made in FY 2016-17. The decrease from FY 2016-17 to FY 2017-18, in the current estimate, is due to the completion of retro payments through FY 2015-16 in FY 2016-17. Additionally, FY 2017-18 has one quarter of payments for the Calendar Year 2017 ACA

HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS

REGULAR POLICY CHANGE NUMBER: 20

FFP of 95%.

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 $4,910,000 for FY 2016-17 and $4,983,000 for FY 2017-18.
3. The Department will also claim the enhanced Title XIX ACA FMAP for beneficiaries receiving services in DPHs and estimates to pay DPHs $101,925,000 in FY 2016-17 and $19,463,000 in FY 2017-18. The estimated pass-through costs are included in the chart below.

(Dollars in Thousands)

FY 2016-17	TF	FF
FY 2013-14, Q 3-4	$ 13,238	$ 13,238
FY 2014-15, Q 1-4	$ 62,856	$ 62,856
FY 2015-16, Q 1-4	$ 21,331	$ 21,331
FY 2016-17, Q 1	$ 4,500	$ 4,500
Net Impact	**$ 101,925**	**$ 101,925**

FY 2017-18	TF	FF
FY 2016-17, Q 2-4	$ 14,729	$ 14,729
FY 2017-18, Q 1	$ 4,734	$ 4,734
Net Impact	**$ 19,463**	**$ 19,463**

Funding:

(Dollars in Thousands)

FY 2016-17	TF	FF
50% Title XIX FF / 50% GF (4260-101-0890/0001)	$ -	$ -
100% Title XIX ACA FF (4260-101-0001)	$ 101,925	$ 101,925
Net Impact	**$ 101,925**	**$ 101,925**

FY 2017-18	TF	FF
50% Title XIX FF / 50% GF (4260-101-0890/0001)	$ -	$ -
100% Title XIX ACA FF (4260-101-0001)	$ 14,729	$ 14,729
95% Title XIX ACA FF / 5% GF (4260-101-0890/0001)	$ 4,734	$ 4,734
Net Impact	**$ 19,463**	**$ 19,463**

PAYMENTS TO PRIMARY CARE PHYSICIANS

REGULAR POLICY CHANGE NUMBER:	22
IMPLEMENTATION DATE:	11/2013
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1659

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	**$8,000,000**	**$2,000,000**
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	34.60 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	**$5,232,000**	**$2,000,000**
STATE FUNDS	$0	$0
FEDERAL FUNDS	**$5,232,000**	**$2,000,000**

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. This policy change also budgets the costs associated with the implementation of the increased payment.

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: 22

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 2016-17 and FY 2017-18, is due to a delay in the completion of reconciliation payments from June 2017 to September 2017. A portion of the reconciliation payments has been shifted to FY 2017-18.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to the remaining reconciliation payments being completed by September 2017.

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 September 2017.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2016-17	$8,000	$0	**$8,000**
FY 2017-18	$2,000	$0	**$2,000**

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

1% FMAP INCREASE FOR PREVENTIVE SERVICES

REGULAR POLICY CHANGE NUMBER:	23
IMPLEMENTATION DATE:	1/2016
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1791

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	**$1,181,000**	-$2,026,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	**$1,181,000**	-$2,026,000
FEDERAL FUNDS	-$1,181,000	**$2,026,000**

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, prescription drugs (including over-the-counter), and for calendar years 2014 through 2016, the expansion newly eligible population. Starting in 2017, FMAP for the newly eligibles goes to 95% and will be claimable for the 1% increase. Also, the 1% FMAP increase is limited to services for children, and most target newborns prior to discharge from the hospital.

1% FMAP INCREASE FOR PREVENTIVE SERVICES

REGULAR POLICY CHANGE NUMBER: 23

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, or if the service for a newborn in a hospital can be pulled out of a bundled rate.

Reason for Change:
The change from the prior estimate, for FY 2016-17 and FY 2017-18, is due to the following for Fee-for-Service (FFS):

- Savings for the periods from FY 2012-13 through FY 2016-17, has been revised due to updated actual data and the revised savings are significantly lower than previously projected.
- Savings for the FY 2015-16 (Q3 – Q4) period, previously included in FY 2017-18, will now occur in FY 2016-17.
- Due to an error, the savings claimed for periods in FY 2012-13, FY 2014-15, and FY 2015-16 were greater than the actual savings available. The Department will repay the over claimed federal funds in FY 2016-17.

The change in the current estimate, from FY 2016-17 to FY 2017-18, is primarily due to the federal funds repayments in FY 2016-17.

Methodology:
1. The 1% FMAP savings is effective January 1, 2013.

2. FFS savings for period January 1, 2013 through March 30, 2013, and July 1, 2013 through June 30, 2016, will occur in FY 2016-17. For FY 2017-18, FFS savings will include period July 1, 2016 through June 30, 2017.

3. Managed care savings for period July 1, 2014 through June 30, 2016 will occur in FY 2016-17. For FY 2017-18, managed care savings will include period July 1, 2016 through June 30, 2018.

FY 2016-17	FFS	Managed Care	Total Savings
FY 2012-13 (Jan 13 - Mar 13)	($65,000)	$0	($65,000)
FY 2013-14 (Jul 13 – Jun 14)	($272,000)	$0	($272,000)
FY 2014-15 (Jul 14 – Jun 15)	($237,000)	($867,000)	($1,104,000)
FY 2015-16 (Jul 15 – Jun 16)	($251,000)	($867,000)	($1,118,000)
Total for FY 2016-17	($825,000)	($1,734,000)	($2,559,000)

FY 2017-18	FFS	Managed Care	Total Savings
FY 2016-17 (Jul 16 – Jun 17)	($292,000)	($867,000)	($1,159,000)
FY 2017-18 (Jul 17 to Jun 18)	$0	($867,000)	($867,000)
Total for FY 2017-18	($292,000)	($1,734,000)	($2,026,000)

1% FMAP INCREASE FOR PREVENTIVE SERVICES

REGULAR POLICY CHANGE NUMBER: 23

4. The Department will repay federal funds, from the General Fund (GF), to the Centers for Medicare and Medicaid Services (CMS), for federal fund overpayments in FY 2016-17. The table below shows the periods and amounts that will be repaid to CMS.

FY 2016-17	Actual 1% FMAP FFS Savings	Federal Funds Claimed	Federal Fund Repayments
FY 2012-13 (Apr 13 to Jun 13)	($65,000)	$3,805,000	$3,740,000
FY 2014-15 (Jan 15 to Jun 15)	($94,000)	$188,000	$94,000
FY 2015-16 (Jul 15 to Jun 16)	($251,000)	$502,000	$251,000
Totals	($410,000)	$4,495,000	$4,085,000

5. Total cost/(savings) for the 1% FMAP increase for preventive services are as follows:

FY 2016-17	TF	GF	FF
FFS:			
FY 2012-13 Savings	$0	($65,000)	$65,000
FY 2012-13 Repayments	$0	$3,740,000	($3,740,000)
FY 2013-14 Savings	$0	($272,000)	$272,000
FY 2014-15 Repayments	$0	$94,000	($94,000)
FY 2014-15 Savings	$0	($331,000)	$331,000
FY 2015-16 Savings	$0	($502,000)	$502,000
FY 2015-16 Repayments	$0	$251,000	($251,000)
Total FFS	$0	$2,915,000	($2,915,000)
Managed Care:			
FY 2014-15 Savings	$0	($867,000)	$867,000
FY 2015-16 Savings	$0	($867,000)	$867,000
Total Managed Care	$0	($1,734,000)	$1,734,000
Total FY 2016-17	**$0**	**$1,181,000**	**($1,181,000)**

1% FMAP INCREASE FOR PREVENTIVE SERVICES

REGULAR POLICY CHANGE NUMBER: 23

FY 2017-18	TF	GF	FF
FFS:			
FY 2016-17 Savings	$0	($292,000)	$292,000
Total FFS	$0	($292,000)	$292,000
Managed Care:			
FY 2016-17 Savings	$0	($867,000)	$867,000
FY 2017-18 Savings	$0	($867,000)	$867,000
Total Managed Care	$0	($1,734,000)	$1,734,000
Total FY 2017-18	**$0**	**($2,026,000)**	**$2,026,000**

Funding:
100% Title XIX (4260-101-0890)
100% GF (4260-101-0001)

STATE-ONLY FORMER FOSTER CARE PROGRAM

REGULAR POLICY CHANGE NUMBER:	24
IMPLEMENTATION DATE:	8/2016
ANALYST:	Jason Moody
FISCAL REFERENCE NUMBER:	1802

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$398,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$398,000	$0
FEDERAL FUNDS	-$398,000	$0

DESCRIPTION

Purpose:
This policy change estimates a technical adjustment in funding from Title XIX 50/50 Federal Medical Assistance Percentage to 100 percent State General Fund (GF) for expenditures related to extending Medi-Cal coverage to former foster youth who turned 21 years old between July 1, 2013 and December 31, 2013.

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

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2014, the Affordable Care Act (ACA) provided states the option to expand Medicaid coverage to previously ineligible persons, primarily childless adults at or below 138 percent of the federal poverty level. Additionally, the ACA required the expansion of Medicaid coverage for former foster care youth up to age 26, beginning January 1, 2014.

Effective July 1, 2013, the Department changed the existing policy for former foster youth currently receiving Medi-Cal benefits. Prior to July 1, 2013, once a former foster youth turned 21 years old they would lose their Medi-Cal coverage. Instead under the new policy, those who turned 21 years old between July 1, 2013 and December 31, 2013 retained their Medi-Cal benefits until age 26. These costs for the July to December 2013 period for this group are funded with 100 percent State GF. This group became eligible for federal financial participation (FFP) under the ACA on January 1, 2014.

Reason for Change:
There is no change from the prior estimate for FY 2016-17.
There is no change from the prior estimate for FY 2017-18.
The change from FY 2016-17 to FY 2017-18, in the current estimate, is a decrease due to the processing of the ineligible FFP repayment in FY 2016-17.

STATE-ONLY FORMER FOSTER CARE PROGRAM

REGULAR POLICY CHANGE NUMBER: 24

Methodology:

1. The Department extended Medi-Cal benefits to former foster youth who turned 21 years old between July 1, 2013 and December 31, 2013.

2. The Department estimated 549 former foster youth turned 21 years old between July 1, 2013 and December 31, 2013.

3. The total expenditures incurred for these eligible former foster youth are $398,000.

4. The repayment of the ineligible FFP to the Centers for Medicare and Medicaid Services was processed in August 2016.

FY	FY 2016-17
GF	$398,000
FFP	($398,000)

Funding:

100% State GF (4260-101-0001)
Title XIX FFP (4260-101-0890)

HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.

REGULAR POLICY CHANGE NUMBER:	25
IMPLEMENTATION DATE:	1/2014
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1821

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$39,616,200	-$36,365,640
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$39,616,200	-$36,365,640
FEDERAL FUNDS	$39,616,200	$36,365,640

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 from the prior estimate, for FY 2016-17 and FY 2017-18, resulted from updated actual claims. The decrease in General Fund savings from FY 2016-17 to FY 2017-18, in the current estimate, results from the enhanced ACA FMAP decreasing from 100% in 2016 to 95% in 2017, and to 94% in 2018.

HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.

REGULAR POLICY CHANGE NUMBER: 25

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 2015-16 Q3, the estimated average quarterly adjustment for FY 2016-17 and FY 2017-18 is $20,316,000.

4. The Department estimates to adjust $81,264,000 TF claims from Title XIX 50/50 FMAP to claim the enhanced Title XIX ACA FMAP in FY 2016-17 and $81,264,000 in FY 2017-18. The estimated funding adjustment is included in the chart below.

(Dollars in Thousands)

FY 2016-17	TF	GF	FF
50% Title XIX FF / 50% GF	$ (81,264)	$ (40,632)	$ (40,632)
100% Title XIX ACA FFP	$ 60,948	$ -	$ 60,948
95% Title XIX FF / 5% GF	$ 20,316	$ 1,016	$ 19,300
Net Impact	**$ -**	**$ (39,616)**	**$ 39,616**

FY 2017-18	TF	GF	FF
50% Title XIX FF / 50% GF	$ (81,264)	$ (40,632)	$ (40,632)
95% Title XIX FF / 5% GF	$ 60,948	$ 3,047	$ 57,901
94% Title XIX FF / 6% GF	$ 20,316	$ 1,219	$ 19,097
Net Impact	**$ -**	**$ (36,366)**	**$ 36,366**

Funding:

100% Title XIX FF (4260-101-0001)
95% Title XIX FF (4260-101-0001)
94% Title XIX FF (4260-101-0001)
50% Title XIX FF (4260-101-0890/0001)

ACA MAGI SAVINGS

REGULAR POLICY CHANGE NUMBER:	26
IMPLEMENTATION DATE:	1/2014
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1845

	FY 2016-17	FY 2017-18
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: 26

Reason for Change:
There is no change from the previous estimate. The change from FY 2016-17 to FY 2017-18 resulted from increased caseload projections.

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 2016-17	FY 2017-18
Individuals who forego applying for disability	($4,779,000)	($5,429,000)
Disabled not enrolled in Medicare but need LTSS	($3,837,000)	($4,258,000)
Medically Needy 19/20 no SOC not *Sneede v. Kizer*	($1,130,000)	($1,272,000)
Medically Needy parents with SOC	($19,803,000)	($22,468,000)
Pregnant women income 109-138% FPL	($2,089,000)	($1,635,000)
SB 87 pending disability individuals	($21,498,000)	($24,352,000)
TOTAL	**($53,136,000)**	**($59,414,000)**

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 2016-17	Fund Number	TF	GF
50% Title XIX FF / 50% GF	4260-101-0890/0001	($106,272)	($53,136)
100% Title XIX ACA FF	4260-101-0890	$53,136	$0
95% Title XIX ACA FF / 5% GF	4260-101-0890/0001	$53,136	$2,657
Net Impact		**$0**	**($50,479)**

FY 2017-18	Fund Number	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		**$0**	**($52,878)**

ACA DSH REDUCTION

REGULAR POLICY CHANGE NUMBER:	28
IMPLEMENTATION DATE:	10/2017
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1995

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	-$137,873,000
- STATE FUNDS	$0	-$64,703,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$137,873,000
STATE FUNDS	$0	-$64,703,000
FEDERAL FUNDS	$0	-$73,170,000

DESCRIPTION

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

Authority:
Affordable Care Act (ACA), 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.

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.

Reason for Change:
There is no change for FY 2016-17 and FY 2017-18 from the prior estimate. The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to the start date of the reductions expected to begin in October 2017.

ACA DSH REDUCTION

REGULAR POLICY CHANGE NUMBER: 28

Methodology:

1. California's DSH allotment for FY 2017-18 is estimated to be $1.239 billion.

2. CMS has not released the DSH reduction methodology for FY 2017-18. Therefore, the estimated DSH reduction is based on the FY 2013-14 DSH reduction methodology published as a final rule in the Federal Register on September 18, 2013 (78 FR 57293). California's FY 2013-14 preliminary reduction was $18.3 million of the $500 million national reduction amount, equating to 3.65% of the national reduction amount.

3. Assuming California's share of the $2 billion national reduction for FY 2017-18 is 3.65%, California's DSH allotment will be reduced by $73 million FF for NDPHs and DPHs in FY 2017-18. The DSH allotment reduction would offset DSH payments for NDPHs and DPHs in the DSH Payment (PC 149) and Global Payment Program (PC 81) policy changes.

4. The DSH allotment amount is applied in the DSH payment methodology to determine the reduction amount for the estimated 2017-18 aggregate DSH replacement funding. That amount is estimated to be $33.8 million TF. The Private DSH allotment reduction would offset Private DSH replacement payments in the Private Hospital DSH Replacement (PC 148) policy change.

5. The FY 2017-18 DSH allotment after the 3.65% reduction is estimated to be $1.17 billion.

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

FY 2017-18	TF	GF	FF	IGT
Private DSH (PC 148)	($33,839,000)	($16,919,000)	($16,920,000)	$0
DSH NDPH (PC 149)	($1,456,000)	($728,000)	($728,000)	$0
DSH UC (PC 149)	($24,225,000)	$0	($16,730,000)	($7,495,000)
GPP (PC 81)	($111,083,000)	$0	($55,542,000)	($55,541,000)
Total Reduction FY 2017-18	($170,603,000)	($17,647,000)	($89,920,000)	($63,036,000)

7. Assume 11/12 of the FY 2017-18 DSH payment reduction is expected to occur in FY 2017-18 for Private Hospital DSH Replacement, DSH NDPH, and DSH UC.

8. Assume 3/4 of the FY 2017-18 DSH payment reduction is expected to occur in FY 2017-18 for GPP.

9. The prorated FY 2017-18 DSH allotment reduction on a cash basis is estimated to be $57.7 million FF for NDPHs, UC hospitals, and GPP, and $15.5 million FF for private hospitals.

ACA DSH REDUCTION

REGULAR POLICY CHANGE NUMBER: 28

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

FY 2017-18	TF	GF***	FF	IGT
Private DSH (PC 148)	($31,019,000)	($15,509,000)	($15,510,000)	$0
DSH NDPH (PC 149)	($1,335,000)	($668,000)	($667,000)	$0
DSH UC (PC 149)*	($22,207,000)	$0	($15,337,000)	($6,870,000)
GPP (PC 81)**	($83,312,000)	$0	($41,656,000)	($41,656,000)
Total Reduction FY 2017-18	**($137,873,000)**	**($16,177,000)**	**($73,170,000)**	**($48,526,000)**

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:	29
IMPLEMENTATION DATE:	10/2016
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1855

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$235,807,000	$213,817,000
- STATE FUNDS	$104,586,100	$93,398,740
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$235,807,000	$213,817,000
STATE FUNDS	$104,586,100	$93,398,740
FEDERAL FUNDS	$131,220,900	$120,418,260

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

Interdependent Policy Changes:
Not Applicable

Background:
SB 870 added Welfare and Institutions (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. The Department is required to implement BHT under the federal interpretation for EPSDT services for children under age 21.

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 of SPA 14-026 on January 21, 2016, to include BHT as a covered Medi-Cal benefit.

Based on actual paid claims data through February 2017, utilization is expected to grow to 11,000 in FY 2016-17 and 12,500 in FY 2017-18.

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

BEHAVIORAL HEALTH TREATMENT

REGULAR POLICY CHANGE NUMBER: 29

met certain eligibility criteria. These services were provided through a system of Regional Centers (RC) contracted with the Department of Developmental Services (DDS).

The Department, in collaboration with DDS, began transitioning responsibility for BHT services starting February 1, 2016. Costs for RC clients are budgeted in the Behavioral Health Treatment – DDS Transition policy change.

Reason for Change:
The change from the prior estimate, for FY 2016-17 and FY 2017-18, is due to updated actual claims data. The number of supplemental capitation payments per beneficiary is lower than previously projected. Annual projected caseload for FY 2016-17 and FY 2017-18 has also decreased based on actual claims data.

The change in the current estimate, from FY 2016-17 to FY 2017-18, is due to FY 2016-17 costs including supplemental capitation payments for FY 2014-15 and FY 2015-16.

Methodology:
1. Coverage for BHT began on September 15, 2014.

2. Managed care payments began in October 2016 for BHT services based on a supplemental capitation payment methodology, retroactive to the implementation date.

3. Assume 1,850 members received BHT services in FY 2014-15 starting September 2014; not all members received BHT services each month. The estimated number of supplemental capitation payments for FY 2014-15 is 7,790.

   FY 2014-15: 7,790 x $1,640.24 = $12,777,000 TF

4. Assume 7,000 members received BHT services in FY 2015-16; not all members received BHT services each month. The estimated number of supplemental capitation payments for FY 2015-16 is 55,675.

   FY 2015-16: 55,675 x $2,054.60 = $114,390,000 TF

5. Assume 11,000 members will receive BHT services in FY 2016-17; not all members will receive BHT services each month. The estimated number of supplemental capitation payments for FY 2016-17 is 67,287.

   FY 2016-17: 67,287 x $2,152.77 = $144,853,000 TF

6. Assume 12,500 members will receive BHT services in FY 2017-18; not all members will receive BHT services each month. The estimated numbers of supplemental capitation payments for FY 2017-18 is 100,000.

   FY 2017-18: 100,000 x $2,368.05 = $236,805,000 TF

7. Assume FY 2014-15 and FY 2015-16 payments will be made in FY 2016-17.

8. Due to the supplemental capitation payment methodology, assume 25% of payments for FY 2016-17 and FY 2017-18 will be paid the following fiscal year.

BEHAVIORAL HEALTH TREATMENT

REGULAR POLICY CHANGE NUMBER: 29

(Dollars in Thousands)

Rate Year	Accrual	FY 2016-17	FY 2017-18
FY 2014-15	$12,777	$12,777	$0
FY 2015-16	$114,390	$114,390	$0
FY 2016-17	$144,853	$108,640	$36,213
FY 2017-18	$236,805	$0	$177,604
Total		**$235,807**	**$213,817**

(Dollars in Thousands)

FY 2016-17	TF	GF	Title XIX	Title XXI
Rate Year 2014-15	$12,777	$6,069	$5,327	$1,381
Rate Year 2015-16	$114,390	$51,061	$47,685	$15,644
Rate Year 2016-17	$108,640	$47,456	$45,288	$15,896
Total	**$235,807**	**$104,586**	**$98,300**	**$32,921**

(Dollars in Thousands)

FY 2017-18	TF	GF	Title XIX	Title XXI
Rate Year 2016-17	$36,213	$15,819	$15,096	$5,298
Rate Year 2017-18	$177,604	$77,580	$74,037	$25,987
Total	**$213,817**	**$93,399**	**$89,133**	**$31,285**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
65% Title XXI / 35% GF (4260-113-0001/0890)
88% Title XXI / 12% GF (4260-113-0001/0890)

ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS

REGULAR POLICY CHANGE NUMBER:	30
IMPLEMENTATION DATE:	5/2013
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1476

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$379,487,000	$245,649,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$379,487,000	$245,649,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$379,487,000	$245,649,000

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: 30

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.

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, 2009 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 for FY 2016-17 and FY 2017-18.

Reason for Change:
The change from the prior estimate, for FY 2016-17 and FY 2017-18, has been revised to reflect updated data. The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to FY 2016-17 including a higher number of prior year expenditures, including the ARRA FMAP increase.

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

(Dollars in Thousands)

	TF	CDDS GF	FF	ARRA
FY 2016-17	$754,698	$375,211	**$377,349**	**$2,138**
FY 2017-18	$491,299	$245,650	**$245,649**	**$0**

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

BEHAVIORAL HEALTH TREATMENT - DDS TRANSITION

REGULAR POLICY CHANGE NUMBER:	31
IMPLEMENTATION DATE:	10/2016
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1973

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$86,168,000	$101,325,000
- STATE FUNDS	$37,639,740	$44,260,260
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$86,168,000	$101,325,000
STATE FUNDS	$37,639,740	$44,260,260
FEDERAL FUNDS	$48,528,260	$57,064,740

DESCRIPTION

Purpose:
This policy change estimates the costs for Medi-Cal beneficiaries that transitioned from Department of Developmental Services (DDS) Regional Centers (RCs) to Medi-Cal for Behavioral Health Treatment (BHT) services.

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.
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.

BEHAVIORAL HEALTH TREATMENT - DDS TRANSITION

REGULAR POLICY CHANGE NUMBER: 31

Furthermore, Medi-Cal beneficiaries under 21 years of age that receive non-BHT services from the RCs will continue to receive their non-BHT services from the RCs under the waiver.

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. The Department will 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 2016-17 and FY 2017-18, is due to the following:

Fee-for-Service
- The FY 2015-16 and FY 2016-17 costs for BHT services have been removed from this estimate.
- Updated actual claims data for FFS beneficiaries are significantly lower than previously projected; therefore, the annual cost for FY 2017-18 has decreased.

Managed Care
- Annual projected caseload for FY 2016-17 and FY 2017-18 has decreased based on actual claims data.
- The number of supplemental capitation payments per beneficiary is lower than previously projected.

The change in the current estimate, from FY 2016-17 to FY 2017-18, is due to FY 2017-18 including more supplemental capitation payments with a higher capitation rate.

Methodology:
Fee-for-Service
1. A total of 1,683 FFS beneficiaries transitioned on February 1, 2016.

2. The IA contract between the Department and DDS is currently in process and is projected to be executed in August 2017. DDS will submit claims on a monthly basis and payments are expected to begin in September 2017.

3. The estimate includes the rate increases to RC providers authorized by ABX2 1 (Chapter 3, Statutes of 2016), effective July 1, 2016.

4. The FFS cost reimbursement estimates were provided by DDS.
    - Costs for FY 2015-16 and FY 2016-17 will not be claimed by DDS.
    - On an accrual basis, FY 2017-18 FFS costs are $7.431 million TF.

BEHAVIORAL HEALTH TREATMENT - DDS TRANSITION

REGULAR POLICY CHANGE NUMBER: 31

5. On a cash basis, FFS reimbursements are estimated to be paid as follows:
    - Payments for FY 2017-18 (July 2017 through December 2017) totaling $3.716 million TF are estimated to be paid starting October 2017.
    - Payments for FY 2017-18 (January 2018 through June 2018) are estimated to be paid in a subsequent fiscal year.

Managed Care

6. Managed care payments for BHT began in October 2016 based on a supplemental capitation payment methodology.

7. A total of 12,372 managed care beneficiaries transitioned to Medi-Cal starting February 2016 through September 2016; 7,174 beneficiaries transitioned in FY 2015-16 (February through June), and the remaining 5,198 beneficiaries transitioned in FY 2016-17 (July through September).

8. The estimated monthly capitation rate for BHT supplemental payments are:

    FY 2015-16 - $2,054.60
    FY 2016-17 - $2,152.77
    FY 2017-18 - $2,368.05

9. Assume 5,000 members received BHT services starting February 1, 2016; not all members received BHT services each month. The estimated number of supplemental capitation payments for FY 2015-16 is 13,899.

    FY 2015-16: 13,899 x $2,054.60 = $28,557,000 TF

10. Assume 10,000 members will receive 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 35,682.

    FY 2016-17: 35,682 x $2,152.77 = $76,815,000 TF

11. Assume 12,372 members will receive BHT services in FY 2017-18; not all members received BHT services each month. The estimated number of supplemental capitation payments for FY 2017-18 is 44,146.

    FY 2017-18: 44,146 x $2,368.05 = $104,540,000 TF

12. Assume all managed care payments for FY 2015-16 will be made in FY 2016-17.

13. Due to the supplemental capitation payment methodology, assume 25% of managed care payments for FY 2016-17 and FY 2017-18 will be paid in the following fiscal year.

BEHAVIORAL HEALTH TREATMENT - DDS TRANSITION

REGULAR POLICY CHANGE NUMBER: 31

14. Total estimated payments are:

(Dollars in Thousands)

Fiscal Year	Accrual	FY 2016-17	FY 2017-18
FY 2015-16 – MC	$28,557	$28,557	$0
FY 2016-17 – MC	$76,815	$57,611	$19,204
FY 2017-18 - FFS	$7,431	$0	$3,716
FY 2017-18 – MC	$104,540	$0	$78,405
Total		**$86,168**	**$101,325**

(Dollars in Thousands)

FY 2016-17	TF	GF	Title XIX	Title XXI
Managed Care	$86,168	$37,640	$35,920	$12,608
Total	**$86,168**	**$37,640**	**$35,920**	**$12,608**

(Dollars in Thousands)

FY 2017-18	TF	GF	Title XIX	Title XXI
Fee-for-Service	$3,716	$1,623	$1,549	$544
Managed Care	$97,609	$42,637	$40,690	$14,282
Total	**$101,325**	**$44,260**	**$42,239**	**$14,826**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
88% Title XXI / 12% GF (4260-113-0001/0890)

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

REGULAR POLICY CHANGE NUMBER:	32
IMPLEMENTATION DATE:	7/2000
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	25

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$123,498,000	$131,106,000
- STATE FUNDS	$78,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$123,498,000	$131,106,000
STATE FUNDS	$78,000	$0
FEDERAL FUNDS	$123,420,000	$131,106,000

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 2016-17, is a decrease due to updated paid claims, withholds, placeholders and reconciliations amounts.

The change from the prior estimate, for FY 2017-18, is a net decrease due to a delay of the FY 2014-15 withhold payments to FY 2017-18, lower FY 2017-18 interim payment amounts, and a delay in the FY 2017-18 placeholder payments to a subsequent fiscal year and no longer in the estimate.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to the FY 2009-10 through FY 2012-13 reconciliations occurring in FY 2016-17.

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

REGULAR POLICY CHANGE NUMBER: 32

Methodology:

1. The estimate is based on the analysis of historical claims submitted by LEAs.
2. The FY 2016-17 and FY 2017-18 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 2013-14, 2014-15, and 2015-16.
4. Estimated adjustment for under collection of withholds due from the LEA for FY 2013-14.
5. Estimated adjustment for placeholders for payment due to the LEAs for delinquent cost report payments in FY 2016-17.
6. Estimated adjustment for cost report reconciliation due back to the State.
7. Amounts adjudicated for an erroneous payment correction (EPC) resulted in payment reimbursements beyond the two year claiming limit, which resulted in payments made from the General Fund to reimburse the Federal Fund.
8. Amount adjudicated for an EPC for the FY 2017-18 annual rate inflation.

FY 2016-17	TF	GF	FF
FY 2016-17 Interim Payments	$131,821,000	$0	$131,821,000
FY 2013-14 Withholds due to the LEAs	$1,696,000	$0	$1,696,000
FY 2013-14 Withholds due from the LEAS	($240,000)	$0	($240,000)
FY 2016-17 Placeholder Payments	$1,000,000	$0	$1,000,000
FY 2009-10 through FY 2012-13 Reconciliation	($10,779,000)	$0	($10,779,000)
EPC/Two Year Limit			
FY 2011-12	$0	$13,000	($13,000)
FY 2012-13	$0	$65,000	($65,000)
FY 2016-17 Total	**$123,498,000**	**$78,000**	**$123,420,000**

FY 2017-18	TF	GF	FF
FY 2017-18 Interim Payments	$128,421,000	$0	$128,421,000
FY 2017-18 Rate Inflation	$750,000	$0	$750,000
FY 2014-15 Withholds due to the LEAs	$1,232,000	$0	$1,232,000
FY 2015-16 Withholds due to the LEAs	$703,000	$0	$703,000
FY 2017-18 Total	**$131,106,000**	**$0**	**$131,106,000**

Funding:

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

MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA

REGULAR POLICY CHANGE NUMBER:	33
IMPLEMENTATION DATE:	7/1984
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	28

	FY 2016-17	FY 2017-18
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 11,797 participants in 9,283 participant slots in FY 2016-17 and FY 2017-18.

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: 33

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 2016-17. The change from the prior estimate, for FY 2017-18, is an increase due to the MSSP's continuing as a waiver benefit until January 1, 2020. There is no change from FY 2016-17 to FY 2017-18 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 2016-17	**$39,778**	$19,889	$19,889
FY 2017-18	**$39,778**	$19,889	$19,889

Funding:
Title XIX 100% FFP (4260-101-0890)
Reimbursement (4260-610-0995)

CCS DEMONSTRATION PROJECT

REGULAR POLICY CHANGE NUMBER:	34
IMPLEMENTATION DATE:	4/2013
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	1775

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$32,792,000	$36,847,000
- STATE FUNDS	$14,906,240	$16,772,780
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$32,792,000	$36,847,000
STATE FUNDS	$14,906,240	$16,772,780
FEDERAL FUNDS	$17,885,760	$20,074,220

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 97 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 will not be implemented until after FY 2017-18. Currently, no dollars are budgeted for this pilot.

Reason for Change:
The change from the prior estimate, for FY 2016-17, is a decrease due to a reduction in the capitation rate. The change from the prior estimate, for FY 2017-18, is a decrease due to a reduction in the capitation rate. The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to a retroactive payment and recoupment that will be paid in FY 2016-17 and not FY 2017-18.

CCS DEMONSTRATION PROJECT

REGULAR POLICY CHANGE NUMBER: 34

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 2016-17 and FY 2017-18 is $1,428.57, including 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 2016-17	2,000	$1,428.57	$2,857,140	$34,286,000
FY 2017-18	2,000	$1,428.57	$2,857,140	$34,286,000

4. Assume 70% of the CCS Medi-Cal administrative costs of $3,658,000 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:
   $3,658,000 x 70% = $2,561,000 TF (monthly $213,000 TF)

5. HPSM received capitation payments beginning May 2013.

6. Assume the June capitation payment will be deferred to the following fiscal year.

7. Assume the CCS demonstration project is budget neutral.

8. The estimated capitation payments on a cash basis are:

Fiscal Year	HPSM TF	COHS	CCS Case Management
FY 2016-17	$36,847,000	$34,286,000	$2,561,000
FY 2017-18	$36,847,000	$34,286,000	$2,561,000

9. An increase in enrollment due to the retroactive addition of ACA aid codes and adjustments in the capitation rate occurred in FY 2014-15 and FY 2015-16. As a result, a retroactive payment of $894,000 for FY 2014-15 and a retroactive recoupment of $4,949,000 for FY 2015-16 is expected to be processed in FY 2016-17.

CCS DEMONSTRATION PROJECT

REGULAR POLICY CHANGE NUMBER: 34

10. Total estimated costs for FY 2016-17 and FY 2017-18 are:

Fiscal Year	TF	HPSM	Retroactive Payment FY 2014-15	Recoupment Payment FY 2015-16
FY 2016-17	**$32,792,000**	$36,847,000	$894,000	($4,949,000)
FY 2017-18	**$36,847,000**	$36,847,000	$0	$0

Funding:

FY 2016-17	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$28,897,000	$14,448,500	$14,448,500
65% Title XXI / 35% GF (4260-113-0001/0890)	($42,000)	($14,700)	($27,300)
88% Title XXI / 12% GF (4260-113-0001/0890)	$3,937,000	$472,440	$3,464,560
Total	**$32,792,000**	**$14,906,240**	**$17,885,760**

FY 2017-18	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$32,503,000	$16,251,500	$16,251,500
88% Title XXI / 12% GF (4260-113-0001/0890)	$4,344,000	$521,280	$3,822,720
Total	**$36,847,000**	**$16,772,780**	**$20,074,220**

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER:	35
IMPLEMENTATION DATE:	12/2008
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1228

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$19,545,000	$19,680,000
- STATE FUNDS	$2,534,000	$2,642,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$19,545,000	$19,680,000
STATE FUNDS	$2,534,000	$2,642,000
FEDERAL FUNDS	$17,011,000	$17,038,000

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 54 California Community Transitions Savings
PC 41 CCT Fund Transfer to CDSS and CDDS
PC 49 Quality of Life Surveys for CCT Participants

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, 2016, through June 30, 2017, are 543 individuals and 498 individuals for July 1, 2017, through June 30, 2018.

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: 35

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 2016-17, is a decrease due to new DD actuals transitioning at a lower rate than previously estimated. There is no significant change from the prior estimate for FY 2017-18. The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to higher enrollment months but slightly offset from DD transitions ending January 2018.

Methodology:
1. Assume estimated costs of waiver impacted services for persons residing year-round in Nursing Facility (NF)-Bs would be $76,405 in FY 2016-17 and $76,373 in FY 2017-18. 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 543 pre-transitions that are unsuccessful for non-DD beneficiaries in FY 2016-17 and 498 in FY 2017-18 cost $1,128 annually; reimbursed at 100% MFP.

4. Assume non-DD beneficiaries, upon transitioning into CCT, cost $18,000 annually in FY 2016-17 and FY 2017-18; 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.

6. Assume DD beneficiaries, upon transitioning into CCT, cost $105,000 in FY 2016-17 and FY 2017-18 upon transitioning into CCT for 1915(c) waiver services; reimbursed at 75% MFP and 25% GF.

7. Estimated below is the overall impact of the CCT Demonstration project in FY 2016-17 and FY 2017-18.

FY 2016-17	**TF**	**GF**	**FF**
CCT Costs (PC 35):			
Total Non-DD GF costs and Total FFP	**$19,545,000**	**$2,534,000**	**$17,011,000**
CCT Savings:			
Total Non-DD savings and Total FFP*	($29,123,000)	($14,562,000)	($14,561,000)
QoL CCT Costs (PC 49)	$97,000	$0	$97,000
CCT Fund Transfer to CDSS & CDDS (PC 41)	$1,825,000	$0	$1,825,000
CCT Outreach - Admin costs (OA 48)	$291,000	$0	$291,000
Total of CCT PCs including pass through	($7,365,000)	($12,028,000)	$4,663,000

*The savings are included in the total, however, they are fully reflected in the base estimates.

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER: 35

FY 2017-18	TF	GF	FF
CCT Costs (PC 35):			
Total Non-DD GF costs and Total FFP	**$19,680,000**	**$2,642,000**	**$17,038,000**
CCT Savings:			
Total Non-DD savings and Total FFP*	($31,071,000)	($15,536,000)	($15,535,000)
CCT Fund Transfer to CDSS & CDDS (PC 41)	$2,458,000	$0	$2,458,000
CCT Outreach - Admin costs (OA 48)	$348,000	$0	$348,000
Total of CCT PCs including pass through	($8,585,000)	($12,894,000)	$4,309,000

*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)

IMPLEMENT AAP BRIGHT FUTURES PERIODICITY FOR EPSDT

REGULAR POLICY CHANGE NUMBER:	36
IMPLEMENTATION DATE:	7/2016
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	1854

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$16,639,000	$16,372,000
- STATE FUNDS	$7,965,340	$7,837,540
PAYMENT LAG	0.7624	1.0000
% REFLECTED IN BASE	77.39 %	71.74 %
APPLIED TO BASE		
TOTAL FUNDS	$2,868,200	$4,626,700
STATE FUNDS	$1,373,050	$2,214,890
FEDERAL FUNDS	$1,495,150	$2,411,840

DESCRIPTION

Purpose:
This policy change increases the number of health assessment screens for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit to align with the American Academy of Pediatrics (AAP) Bright Futures health assessment periodicity schedule.

Authority:
State Plan Amendment (SPA) 13-014
Affordable Care Act (ACA) (P.L. 111-148) Section 2713(a)(3)
The Health Insurance Affordability and Accountability Act of 1986 (P.L. 104-191).

Interdependent Policy Changes:
Not Applicable

Background:
The Child Health and Disability Prevention (CHDP) program is responsible for the “early and periodic” health assessment screening component of the EPSDT benefit of the Medi-Cal program, including the health assessments, immunizations, and laboratory screening procedures for Fee-for-Service (FFS) Medi-Cal children and youth.

The CHDP legacy periodicity schedule provides for 15 periodic well child health assessments between birth and age 21. The AAP Bright Futures periodicity schedule provides for 29 periodic well child health assessments between birth and age 21. Implementation of the AAP Bright Futures periodicity schedule conforms Medi-Cal FFS EPSDT well child health assessments for children who are full scope Medi-Cal beneficiaries to the periodicity required by the ACA and SPA.

Reason for Change:
The change from the prior estimate, for FY 2016-17, is a decrease due to a reduction in the legacy periodicity base costs. The change from the prior estimate, for FY 2017-18, is a decrease due to a reduction in the legacy periodicity base costs. The change from FY 2016-17 to FY 2017-18, in the current estimate, is a decrease due to a reduction in the legacy periodicity base costs in FY 2017-18.

IMPLEMENT AAP BRIGHT FUTURES PERIODICITY FOR EPSDT

REGULAR POLICY CHANGE NUMBER: 36

Methodology:
The following assumptions were used to estimate the additional health assessment cost for FY 2016-17 and FY 2017-18:

1. Implementation began July 1, 2016.

2. Assume legacy periodicity base costs are:

   For FY 2016-17: $35,413,000 less 25% for lab, vaccine administration and billable tests.

   $35,413,000 – ($35,413,000 x 25%) = $26,560,000

   For FY 2017-18: $34,832,000 less 25% for lab, vaccine administration and billable tests.

   $34,832,000 – ($34,832,000 x 25%) = $26,124,000

3. Assume reduction for utilization and FFS caseload decline of 40% due to additional shifts to managed care.

   For FY 2016-17: $26,560,000 – ($26,560,000 x 40%) = $15,936,000

   For FY 2017-18: $26,124,000 – ($26,124,000 x 40%) = $15,674,000

4. Increase in periodicity from 15 lifetime screens to 29 lifetime screens.

   For FY 2016-17:
   $15,936,000 / 15 screens = $1,062,000 per screen
   1,062,000 x 14 additional screens = $14,868,000 for additional screens

   For FY 2017-18:
   $15,674,000 / 15 screens = $1,045,000 per screen
   1,045,000 x 14 additional screens = $14,630,000 for additional screens

5. Assume an increase (5% of base) for Bright Futures autism screen and lipid panel due to the autism assessment requirement in the Bright Futures periodicity schedule and increased autism awareness.

   For FY 2016-17: $35,413,000 x 5% = $1,771,000

   For FY 2017-18: $34,832,000 x 5% = $1,742,000

6. Assume that 94.40% of screens are for Medi-Cal children and 5.60% of screens are for the Optional Targeted Low Income Children Program (OTLICP).

7. Full year costs are estimated to be:

   FY 2016-17: $14,868,000 + $1,771,000**= $16,639,000 TF ($7,965,000 GF)**

   FY 2017-18: $14,630,000 + $1,742,000 **= $16,372,000 TF ($7,838,000 GF)**

IMPLEMENT AAP BRIGHT FUTURES PERIODICITY FOR EPSDT

REGULAR POLICY CHANGE NUMBER: 36

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
88% Title XXI / 12% GF (4260-113-0001/0890)

YOUTH REGIONAL TREATMENT CENTERS

REGULAR POLICY CHANGE NUMBER:	38
IMPLEMENTATION DATE:	1/2014
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1772

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$4,259,000	$5,825,000
- STATE FUNDS	$62,000	$29,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$4,259,000	$5,825,000
STATE FUNDS	$62,000	$29,000
FEDERAL FUNDS	$4,197,000	$5,796,000

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:
The change from the prior estimate, for FY 2016-17, is an increase due to the addition of out-of-state enrollees in calendar year (CY) 2017 but slightly offset from a two month delay in the implementation of a new in-state YRTC facility. The change from the prior estimate, for FY 2017-18, is an increase due to an updated federal register rate adjustment which increased the daily rate of about 4%. The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to a 4% increase in the daily rate.

Methodology:
1. The program was implemented January 2014 with an effective date of September 1, 2013.

2. Based on FY 2015-16 data, assume the average monthly enrollment of out-of-state facilities is 14 Medi-Cal beneficiaries.

YOUTH REGIONAL TREATMENT CENTERS

REGULAR POLICY CHANGE NUMBER: 38

3. In March 2017, a new in-state YRTC is expected to open with an estimated average monthly enrollment of 16 Medi-Cal beneficiaries.

4. Assume enrollment in the in-state YRTC will be phased in over a two-month period and payments will begin in April 2017.

5. Assume enrollment in out-of-state facilities will decrease by 75% when the in-state YRTC opens.

6. In FY 2017-18, assume the average monthly enrollment of Medi-Cal beneficiaries will be 20.

7. Assume CY 2016 daily rate per youth is $736, $782 in CY 2017, and $814 in CY 2018.

   CY 2016: $736 daily rate x 365 days ÷ 12 months = $22,387 monthly
   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

FY 2016-17
CY 2016 enrollee costs:
84 enrollee months x $22,387 = $1,880,000

CY 2017 enrollee costs:
56 in-state enrollee months x $23,786 = $1,332,000
44 out-of-state enrollee months x $23,786 = $1,047,000

$1,880,000 + $1,332,000 + $1,047,000 = **$4,259,000 TF**

FY 2017-18
Monthly enrollee costs:
20 enrollees x 6 months x $23,786 = $2,854,000
20 enrollees x 6 months x $24,759 = $2,971,000

$2,854,000 + $2,971,000 = **$5,825,000 TF**

8. Assume the program will pay expenditures at 50% GF/50% FFP upfront and receive 100% FFP reimbursement in the following quarter.

9. $652,000 FFP from last quarter of FY 2015-16 will be reimbursed in FY 2016-17 and $714,000 from last quarter FY 2016-17 will be reimbursed in FY 2017-18.

FY 2016-17	TF	GF	FFP
*Apr - June 2016	$0	($652,000)	$652,000
Jul - Sep 2016	$940,000	$0	$940,000
Oct - Dec 2016	$940,000	$0	$940,000
Jan - Mar 2017	$952,000	$0	$952,000
**Apr - Jun 2017	$1,427,000	$714,000	$713,000
Total	**$4,259,000**	**$62,000**	**$4,197,000**

YOUTH REGIONAL TREATMENT CENTERS

REGULAR POLICY CHANGE NUMBER: 38

FY 2017-18	TF	GF	FFP
*Apr - June 2017	$0	($714,000)	$713,000
Jul - Sep 2017	$1,427,000	$0	$1,427,000
Oct - Dec 2017	$1,427,000	$0	$1,427,000
Jan - Mar 2018	$1,486,000	$0	$1,486,000
**Apr - Jun 2018	$1,486,000	$743,000	$743,000
Total	**$5,826,000**	**$29,000**	**$5,797,000**

*Totals may differ due to rounding

* FFP reimbursement from previous quarter
** FFP to be reimbursed in the following fiscal year

Funding:
50% Title XIX FFP / 50% GF (4260-101-001/0890)
100% Title XIX FFP (4260-101-0890)

PEDIATRIC PALLIATIVE CARE WAIVER

REGULAR POLICY CHANGE NUMBER:	39
IMPLEMENTATION DATE:	7/2013
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	1787

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$2,946,000	$4,533,000
- STATE FUNDS	$2,179,600	$2,117,190
PAYMENT LAG	0.8790	0.9740
% REFLECTED IN BASE	33.29 %	20.03 %
APPLIED TO BASE		
TOTAL FUNDS	$1,727,500	$3,530,800
STATE FUNDS	$1,278,080	$1,649,100
FEDERAL FUNDS	$449,400	$1,881,690

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 51 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.

Effective July 1, 2013, the Department began reimbursing PPCW agencies $300 per member per month (PMPM) for administrative costs. The $300 PMPM costs will be paid at 100% General Fund (GF) through June 30, 2017.

The Department is proposing to include a supplemental payment for specified services in the waiver amendment to be submitted no sooner than March 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 ensure increased access. This change is contingent on CMS approval and the Department would be able to draw down 50% federal financial participation (FFP). The change would be effective no sooner than July 1, 2017.

PEDIATRIC PALLIATIVE CARE WAIVER

REGULAR POLICY CHANGE NUMBER: 39

Based upon an independent evaluation by the University of California, Los Angeles, Center for Health Policy Research, the PPCW pilot project was found to be cost-effective. A gross claims cost reduction of $3,133 PMPM was predominately driven by a major decrease in inpatient care costs. Associated reimbursement costs affect the reduction, but the project remains cost-effective.

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. Program 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. Program 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 October 1, 2009 through December 31, 2013 will be paid in FY 2016-17 and 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.

Reason for Change:
The change from the prior estimate, for FY 2016-17, is a decrease due to reducing the number of additional members to be enrolled by the end of FY 2016-17 from 130 to 82.

The change from the prior estimate, for FY 2017-18, is due to the addition of supplemental payments and reducing the number of additional members to be enrolled by the end of FY 2017-18 from 250 to 142, resulting in an overall increase of costs.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to back payments of PPCW provider claims that are scheduled to be paid and the increase of additional members to be enrolled by the end of FY 2017-18.

Methodology:
The following assumptions were used to estimate the program cost adjustment:

1. Assume 172 members were enrolled in PPCW for FY 2016-17 prior to caseload expansion.

   172 members x 12 months = 2,064 member months (MM) prior to caseload expansion.

2. Assume caseload expanding to 314 members incrementally by the end of FY 2017-18.

   For FY 2016-17 caseload expansion includes an additional 417 MM.

   For FY 2017-18 caseload expansion includes an additional 1,374 MM.

3. For FY 2016-17, assume a $300 PMPM cost at 100% GF for administrative costs paid as a fee through June 30, 2017.

   2,064 MM x $300 PMPM = $619,000 TF (prior to caseload expansion)

   417 MM x $300 PMPM = $125,000 (FY 2016-17 caseload expansion)

   $619,000 + $125,000 = $744,000 TF (rounded)

PEDIATRIC PALLIATIVE CARE WAIVER

REGULAR POLICY CHANGE NUMBER: 39

4. For FY 2017-18, assume the continuation of the $300 PMPM payment in the form of a supplemental payment to providers at 50% FFP.

   2,064 MM x $300 PMPM = $619,000 TF (prior to caseload expansion)

   1,374 MM x $300 PMPM = $412,000 (FY 2017-18 caseload expansion)

   $619,000 + $412,000 = $1,031,000 TF (rounded)

5. Assume an average claims payment of $562.78 PMPM.

   For FY 2016-17: (2,064 MM + 417 MM) x $562.78 = $1,396,000 TF (rounded)

   For FY 2017-18: (2,064 MM + 1,374 MM) x $562.78 = $1,935,000 TF (rounded)

6. Assume $806,000 in back payments of PPCW provider claims from October 1, 2009 through December 31, 2013 will be paid in FY 2016-17 at 100% GF.

7. Assume $1,567,000 in back payments of PPCW provider claims from January 1, 2014 through June 30, 2016 will be paid in FY 2017-18 and include FFP.

8. Total estimated PPCW costs are:

   FY 2016-17: $2,946,000 TF ($2,179,000 GF)

   FY 2017-18: $4,533,000 TF ($2,117,000 GF)

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
65% Title XXI / 35% GF (4260-113-0001/0890)
88% Title XXI / 12% GF (4260-113-0001/0890)
100% GF (4260-101-0001)

DENTAL CHILDREN'S OUTREACH AGES 0-3

REGULAR POLICY CHANGE NUMBER:	40
IMPLEMENTATION DATE:	1/2015
ANALYST:	Nikaela Ratliff
FISCAL REFERENCE NUMBER:	1832

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$3,180,000	$5,724,000
- STATE FUNDS	$1,590,000	$2,862,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,180,000	$5,724,000
STATE FUNDS	$1,590,000	$2,862,000
FEDERAL FUNDS	$1,590,000	$2,862,000

DESCRIPTION

Purpose:
The policy change (PC) estimates the cost of implementing strategies to increase utilization rates for children. This policy estimates the increase in outreach activities and dental utilization for children ages 0-3 who have not had a dental visit during the past twelve months.

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:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
The American Dental Association recommends that a child be seen by a dentist as soon as his or her first tooth erupts, but at least no later than the first birthday. Early dental intervention can serve to: detect dental disease, demonstrate proper cleaning techniques for brushing a baby's teeth, discuss diet and fluoride needs, recommend oral care products, build a strong foundation for oral care, and form a rapport for continuous dental visits.

The Department has identified effective strategies which will have positive health outcomes while increasing utilization of services for the aforementioned children. The Department identified beneficiaries ages 0-3 that have not had a dental visit during the past 12 months in order to mail their parents/legal guardians information. These mailings include a letter encouraging them to take their children to see a dental provider as well as educational information about the importance of early dental visits. The outreach effort to these beneficiaries operates over a 15 month cycle.

DENTAL CHILDREN'S OUTREACH AGES 0-3

REGULAR POLICY CHANGE NUMBER: 40

Reason for Change:
There is no change from the prior estimate.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to the larger portion of the outreach efforts occurring in FY 2017-18, as well as, a higher utilization rate expected than in FY 2016-17.

Methodology:
1. The mailing campaign to beneficiaries aged 0-3 began in January 2015 and a new 15 month cycle of outreach begins January 2017.

2. Assume, for FY 2016-17, the mailing campaign will result in an increase of 10% in annual utilization within the targeted population that consists of children ages 0-3 who did not utilize dental services during the past 12 months.

   FY 2016-17: 393,432 (total beneficiaries outreached) x 10% = 39,343 increased users

3. Assume, for FY 2017-18, the mailing campaign will result in an increase of 12% in annual utilization for children ages 0-3 within the targeted population that consists of children ages 0-3 who did not utilize dental services during the past 12 months.

   FY 2017-18: 590,147 (total beneficiaries outreached) x 12% = 70,818 increased users

4. The average cost per user ages 0-3 is $384.86

   FY 2016-17: 39,343 x $384.86 = $15,142,000 TF

   FY 2017-18: 70,818 x $384.86 = $27,255,000 TF

5. This PC shows the full cost of the policy, above, but only budgets the costs of the non-capitated FFS population. 21% of the overall population of children ages 0-3 fall under non-capitated FFS.

Fiscal Year	TF	GF	FF
FY 2016-17	$3,180,000	$1,590,000	$1,590,000
FY 2017-18	$5,724,000	$2,862,000	$2,862,000

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

CCT FUND TRANSFER TO CDSS AND CDDS

REGULAR POLICY CHANGE NUMBER:	41
IMPLEMENTATION DATE:	10/2011
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1562

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	**$1,825,000**	**$2,458,000**
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	**$1,825,000**	**$2,458,000**
STATE FUNDS	$0	$0
FEDERAL FUNDS	**$1,825,000**	**$2,458,000**

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).

Reason for Change:
The change from the prior estimate, for FY 2016-17, is a decrease due to lower DD beneficiaries transitioning in the first quarter of FY 2016-17. There is no significant change from the prior estimate for FY 2017-18. The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to a slight increase in enrollment months for FY 2017-18.

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 20% of all non-DD enrollees utilize IHSS under CCT. Assume each case costs $9,030 in FY 2016-17 and $13,122 in FY 2017-18. 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 2016-17	FY 2017-18
CDSS	$179,000	$259,000
CDDS	$1,645,000	$2,199,000
Total	**$1,825,000**	**$2,458,000**

FY 2016-17	TF	GF	FF
CCT Costs (PC 35):			
Total Non-DD GF costs and Total FFP	$19,545,000	$2,534,000	$17,011,000
CCT Savings:			
Total Non-DD savings and Total FFP*	($29,123,000)	($14,562,000)	($14,561,000)
QoL CCT Costs (PC 49)	$97,000	$0	$97,000
CCT Fund Transfer to CDSS & CDDS (PC 41)	**$1,825,000**	**$0**	**$1,825,000**
CCT Outreach - Admin costs (OA 48)	$291,000	$0	$291,000
Total of CCT PCs including pass through	($7,365,000)	($12,028,000)	$4,663,000

*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 2017-18	TF	GF	FF
CCT Costs (PC 35):			
Total Non-DD GF costs and Total FFP	$19,680,000	$2,642,000	$17,038,000
CCT Savings:			
Total Non-DD savings and Total FFP*	($31,071,000)	($15,536,000)	($15,535,000)
CCT Fund Transfer to CDSS & CDDS (PC 41)	**$2,458,000**	**$0**	**$2,458,000**
CCT Outreach - Admin costs (OA 48)	$348,000	$0	$348,000
Total of CCT PCs including pass through	($8,585,000)	($12,894,000)	$4,309,000

*The savings are included in the total, however, they are fully reflected in the base estimates.

Funding:
MFP Federal Grant (4260-106-0890)

DENTAL TRANSFORMATION INITIATIVE UTILIZATION

REGULAR POLICY CHANGE NUMBER:	42
IMPLEMENTATION DATE:	7/2016
ANALYST:	Nikaela Ratliff
FISCAL REFERENCE NUMBER:	1976

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$4,538,000	$6,490,000
- STATE FUNDS	$2,269,000	$3,245,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$4,538,000	$6,490,000
STATE FUNDS	$2,269,000	$3,245,000
FEDERAL FUNDS	$2,269,000	$3,245,000

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 TRANSFORMATION INITIATIVE UTILIZATION

REGULAR POLICY CHANGE NUMBER: 42

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 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 overall increase from the prior estimate for FY 2016-17 and FY 2017-18 is due to updated data for Domain 1 showing an overall increase in expenses due to the number of expected services. The change from FY 2016-17 to FY 2017-18 in the current estimate is due to the expected increased utilization.

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.

DENTAL TRANSFORMATION INITIATIVE UTILIZATION

REGULAR POLICY CHANGE NUMBER: 42

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 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: Local Dental Pilot Programs (LDPPs) have been selected; however, the related utilization is unknown at this time.

5. This PC budgets the costs for the non-capitated FFS population. 10% of the overall dental population falls under non-capitated FFS.

   FY 2016-17: Domain 1 = $44,611,000 TF x 10% = $4,461,000 TF ($2,230,550 GF)

   Domain 3 = $774,000 TF x 10% = $77,000 TF ($38,500 GF)

   FY 2016-17 Total: **$4,538,000 TF ($2,269,000 GF)**

   FY 2017-18: Domain 1 = $63,328,000 TF x 10% = $6,333,000 TF ($3,166,500 GF)

   Domain 3 = $1,568,000 TF x 10% = $157,000 TF ($78,500 GF)

   FY 2017-18 Total: **$6,490,000 TF ($3,245,000 GF)**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
OTLICP funding identified in PC 194 Funding Adjust.—OTLICP

END OF LIFE SERVICES

REGULAR POLICY CHANGE NUMBER:	43
IMPLEMENTATION DATE:	5/2017
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1943

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$36,000	$668,000
- STATE FUNDS	$36,000	$668,000
PAYMENT LAG	0.6641	0.9880
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$23,900	$660,000
STATE FUNDS	$23,910	$659,980
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 2016-17 and FY 2017-18, is due to a lower projection of End of Life services utilization based on updated actual data. Payments are now assumed to begin in May 2017.

The change in the current estimate, for both FY 2016-17 and FY 2017-18, is due to a higher projected utilization in FY 2017-18.

END OF LIFE SERVICES

REGULAR POLICY CHANGE NUMBER: 43

Methodology:

1. Payments for End of Life services are expected to begin in May 2017.
2. Assume six beneficiaries will request End of Life services in FY 2016-17 and 114 beneficiaries in FY 2017-18.
3. Two physician visits are required, per beneficiary, at a cost of $69.59 per visit.
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. In FY 2016-17, costs for End of Life services are estimated to be $36,000 TF.

FY 2016-17	TF	GF
Physician Visit (2 Visits)	$1,000	$1,000
Consulting Physician (1 Visit)	$1,000	$1,000
Psychiatrist (2 Visits)	$2,000	$2,000
Cost for End of Life Drug	$32,000	$32,000
Total	**$36,000**	**$36,000**

9. In FY 2017-18, costs for End of Life services are estimated to be $668,000 TF.

FY 2017-18	TF	GF
Physician Visit (2 Visits)	$16,000	$16,000
Consulting Physician (1 Visit)	$7,000	$7,000
Psychiatrist (2 Visits)	$29,000	$29,000
Cost for End of Life Drug	$616,000	$616,000
Total	**$668,000**	**$668,000**

Funding:

100% GF (4260-101-0001)

DENTAL BENEFICIARY OUTREACH AND EDUCATION PROGRAM

REGULAR POLICY CHANGE NUMBER:	44
IMPLEMENTATION DATE:	4/2016
ANALYST:	Nikaela Ratliff
FISCAL REFERENCE NUMBER:	1934

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$53,000	$725,000
- STATE FUNDS	$26,500	$362,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$53,000	$725,000
STATE FUNDS	$26,500	$362,500
FEDERAL FUNDS	$26,500	$362,500

DESCRIPTION

Purpose:
The policy change (PC) estimates the cost of implementing strategies to increase utilization for Medi-Cal dental services for the current Fiscal Intermediary (FI) and the future Administrative Services Organization (ASO) contractor.

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:
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.

DENTAL BENEFICIARY OUTREACH AND EDUCATION PROGRAM

REGULAR POLICY CHANGE NUMBER: 44

Outreach activities include:

- Informational notices to newly enrolled beneficiaries,
- Telephone service center (TSC) calls and mailers to beneficiaries who have not utilized in the prior year,
- Direct outreach to State, County, and Community agencies,
- Website enhancements to the Denti-Cal website, and
- Development of a social media beneficiary mobile app.

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.

Reason for Change:
The decrease from the prior estimate for FY 2016-17 is due to a change in the implementation date of the program resulting in only a partial year costing. There is an increase from the prior estimate for FY 2017-18 due to assumed population growth thus increasing the anticipated additional number of users.

The change from FY 2016-17 to FY 2017-18 in the current estimate is due to costing for only a partial in FY 2016-17.

Methodology:
1. The Beneficiary Outreach and Education program will begin June 1, 2017.

2. Assume the campaign will result in a 2 percentage point utilization increase in FY 2016-17 and a 2 percentage point utilization increase in FY 2017-18.

3. The annualized impact for the increase in benefits are:

   FY 2016-17(annual) = $6,392,000 TF ($3,196,000 GF)

   FY 2017-18 (annual) = $7,327,000 TF ($3,664,000 GF)

4. This PC shows the full cost of the policy, above, 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 2016-17	$53,000	$26,500	$26,500
FY 2017-18	$725,000	$362,500	$362,500

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

MEDICAL MANAGEMENT AND TREATMENT FOR ALD

REGULAR POLICY CHANGE NUMBER:	45
IMPLEMENTATION DATE:	7/2016
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	1958

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$440,000	$440,000
- STATE FUNDS	$198,340	$198,720
PAYMENT LAG	0.7624	1.0000
% REFLECTED IN BASE	77.39 %	71.74 %
APPLIED TO BASE		
TOTAL FUNDS	$75,800	$124,300
STATE FUNDS	$34,190	$56,160
FEDERAL FUNDS	$41,660	$68,190

DESCRIPTION

Purpose:
This policy change estimates the California Children's Services (CCS) costs associated with the medical management and treatment for children identified with Adrenoleukodystrophy (ALD).

Authority:
AB 1559 (Chapter 565, Statutes of 2014)

Interdependent Policy Changes:
Not Applicable

Background:
AB 1559 requires the California Department of Public Health (CDPH) Genetic Disease Screening Program (GDSP) to expand statewide screening of newborns to include screening for ALD. ALD has a higher rate of occurrence in males than females. Children identified with the genetic disorder will require ongoing medical management and treatment. Adrenal insufficiency occurs in 90 percent of identified males, with onset as early as 6 months of age and can lead to rapid progression of symptoms to death within several years. Onset of symptoms for the cerebral form of the condition is generally between the ages of 4-10 years old. Medical management and treatment may include, but is not limited to:

- Ongoing medical management by specialists affiliated with several CCS Special Care Center teams including genetics, neurology, and endocrinology,
- Laboratory studies to assess adrenal gland function and detect insufficiency,
- Hormone/steroid treatment for adrenal insufficiency,
- Magnetic resonance imaging of the brain performed every six months to detect changes in myelin, and
- Bone marrow/stem cell transplant and post-transplant follow up.

The GDSP is required to add ALD to the Newborn Screening (NBS) Program and begin screening all babies in California for the disease. With universal screening for ALD, the protocols for the medical management of the condition are expected to evolve quickly as more individuals with the condition are identified.

MEDICAL MANAGEMENT AND TREATMENT FOR ALD

REGULAR POLICY CHANGE NUMBER: 45

Additional clinical protocols to test mothers, as well as older siblings, of newborns identified with the ALD mutation are currently in development. These clinical protocols will identify a small but unknown number of additional children and adults needing a varying degree of medical management and genetic counseling. Costs for these additional protocols are unknown at this time.

Reason for Change:
There is no change from the prior estimate for FY 2016-17.
There is no change from the prior estimate for FY 2017-18.
There is no change from FY 2016-17 to FY 2017-18 in the current estimate.

Methodology:
1. Implementation began July 1, 2016.

2. The estimated number of births in California each year is 507,917. GDSP assumes approximately 97.428% of newborns will be screened by the NBS Program in FY 2016-17 and 98.042% of newborns will be screened by the NBS Program in FY 2017-18.

   FY 2016-17: 507,917 x 97.428% = 494,853 (rounded)

   FY 2017-18: 507,917 x 98.042% = 497,972 (rounded)

3. Assume the incidence of ALD is 1 out of every 20,000 newborns screened.

   FY 2016-17: 494,853 x (1/20,000) = 25 newborns with ALD identified annually (rounded)

   FY 2017-18: 497,972 x (1/20,000) = 25 newborns with ALD identified annually (rounded)

4. Approximately 45% of newborns screened are from the Medi-Cal population.

   25 x 45% = 11 newborns with ALD eligible for Medi-Cal per year (rounded)

5. Assume the cost of ALD medical management and treatment is $40,000 per eligible per year.

   FY 2016-17: $40,000 x 11 = **$440,000 TF**

   FY 2017-18: $40,000 x 11 = **$440,000 TF**

Funding:

FY 2016-17	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$383,328	$191,664	$191,664
88% Title XXI / 12% GF (4260-113-0001/0890)	$56,672	$6,801	$49,871
Total	**$440,000**	**$198,465**	**$241,535**

FY 2017-18	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$384,252	$192,126	$192,126
88% Title XXI / 12% GF (4260-113-0001/0890)	$55,748	$6,690	$49,058
Total	**$440,000**	**$198,816**	**$241,184**

ALLIED DENTAL PROFESSIONALS ENROLLMENT

REGULAR POLICY CHANGE NUMBER:	46
IMPLEMENTATION DATE:	2/2017
ANALYST:	Nikaela Ratliff
FISCAL REFERENCE NUMBER:	1877

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$252,000	$763,000
- STATE FUNDS	$126,000	$381,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$252,000	$763,000
STATE FUNDS	$126,000	$381,500
FEDERAL FUNDS	$126,000	$381,500

DESCRIPTION

Purpose:
This policy change (PC) estimates the cost of increased utilization of dental services as a result of enrolling Registered Dental Hygienists (RDHs), Registered Dental Hygienists in Extended Functions (RDHEFs), and Registered Dental Hygienists in Alternative Practice (RDHAPs) in the Medi-Cal Dental Services Program.

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:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
The Department proposes the implementation of administrative changes to allow RDHs and 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. This includes allowing RDHs and RDEFs to enroll as rendering providers if the public health program that employs them is registered as a billing provider in the Medi-Cal Dental Services Program. Reimbursement for services provided by the aforementioned 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.

ALLIED DENTAL PROFESSIONALS ENROLLMENT

REGULAR POLICY CHANGE NUMBER: 46

The Centers for Medicare and Medicaid Services (CMS) directed the Department to update the State Plan to include these allied dental professionals as well as RDHAPs to accurately reflect the permissibility of their enrollment in the Medi-Cal Dental Services Program. As such, State Plan Amendment (SPA) 15-005 was submitted to and approved by CMS as the enrollment of these allied dental professionals is permissible under existing state law.

Reason for Change:
The decrease from the prior estimate for FY 2016-17 is due to updated data reflecting a lower annual average amount paid per allied professional and a shift in initial payment timing to March 2017. The increase from the prior estimate for FY 2017-18 is due to an overall increase in the number of allied professionals anticipated to enroll in the program based on updated actual data.

The change from FY 2016-17 to FY 2017-18 in the current estimate is due to the policy being effective for part of FY 2016-17, while a whole year with a growth factor is calculated for FY 2017-18.

Methodology:
1. The policy will implement in February 2017 and the first payment will be in March 2017.

2. Assume the enrollment of these allied professionals will result in an increase in the utilization of dental services that are within the scope of their licensure to provide.

3. Assume that 33% of the total number of RDHs and RDHEFs licensed in the State will enroll in the Denti-Cal program.

4. RDHAPs perform services at four types of locations. RDHs and RDHEFs can only perform services at one out of the four types of locations (public health facilities). Therefore, assume that an RDH or RDHEF can provide services that are equivalent to a RDHAP in 0.25 locations.

5. Assume the annual average amount paid per allied professional based on FY 2015-16 billed amounts and provider enrollment figures from January 2017 is $4,002 and the projected number of RDHs and RDHEFs to be enrolled in Denti-Cal is 7,458. An estimated growth factor of 1.027% from FY 2015-16 to FY 2016-17 and 1.01% between FY 2016-17 and FY 2017-18 is applied to the overall cost to determine the appropriate amounts for FY 2016-17 and FY 2017-18.

6. The full cost of the policy for services provided in FY 2016-17 is estimated at $3,148,472 TF and $7,632,651 TF for FY 2017-18.

7. This PC only budgets the costs for the non-capitated FFS population. 10% of the overall dental population falls under non-capitated FFS. Including a one month payment lag the estimated costs are as follows:

   FY 2016-17 **= $ 252,000 TF ($126,000 GF)**

   FY 2017-18 **= $ 763,000 TF ($ 381,500 GF)**

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

SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER

REGULAR POLICY CHANGE NUMBER:	48
IMPLEMENTATION DATE:	8/2012
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1436

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$153,000	$56,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$153,000	$56,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$153,000	$56,000

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: 48

Reason for Change from Prior Estimate:
The change from the prior estimate, for FY 2016-17 and FY 2017-18, is due to a slight increase in average monthly cost per eligible. The only costs in FY 2017-18 are the 4-month lagged costs from FY 2016-17 due to the waiver ending June 30, 2017.

Methodology:
1. The waiver was amended in 2014 to reduce the maximum capacity to 90 over five years. These slots will be continuously enrolled by backfilling available slots. Enrollment began in August 2012. Target monthly enrollment for the period of July 1, 2016 through June 30, 2017 has been revised to 24 individuals.

2. The Department will utilize 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 will be phased in throughout the year. Total participant months reflected for FY 2016-17 are 258, consisting of 79 from FY 2015-16 and 179 from FY 2016-17.

4. Total participant months reflected for FY 2017-18 are 94 from FY 2016-17.

5. The average monthly eligible cost is estimated to be $1,139 for FY 2015-16, and $1,201 for FY 2016-17.

6. Assume State Plan services will remain constant, but to the extent beneficiaries enroll into the waiver from skilled nursing facilities, there may be GF savings to the Medi-Cal program.

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

QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS

REGULAR POLICY CHANGE NUMBER:	49
IMPLEMENTATION DATE:	7/2010
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1550

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$97,000	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$97,000	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$97,000	$0

DESCRIPTION

Purpose:
This policy change estimates the cost of the Quality of Life (QoL) surveys administered to all California Community Transitions (CCT) project participants.

Authority:
Affordable Care Act (P.L. 111-148), Section 2403
Deficit Reduction Act of 2005 (P.L. 109-171), Section 6071
Money Follows the Person (MFP) Rebalancing Demonstration (P.L. 109-171)

Interdependent Policy Changes:
Not Applicable

Background:
The Centers for Medicare and Medicaid Services (CMS) requires the Department to conduct QoL surveys with CCT participants in receipt of MFP grant funds. QoL surveys are given within specified timeframes and follow a specific methodology. CCT provider agencies, which are Medi-Cal Home and Community Based Services (HCBS) enrolled providers, conduct QoL surveys designed for the following situations:

1. Baseline QoL-Conducted within 30-days before transition or within 14 days after the initial transition.
2. First Follow-up QoL-Conducted 11-12 months after the initial transition.
3. Second Follow-up QoL-Conducted 24 months after initial transition.

The QoL surveys were designed to measure seven domains: living situation, choice and control, access to personal care services, respect/dignity, community integration/inclusion, overall life satisfaction, and health status.

QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS

REGULAR POLICY CHANGE NUMBER: 49

The Department received notification from CMS in April 2016 that there was no longer a requirement to conduct QoL surveys. Effective June 1, 2016 the Department has discontinued the requirement to conduct Baseline QoL surveys and discontinued reimbursement for the service. Effective January 1, 2017 the Department will discontinue the requirement for First and Second Follow-up QoL surveys and will discontinue reimbursement for QoL surveys conducted after that date.

Reason for Change:
The change from the prior estimate, for FY 2016-17, is an increase due to a higher number of completed transitions for FY 2014-15 and FY 2015-16 than previously estimated.

Methodology:
1. The QoL surveys began in July 2010.

2. In FY 2014-15, 446 beneficiaries were transitioned in the CCT demonstration project and 520 additional beneficiaries transitioned into CCT in FY 2015-16. Projected enrollments are 542 in FY 2016-17 and 498 in FY 2017-18.

3. Assume the QoL surveys are administered to all CCT participants three times over a span of three years. Assume no Baseline QoLs will be administered after June 1, 2016. Assume first follow-up QoLs are conducted 11 months after the initial transition. The second follow-up survey is conducted approximately two years after they have been living in community settings. Assume the first follow-up and second follow-up QoLs will continue until December 31, 2016.

4. Assume the Department reimburses $100 to Medi-Cal providers per completed survey for survey administration. Assume up to a four-month lag for payment.

FY 2015-16 First follow up	520 x $100 = $52,000
FY 2014-15 Second follow up	446 x $100 = $44,600
FY 2016-17 Estimated Costs:	**$97,000 TF** (rounded)

FY 2016-17	**TF**	**GF**	**FF**
CCT Costs (PC 35):			
Total Non-DD GF costs and Total FFP	$19,545,000	$2,534,000	$17,011,000
CCT Savings:			
Total Non-DD savings and Total FFP*	($29,123,000)	($14,562,000)	($14,561,000)
QoL CCT Costs (PC 49)	**$97,000**	**$0**	**$97,000**
CCT Fund Transfer to CDSS & CDDS (PC 41)	$1,825,000	$0	$1,825,000
CCT Outreach - Admin costs (OA 48)	$291,000	$0	$291,000
Total of CCT PCs including pass through	($7,365,000)	($12,028,000)	$4,663,000

*The savings are included in the total, however, they are fully reflected in the base estimates.

QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS

REGULAR POLICY CHANGE NUMBER: 49

FY 2017-18	TF	GF	FF
CCT Costs (PC 35):			
Total Non-DD GF costs and Total FFP	$19,680,000	$2,642,000	$17,038,000
CCT Savings:			
Total Non-DD savings and Total FFP*	($31,071,000)	($15,536,000)	($15,535,000)
CCT Fund Transfer to CDSS & CDDS (PC 41)	$2,458,000	$0	$2,458,000
CCT Outreach - Admin costs (OA 48)	$348,000	$0	$348,000
Total of CCT PCs including pass through	($8,585,000)	($12,894,000)	$4,309,000

*The savings are included in the total, however, they are fully reflected in the base estimates.

Funding:
MFP Federal Grant (4260-106-0890)

PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINGS

REGULAR POLICY CHANGE NUMBER:	51
IMPLEMENTATION DATE:	1/2016
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	1885

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	-$1,071,000	-$4,305,000
- STATE FUNDS	-$483,060	-$1,945,400
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	68.10 %	33.40 %
APPLIED TO BASE		
TOTAL FUNDS	-$341,600	-$2,867,100
STATE FUNDS	-$154,100	-$1,295,640
FEDERAL FUNDS	-$187,550	-$1,571,490

DESCRIPTION

Purpose:
This policy change budgets projected savings attributed to the expansion of the Pediatric Palliative Care Waiver (PPCW).

Authority:
AB 1745 (Chapter 330, Statutes of 2006)
Social Security Act, Section 1915(c)

Interdependent Policy Changes:
Not Applicable

Background:
AB 1745, also known as “The Nick Snow Children’s Hospice & Palliative Care Act of 2006,” 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 142 additional members; the current level of participants is 172 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.

PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINGS

REGULAR POLICY CHANGE NUMBER: 51

Reason for Change:
The change from the prior estimate, for FY 2016-17, is a decrease due to a reduction in the anticipated caseload expansion. The change from the prior estimate, for FY 2017-18, is a decrease due to a reduction in the anticipated caseload expansion. The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to an increase in additional members to be enrolled by the end of FY 2017-18.

Methodology:
The following assumptions were used to estimate the caseload expansion cost and program savings:

1. Assume 314 members enroll in PPCW by the end of FY 2017-18.

2. Based on the number of members enrolled each year and $3,133 PMPM savings, assume a gross savings of $1,071,000 for FY 2016-17 and $4,305,000 for FY 2017-18.

3. 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 2016-17	TF	GF	FF
OA 2-CCS Case Management	$158,000	$40,000	$119,000
PC 39-PPCW	$360,000	$231,500	$128,500
Savings	**($1,071,000)**	**($483,500)**	**($587,500)**
Net Savings	($553,000)	($212,000)	($340,000)

FY 2017-18	TF	GF	FF
OA 2-CCS Case Management	$768,000	$192,000	$576,000
PC 39-PPCW	$1,185,000	$555,500	$629,500
Savings	**($4,305,000)**	**($1,945,000)**	**($2,360,000)**
Net Savings	($2,352,000)	($1,197,500)	($1,154,500)

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
88% Title XXI / 12% GF (4260-113-0001/0890)

SRP PRIOR AUTH. & PREVENTIVE DENTAL SERVICES

REGULAR POLICY CHANGE NUMBER:	52
IMPLEMENTATION DATE:	7/2016
ANALYST:	Nikaela Ratliff
FISCAL REFERENCE NUMBER:	1933

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	-$3,168,000	-$3,201,000
- STATE FUNDS	-$1,584,000	-$1,600,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$3,168,000	-$3,201,000
STATE FUNDS	-$1,584,000	-$1,600,500
FEDERAL FUNDS	-$1,584,000	-$1,600,500

DESCRIPTION

Purpose:
This policy change estimates the cost savings as a result of implementing prior authorization (PA) requirements for Registered Dental Hygienists in Alternative Practice (RDHAPs) for scaling and root planing services (SRP). This policy change also estimates the cost of increasing the prophylaxis and fluoride treatments to Department of Developmental Services (DDS) beneficiaries who reside in Skilled Nursing Facilities (SNFs) and Intermediate Care Facilities (ICFs) to once every four months rather than once per year. This policy also estimates the costs of making full mouth debridement a covered Denti-Cal benefit and savings by decreasing the reimbursement amount for periodontal maintenance.

Authority:
Title 22, California Code of Regulations (CCR), Section 51003

Interdependent Policy Changes:
Not Applicable

Background:
The Department requires RDHAPs to abide by the submission requirements in the Denti-Cal Manual of Criteria for Medi-Cal Authorization for Dental services for SRP and periodontal maintenance services.

A prophylaxis is a dental cleaning and does not require pre-treatment radiographs or PA. Fluoride treatments help to prevent decay, especially along the root surfaces, which is more exposed in adult populations. Historically, these treatments are provided once a year to beneficiaries age 21 and over as part of the Medi-Cal full-scope benefit package for long term care patients. This policy change is intended to provide needed oral hygiene treatment to beneficiaries residing in SNFs or ICFs. It is recognized that in many cases these residents may not receive daily oral care and have very poor oral hygiene.

SRP PRIOR AUTH. & PREVENTIVE DENTAL SERVICES

REGULAR POLICY CHANGE NUMBER: 52

The Department increased the frequency of prophylaxis and fluoride treatments for residents who reside in these facilities to once every four months from once per year. This allows residents to be treated on a more regular basis. However, should it be determined that based on the presence of periodontal disease that SRP procedures are the appropriate course of treatment, the dental provider will need to submit radiographs and proceed through the PA process so that the Medi-Cal Dental Services Program may determine the medical necessity for such services.

Additionally, a full mouth debridement is allowed as a covered Denti-Cal procedure. Furthermore, DHCS reduced the reimbursement cost of periodontal maintenance.

An exemption process for the SRP PA policy has minimal, but indeterminate cost implications.

Reason for Change:
The increase in savings from the prior estimate for both FY 2016-17 and FY 2017-18 is due to updated data reflecting a higher amount billed for SRPs by RDHAPs than previously estimated, thus increasing savings.

The change from FY 2016-17 to FY 2017-18 in the current estimate is due to the application of a population growth factor.

Methodology:
1. The policy implementation date is July 1, 2016.

Savings as a Result of Implementing Prior Authorization
2. Assume the estimated expenditures without PA for SRP and periodontal maintenance would have been $13,295,000 in FY 2016-17 and $13,428,000 in FY 2017-18.

3. Assume the PA approval rate for RDHAPs for SRP services are the same as enrolled dentists' approval rate of 57.5%, resulting in estimated expenditures of $7,645,000 in FY 2016-17 and $7,721,000 in FY 2017-18.

4. The estimated cost savings as a result of implementing PA requirements for RDHAPs is:

   FY 2016-17: $13,295,000 - $7,645,000 = $5,650,000

   FY 2017-18: $13,428,000 - $7,721,000 = $5,707,000

Cost as a Result of Increasing Prophylaxis and Fluoride Treatments
5. Assume that denied SRPs results in prophylaxis and fluoride treatments. Also, assume some beneficiaries that were not denied SRPs are likely to use additional services. The estimated number of beneficiaries receiving preventive treatments is 31,289 in FY 2016-17 and 31,602 in FY 2017-18. Prophylaxis and Fluoride treatments cost $198 per year for each beneficiary.

6. The estimated cost as a result of increasing the frequency of prophylaxis and fluoride treatments is

   FY 2016-17: 31,289 x $198 = $6,195,000

   FY 2017-18: 31,602 x $198 = $6,257,000

SRP PRIOR AUTH. & PREVENTIVE DENTAL SERVICES

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Cost as a Result of Allowing Debridement as a Covered Denti-Cal Benefit

7. Assume the total number of beneficiaries potentially eligible for debridement is estimated to be 79,296 in FY 2016-17 and 80,089 in FY 2017-18.

8. Assume 50 percent of these beneficiaries would utilize a full mouth debridement, totaling 39,648 beneficiaries in FY 2016-17 and 40,045 in FY 2017-18.

9. The cost per full mouth debridement is $75.

10. The estimated cost as a result of allowing debridement as a covered Denti-Cal benefit is:

    FY 2016-17: 39,648 x $75 = $2,974,000

    FY 2017-18: 40,045 x $75 = $3,003,000

Savings as a Result of Reducing the Reimbursement of Periodontal Maintenance Treatments

11. Assume the total number of beneficiaries approved for SRP would then receive three periodontal maintenance treatments. This population is estimated to be 29,721 beneficiaries in FY 2016-17 and 30,018 in FY 2017-18.

12. With the cost of each periodontal maintenance treatment reduced to $55 per treatment, this results in a savings of $75 per treatment.

13. The estimated savings as a result of reducing the SMA of periodontal maintenance treatments is:

    FY 2016-17: 29,721 x 3 treatments x $75 = $6,688,000

    FY 2017-18: 30,018 x 3 treatments x $75 = $6,754,000

Total Cost of the Policy Change

(Dollars in Thousands)

FY 2016-17	TF	GF	FF
Savings as a Result of Implementing Prior Authorization	($5,650)	($2,825)	($2,825)
Cost as a Result of Increasing Prophylaxis and Fluoride Treatments	$6,195	$3,098	$3,098
Cost as a Result of Allowing Debridement as a Covered Denti-Cal Benefit	$2,974	$1,487	$1,487
Savings as a Result of Reducing the Reimbursement of Periodontal Maintenance Treatments (D4910)	($6,688)	($3,344)	($3,344)
Total	**($3,168)**	**($1,584)**	**($1,584)**

SRP PRIOR AUTH. & PREVENTIVE DENTAL SERVICES

REGULAR POLICY CHANGE NUMBER: 52

(Dollars in Thousands)

FY 2017-18	TF	GF	FF
Savings as a Result of Implementing Prior Authorization	($5,707)	($2,854)	($2,854)
Cost as a Result of Increasing Prophylaxis and Fluoride Treatments	$6,257	$3,129	$3,129
Cost as a Result of Allowing Debridement as a Covered Denti-Cal Benefit	$3,003	$1,502	$1,501
Savings as a Result of Reducing the Reimbursement of Periodontal Maintenance Treatments (D4910)	($6,754)	($3,377)	($3,377)
Total	**($3,201)**	**($1,601)**	**($1,601)**

*Note may be slight variations in total due to rounding

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

WOMEN'S HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER:	53
IMPLEMENTATION DATE:	12/2015
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1770

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	-$6,467,000	-$7,932,000
- STATE FUNDS	-$1,458,500	-$1,787,500
PAYMENT LAG	0.9119	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$5,897,300	-$7,932,000
STATE FUNDS	-$1,330,010	-$1,787,500
FEDERAL FUNDS	-$4,567,250	-$6,144,500

DESCRIPTION

Purpose:
This policy change estimates the fiscal impact from reproductive health services benefit changes to the Family Planning, Access, Care and Treatment (Family PACT) and Medi-Cal programs.

Authority:
Welfare & Institutions Code 14132(aa)(8)
Affordable Care Act, Section 2303(a)(3)

Interdependent Policy Changes:
Not Applicable

Background:
The Department conducts on-going monitoring and utilization management of reproductive health services to expand access to services, evaluate the cost-effectiveness of services, and identify opportunities to reduce program costs while maintaining the same quality of care.

Effective December 1, 2015, the Department added onsite dispensing for the contraceptive patch and ring to ensure continuity of care for women transitioning from the Family PACT program to Medi-Cal.

Effective June 1, 2016, the Department adopted a Medi-Cal Preferred List for oral contraceptives.

Under the Family PACT program, certain community clinics are allowed to dispense a limited number of miscellaneous drugs with a nominal dispensing fee of $3.00. Effective March 1, 2018, the Department plans to revise the benefit to allow community clinics to dispense these limited number of miscellaneous drugs covered under the Family PACT program to Medi-Cal fee-for-service (FFS) beneficiaries. This change would align clinic dispensing coverage for a number of family health related miscellaneous drugs for both Family PACT and Medi-Cal FFS beneficiaries.

Reason for Change:
The change from the prior estimate, for FY 2016-17 and FY 2017-18, is due to the delay of the implementation of the clinical dispensing of miscellaneous drugs to Medi-Cal FFS beneficiaries from

WOMEN'S HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER: 53

January 2017 to March 2018. The change in the current estimate, from FY 2016-17 to FY 2017-18, is due to including a half year's cost for the clinical dispensing of miscellaneous drugs in FY 2017-18 and updating the percent in base and payment lag calculations.

Methodology:

1. For onsite dispensing of contraceptive patch and ring, the estimated annual cost is $4.5 million TF. Total costs on a cash basis, after applying payment lags and a percent in base, is estimated to be:

   FY 2016-17: $1,706,000 TF costs
   FY 2017-18: $955,000 TF costs

2. For the Medi-Cal Preferred List of oral contraceptives, the estimated annual savings is $10.3 million TF. Total savings on a cash basis, after applying payment lags and a percent in base, is estimated to be:

   FY 2016-17: ($8,173,000) TF savings
   FY 2017-18: ($8,892,000) TF savings

3. For clinical dispensing change, the estimated annual cost is $16,000 TF. Total costs on a cash basis, after applying payment lags and a percent in base, is estimated to be:

   FY 2017-18: $5,000 TF costs

4. The Family PACT program is budgeted at 90% FFP /10% GF. Family planning related services are budgeted at 50% FFP / 50% GF. It is assumed that 13.95% of the Family PACT population are undocumented persons and are budgeted at 100% General Fund (GF).

Cash Basis	**FY 2016-17 TF**	**FY 2017-18 TF**
Medi-Cal Preferred List for Oral Contraceptives	($8,172,741)	($8,892,000)
Onsite Dispensing for Contraceptive Patch and Ring	$1,705,980	$955,000
Clinical Dispensing Fee	$0	$5,000
Total Fund	**($6,466,761)**	**($7,932,000)**

Funding:

FY 2016-17	**TF**	**GF**	**FF**
90% Title XIX / 10% GF (4260-101-001/0890)	($5,565,000)	($556,500)	($5,008,500)
100% GF (4260-101-0001)	($902,000)	($902,000)	$0
Total	**($6,467,000)**	**($1,458,500)**	**($5,008,500)**

FY 2017-18	**TF**	**GF**	**FF**
90% Title XIX / 10% GF (4260-101-001/0890)	($6,830,000)	($683,000)	($6,147,000)
50% Title XIX / 50% GF (4260-101-001/0890)	$5,000	$2,500	$2,500
100% GF (4260-101-0001)	($1,107,000)	($1,107,000)	$0
Total	**($7,932,000)**	**($1,787,500)**	**($6,144,500)**

NEW HIGH COST TREATMENTS FOR SPECIFIC CONDITIONS

REGULAR POLICY CHANGE NUMBER:	55
IMPLEMENTATION DATE:	7/2015
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	1931

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$28,263,000	$87,390,000
- STATE FUNDS	$13,050,400	$39,927,680
PAYMENT LAG	0.9230	0.9650
% REFLECTED IN BASE	55.26 %	17.66 %
APPLIED TO BASE		
TOTAL FUNDS	$11,671,200	$69,438,400
STATE FUNDS	$5,389,170	$31,725,780
FEDERAL FUNDS	$6,282,050	$37,712,660

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 two-drug therapy combining the drugs ivacaftor with lumacaftor in a single pill designed to address chloride channel abnormalities in cystic fibrosis (CF) patients.
- DEFLAZACORT: A once weekly lifetime intravenous infusion for the treatment of Duchenne Muscular Dystrophy (DMD) patients.
- Exondys 51: A once weekly lifetime intravenous infusion for the treatment of DMD in patients who have a confirmed mutation in the DMD gene that is amenable to Exondys 51 skipping.
- SPINRAZA: A continuous, life long, intrathecally administered drug treatment program for spinal muscular atrophy (SMA).

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: 55

Reason for Change:

The change from the prior estimate, for FY 2016-17, is an overall increase due to:

- The addition of three recently approved treatments and services (DEFLAZACORT, Exondys 51 and SPINRAZA) for CCS beneficiaries, and
- A lower than anticipated number of GHPP beneficiaries receiving Orkambi.

The change from the prior estimate, for FY 2017-18, is an overall increase due to:

- The addition of three recently approved treatments and services (DEFLAZACORT, Exondys 51 and SPINRAZA) for CCS beneficiaries,
- The CCS removal of the Orkambi forced expiratory volume (FEV) threshold and hospitalization authorization criteria for beneficiaries 20 years of age or younger, and
- A lower than anticipated number of GHPP beneficiaries receiving Orkambi.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to:

- The continued phase-in of additional CCS beneficiaries receiving the three recently approved treatments and services (DEFLAZACORT, Exondys 51 and SPINRAZA), and
- The CCS removal of the Orkambi FEV threshold and hospitalization authorization criteria for beneficiaries 20 years of age or younger.

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. For FY 2016-17 and FY 2017-18, Orkambi cost are estimated as follows:

- The cost of Orkambi for FY 2015-16 was $224,000 per beneficiary per year.
- Based on actuals, assume a 5% increase in Orkambi costs per beneficiary per year.

  FY 2016-17: $224,000 + 5% = $235,000 per beneficiary per year
  FY 2017-18: $235,000 + 5% = $247,000 per beneficiary per year

- Assume a 24-month phase-in of eligibles beginning July 1, 2015.
- Assume 71 CCS and 37 GHPP beneficiaries will be prescribed Orkambi by the end of FY 2016-17.
- 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 2016-17	FY 2017-18
CCS Medi-Cal:	$11,144,000	$17,488,000
CCS OTLICP:	$1,648,000	$2,537,000
GHPP:	$6,180,000	$9,146,000
Total Orkambi:	$18,972,000	$29,171,000

NEW HIGH COST TREATMENTS FOR SPECIFIC CONDITIONS
REGULAR POLICY CHANGE NUMBER: 55

2. For FY 2016-17 and FY 2017-18, 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 February 1, 2017.
    - Total estimated costs DEFLAZACORT are:

	FY 2016-17	FY 2017-18
CCS Medi-Cal:	$1,450,000	$13,378,000
CCS OTLICP:	$215,000	$1,940,000
Total DEFLAZACORT:	$1,665,000	$15,318,000

3. For FY 2016-17 and FY 2017-18, 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 September 1, 2016.
    - Total estimated costs for Exondys 51 are:

	FY 2016-17	FY 2017-18
CCS Medi-Cal:	$1,416,000	$7,074,000
CCS OTLICP:	$210,000	$1,027,000
Total Exondys 51:	$1,626,000	$8,101,000

4. For FY 2016-17 and FY 2017-18, SPINRAZA cost are estimated as follows:

    - Assume 55 existing beneficiaries are eligible to receive SPINRAZA.
    - Assume a 24-month phase-in of the existing beneficiaries beginning January 1, 2017.
    - Assume each beneficiary will receive loading doses over the first 72 days of treatment for a total one-time cost of $750,000 per beneficiary, and then one dose every four months, for life, at a cost of $350,000 per does.
    - Total estimated costs for SPINRAZA are:

	FY 2016-17	FY 2017-18
CCS Medi-Cal:	$5,228,000	$30,390,000
CCS OTLICP:	$772,000	$4,410,000
Total SPINRAZA:	$6,000,000	$34,800,000

5. Of the nonfederal share for this policy change in 2017-18, $12,170,000 in new growth as compared to the 2016 Budget Act will be funded with Proposition 56 revenue.

NEW HIGH COST TREATMENTS FOR SPECIFIC CONDITIONS
REGULAR POLICY CHANGE NUMBER: 55

6. County funds will be allocated in the County Share of OTLICP-CCS Costs policy change.

FY 2016-17	TF	GF	FF
CCS-Medi-Cal	$19,238,000	$9,619,000	$9,619,000
CCS OTLICP	$2,845,000	$342,000	$2,503,000
GHPP-Medi-Cal	$6,180,000	$3,090,000	$3,090,000
Total	**$28,263,000**	**$13,051,000**	**$15,212,000**

FY 2017-18	TF	GF	FF
CCS-Medi-Cal	$68,330,000	$34,165,000	$34,165,000
CCS OTLICP	$9,914,000	$1,190,000	$8,724,000
GHPP-Medi-Cal	$9,146,000	$4,573,000	$4,573,000
Total	**$87,390,000**	**$39,928,000**	**$47,462,000**

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)
Healthcare Treatment Fund (4260-101-3305)

NON FFP DRUGS

REGULAR POLICY CHANGE NUMBER:	56
IMPLEMENTATION DATE:	3/2007
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	108

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$39,000	$69,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$39,000	$69,500
FEDERAL FUNDS	-$39,000	-$69,500

DESCRIPTION

Purpose:
This policy change budgets 100% General Fund (GF) costs to reimburse the federal share to the Centers for Medicare and Medicaid Services (CMS) for drugs ineligible for federal funds (FF) (Non-FFP drugs).

Authority:
Social Security Act, section 1927 [42 U.S.C. 1396r–8]

Interdependent Policy Changes
Not Applicable

Background:
Federal Medicaid rules specify that there is no FF for drugs provided by state Medicaid programs if the manufacturer of the drug has not signed a rebate contract with the CMS. Examples include, but are not limited to:

- Drugs terminated by the manufacturer, or
- Drugs that are no longer covered benefits of the Medicaid program.

Effective March 2007, an automated quarterly report was made available to determine the costs of drugs for which there is no FF. The Department reimburses the federal government for FF claimed for these drugs.

Reason for Change:
The change from the prior estimate, for FY 2016-17, is due to updated pharmacy expenditures for two additional quarters. The change from the prior estimate, for FY 2017-18 and the difference between FY 2016-17 and FY 2017-18, in the current estimate, is due to updating projections based on the average cost data.

NON FFP DRUGS

REGULAR POLICY CHANGE NUMBER: 56

Methodology:

1. The Department reimburses CMS quarterly for ongoing non-FF drugs purchased. Based on data from July 2004 to December 2016, the FF actual total costs were compared to the base estimate amounts which created a percentage used to calculate the estimate.

	Non-FF Drug Expenditures	Est. FF Repayment
FY 2016-17	$78,000	**$39,000**
FY 2017-18	$139,000	**$69,500**

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)
100% GF (4260-101-0001)

BCCTP DRUG REBATES

REGULAR POLICY CHANGE NUMBER:	57
IMPLEMENTATION DATE:	1/2010
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1433

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	-$12,486,000	-$11,263,000
- STATE FUNDS	-$3,947,650	-$3,545,150
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$12,486,000	-$11,263,000
STATE FUNDS	-$3,947,650	-$3,545,150
FEDERAL FUNDS	-$8,538,350	-$7,717,850

DESCRIPTION

Purpose:
This policy change estimates the revenues collected from the Breast and Cervical Cancer Treatment Program (BCCTP) drug rebates.

Authority:
Welfare & Institutions Code 14105.33(b)(4)

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 2016-17 and FY 2017-18, is the result of projecting increased collections based on:

- The addition of two quarters of actual BCCTP rebate collections from July 2016 through December 2016;
- Increased BCCTP drug expenditures for the applicable expenditure period;
- Updated estimated ACA Offset funding based on actuals through December 2016.

The change between FY 2016-17 and FY 2017-18, in the current estimate, is due to an estimated decline in BCCTP drug expenditures.

BCCTP DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 57

Methodology:

1. Payments began in January 2010.

2. Rebates are invoiced quarterly.

3. The estimated rebates to collect are $12,486,000 in FY 2016-17 and $11,263,000 in FY 2017-18.

4. Assume, of the total BCCTP rebates collected, the ACA offset for BCCTP is $1,207,000 in FY 2016-17 and $1,134,000 in FY 2017-18.

(Dollars in Thousands)

FY 2016-17	TF	GF	FF
65% Title XIX / 35% GF	($11,279)	($3,948)	($7,331)
ACA Offset	($1,207)	$0	($1,207)
Total	**($12,486)**	**($3,948)**	**($8,538)**

(Dollars in Thousands)

FY 2017-18	TF	GF	FF
65% Title XIX / 35% GF	($10,129)	($3,545)	($6,584)
ACA Offset	($1,134)	$0	($1,134)
Total	**($11,263)**	**($3,545)**	**($7,718)**

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:	58
IMPLEMENTATION DATE:	12/1999
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	51

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	-$20,748,000	-$17,183,000
- STATE FUNDS	-$2,585,000	-$2,132,400
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$20,748,000	-$17,183,000
STATE FUNDS	-$2,585,000	-$2,132,400
FEDERAL FUNDS	-$18,163,000	-$15,050,600

DESCRIPTION

Purpose:
This policy change estimates the revenues collected from the Family Planning Access, Care and Treatment (FPACT) drug rebates.

Authority:
Welfare & Institutions Code 14105.33(b)(4)

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 2016-17 and FY 2017-18, is an increase due to the revised collection projections based on:

- The addition of two quarters of actual FPACT rebate collections from July 2016 through December 2016;
- Increased estimated FPACT drug expenditures for the applicable expenditure period;
- Decreased estimated ACA Offset funding based on actual data through December 2016.

The change between FY 2016-17 and FY 2017-18, in the current estimate, continues to estimate a decline in FPACT drug rebates based on the projected FPACT pharmacy expenditures.

FAMILY PACT DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 58

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 $714,000 for FY 2016-17 and $659,000 for FY 2017-18.

3. Actual data from July 2013 to December 2016 is used to project rebates.

(Dollars in Thousands)

Fiscal Year	FPACT Drug Expenditures	FPACT Rebate
FY 2016-17	$62,446	($20,748)
FY 2017-18	$49,518	($17,183)

(Dollars in Thousands)

FY 2016-17	**TF**	**GF**	**FF**
50% Title XIX /50% GF	($1,454)	($727)	($727)
90% Title XIX / 10% GF	($18,580)	($1,858)	($16,722)
ACA Offset	($714)	$0	($714)
Total	**($20,748)**	**($2,585)**	**($18,163)**

FY 2017-18	**TF**	**GF**	**FF**
50% Title XIX /50% GF	($1,200)	($600)	($600)
90% Title XIX / 10% GF	($15,324)	($1,532)	($13,792)
ACA Offset	($659)	$0	($659)
Total	**($17,183)**	**($2,132)**	**($15,051)**

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:	59
IMPLEMENTATION DATE:	10/2006
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1181

	FY 2016-17	FY 2017-18
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.

Reason for Change:
The change from the prior estimate, for FY 2016-17 and FY 2017-18, is a decrease due to forecasting based on the average of the most recent four complete quarters of actual data through December 2016. In the current estimate, there is no change estimated from FY 2016-17 to FY 2017-18.

MEDICAL SUPPLY REBATES

REGULAR POLICY CHANGE NUMBER: 59

Methodology:

1. Based on actual rebate data for the last four quarters, the average quarterly collection is $6,229,000.

2. Assume the medical supply rebates collected are $24,916,000 in FY 2016-17 and FY 2017-18.

3. Based on the current contract terms, it is assumed that there will be no significant change in rebates collected for FY 2016-17 and FY 2017-18.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2016-17	($24,916)	($12,458)	($12,458)
FY 2017-18	($24,916)	($12,458)	($12,458)

Funding:

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

LITIGATION SETTLEMENTS

REGULAR POLICY CHANGE NUMBER:	60
IMPLEMENTATION DATE:	8/2009
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	1449

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	-$29,867,000	$0
- STATE FUNDS	-$29,867,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$29,867,000	$0
STATE FUNDS	-$29,867,000	$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 2016-17, is an increase is due to additional settlements being added. There is no change from the prior estimate for FY 2017-18. The change from FY 2016-17 to FY 2017-18, 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: 60

Methodology:
The following settlements are expected to be received in FY 2016-17:

Settlement	FY 2016-17
Biocompatibles, Inc.	($268,000)
Forest Pharmaceuticals	($70,000)
Maxim	($87,000)
Modi	($839,000)
Olympus Corporation	($3,847,000)
Omnicare, Inc.	($63,000)
Omnicare - Depakote	($269,000)
OSI Pharmaceuticals/Genentech	($667,000)
PharMerica	($172,000)
Salix, Inc.	($282,000)
Shire Pharmaceuticals	($399,000)
Walgreen Company	($176,000)
Warner Chilcott	($1,544,000)
Wyeth	($21,184,000)
Total GF Savings	**($29,867,000)**

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

STATE SUPPLEMENTAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER:	61
IMPLEMENTATION DATE:	1/1991
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	54

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	-$208,826,000	-$192,285,000
- STATE FUNDS	-$27,590,660	-$65,423,790
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$208,826,000	-$192,285,000
STATE FUNDS	-$27,590,660	-$65,423,790
FEDERAL FUNDS	-$181,235,340	-$126,861,210

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).

Retroactive adjustments will be made for the Affordable Care Act (ACA) optional rebates. See the Drug Rebates — Retroactive ACA Adjustments policy change for more information.

Reason for Change:
The change from the prior estimate, for FY 2016-17 and FY 2017-18, is 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 July 2016 through December 2016 which were higher than previously estimated;
- Increased ACA optional and Title XXI rebates based on data through December 2016, therefore increasing the estimated federal share of the State supplemental rebates; and
- Decreased fee-for-service (FFS) pharmacy expenditures related to the periods used to project the estimated rebates.

STATE SUPPLEMENTAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 61

The change from FY 2016-17 to FY 2017-18, in the current estimate, is a decrease due to projecting a decline for FY 2017-18 State supplemental drug rebates based on the decreased pharmacy expenditures that were applied to the FY 2017-18 projections. In addition, the FY 2016-17 collections are estimated to be higher than FY 2017-18 based the inclusion of the actual collections from the October 2016 to December 2016 quarter which were higher than the projected average quarterly State supplemental rebate collections.

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 expenditures are estimated to be $9,608,000 TF for FY 2016-17 and $7,382,000 TF in FY 2017-18, funded at 88% FF and 12% GF.

4. The optional expansion ACA population collections are estimated to be $146,309,000 TF for FY 2016-17, funded at 100% FF. For FY 2017-18, the ACA collections are estimated to be $61,943,000 TF, funded at 95% FF and 5% GF.

(Dollars in Thousands)

FY 2016-17	TF	GF	FFP
50% Title XIX / 50% GF	($52,867)	($26,434)	($26,433)
100% ACA Title XIX FF	($146,309)	$0	($146,309)
90% Title XIX / 10% GF	($42)	($4)	($38)
88% Title XXI / 12 % GF	($9,608)	($1,153)	($8,455)
Total	**($208,826)**	**($27,591)**	**($181,235)**

(Dollars in Thousands)

FY 2017-18	TF	GF	FFP
50% Title XIX / 50% GF	($122,862)	($61,431)	($61,431)
95% Title XIX/ 5% GF	($61,943)	($3,097)	($58,846)
90% Title XIX / 10% GF	($98)	($10)	($88)
88% Title XXI / 12 % GF	($7,382)	($886)	($6,496)
Total	**($192,285)**	**($65,424)**	**($126,861)**

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX / 10% GF (4260-101-0001/0890)
100% ACA Title XIX FF (4260-101-0890)
95% ACA Title XIX FF / 5% GF (4260-101-0001/0890)
88% Title XXI / 12% GF (4260-113-0001/0890)

FEDERAL DRUG REBATE PROGRAM

REGULAR POLICY CHANGE NUMBER:	62
IMPLEMENTATION DATE:	7/1990
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	55

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	-$2,201,821,000	-$2,139,644,000
- STATE FUNDS	-$711,404,400	-$712,018,900
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$2,201,821,000	-$2,139,644,000
STATE FUNDS	-$711,404,400	-$712,018,900
FEDERAL FUNDS	-$1,490,416,600	-$1,427,625,100

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 State Medi-Cal Drug Discount Program and OBRA 1990 allow the Department to obtain price discounts for drugs.

Retroactive adjustments will be made for the Affordable Care Act (ACA) optional rebates. See the Drug Rebates — Retroactive ACA Adjustments policy change for more information.

Reason for Change:
The change from the prior estimate, for FY 2016-17 and FY 2017-18, is 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 July 2016 through December 2016 which were higher than previously estimated;
- Increased ACA optional, ACA offset, and Title XXI rebates based on data through December 2016; and
- Decreased fee-for-service (FFS) pharmacy expenditures related to the periods used to project the estimated rebates.

FEDERAL DRUG REBATE PROGRAM

REGULAR POLICY CHANGE NUMBER: 62

The change from FY 2016-17 to FY 2017-18, in the current estimate, is a decrease due to projecting a decline for FY 2017-18 federal drug rebates based on the decreased pharmacy expenditures that were applied to the FY 2017-18 projections. In addition, the FY 2016-17 collections are estimated to be higher than FY 2017-18 based the inclusion of the actual collections from the October 2016 to December 2016 quarter which were higher than the projected average quarterly federal rebate collections.

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 expenditures are estimated to be $121,065,000 TF in FY 2016-17 and $93,015,000 TF in FY 2017-18. Beginning October 2015, these rebates are funded at 88% FF / 12% GF.

4. The optional expansion ACA population collections are estimated to be $570,519,000 TF for FY 2016-17 at 100% FF and $598,406,000 TF for FY 2017-18, funded at 95% FF / 5% GF.

5. The ongoing additional FF claimed by CMS (ACA Offset) is fully reflected in this policy change. The additional FF is $115,591,000 TF for FY 2016-17 and $105,371,000 TF for FY 2017-18.

(Dollars in Thousands)

FY 2016-17	TF	GF	FF
50% Title XIX / 50% GF	($1,393,530)	($696,765)	($696,765)
100% ACA Title XIX FF	($570,519)	$0	($570,519)
90% Title XIX / 10% GF	($1,116)	($112)	($1,004)
ACA Offset	($115,591)	$0	($115,591)
88% Title XXI / 12 % GF	($121,065)	($14,528)	($106,537)
Total	**($2,201,821)**	**($711,405)**	**($1,490,416)**

(Dollars in Thousands)

FY 2017-18	TF	GF	FF
50% Title XIX / 50% GF	($1,341,629)	($670,814)	($670,815)
95% Title XIX/ 5% GF	($598,406)	($29,920)	($568,486)
90% Title XIX / 10% GF	($1,223)	($123)	($1,100)
ACA Offset	($105,371)	$0	($105,371)
88% Title XXI / 12 % GF	($93,015)	($11,162)	($81,853)
Total	**($2,139,644)**	**($712,019)**	**($1,427,625)**

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)
100% ACA Title XIX FFP (4260-101-0890)
95% ACA Title XIX FF / 5% 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:	64
IMPLEMENTATION DATE:	4/2017
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	2012

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$21,503,000	$580,548,000
- STATE FUNDS	$4,162,000	$124,364,740
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$21,503,000	$580,548,000
STATE FUNDS	$4,162,000	$124,364,740
FEDERAL FUNDS	$17,341,000	$456,183,260

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: 64

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 65% and 88%. ACA Optional population is eligible for Title XIX federal reimbursement at 100% until December 2016, 95% beginning January 2017, and 94% beginning January 2018.

Reason for Change:
This change from the prior estimate, for FY 2016-17 and FY 2017-18, is due to the following:
- Updated county implementation schedule – The prior estimate assumed 16 counties to implement the DMC-ODS, six counties in FY 2016-17 and ten counties in FY 2017-18. The current estimate assumes seven counties to implement the waiver in FY 2016-17, and nine counties in FY 2017-18.
- System change delays – Payments to counties were delayed to April 2017.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

REGULAR POLICY CHANGE NUMBER: 64

- Updated approved county rates – The current estimate includes approved rates for three additional counties, for a total eight counties with approved rates.
  - FY 2016-17 – Riverside County's rates were revised and are significantly higher than previously estimated. As a result, the total cost for FY 2016-17 is slightly higher than the previous estimate.
  - FY 2017-18 – Los Angeles County's rates were revised and significantly lower than previously estimated. The projected annual cost for the remaining counties have decreased, and as a result, the total cost for FY 2017-18 have decreased significantly from the previous estimate.

The change in the current estimate, from FY 2016-17 to FY 2017-18, is primarily due to additional counties implementing the optional DMC-ODS waiver services in FY 2017-18 on a phase-in basis.

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. DMC-ODS waiver services for opt-in counties are assumed to begin in February 2017 on a phase-in basis. County implementation is expected to phase-in as follows:
   - Seven counties (San Mateo, Santa Cruz, Riverside, Santa Clara, Marin, San Francisco and Contra Costa) will begin providing services in FY 2016-17.
   - Nine additional counties (for a total of 16 counties) will begin providing services in FY 2017-18.

2. 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.

3. Of the nonfederal share for this policy change in 2017-18, $97.289 million in new growth as compared to the 2016 Budget Act will be funded with Proposition 56 revenue.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

REGULAR POLICY CHANGE NUMBER: 64

DMC-ODS Waiver Costs

4. Costs for the new DMC-ODS waiver services are estimated to be:

New Waiver Services	FY 2016-17		FY 2017-18	
Required	Accrual	Cash	Accrual	Cash
Recovery Services	$3,140,000	$1,239,000	$56,551,000	$47,731,000
Case Mgmt	$4,116,000	$1,790,000	$48,019,000	$41,242,000
Physician Consult.	$342,000	$185,000	$8,182,000	$6,789,000
WM 1.0, 2.0, 3.2	$1,388,000	$583,000	$20,504,000	$17,421,000
MAT Expansion	$1,277,000	$494,000	$11,516,000	$10,324,000
Subtotal	$10,263,000	$4,291,000	$144,772,000	$123,507,000
Optional				
Partial Hospitalization	$269,000	$91,000	$1,379,000	$1,249,000
Additional MAT	$1,089,000	$443,000	$3,466,000	$3,143,000
Subtotal	$1,358,000	$534,000	$4,845,000	$4,392,000
	$11,621,000	$4,825,000	$149,617,000	$127,899,000

5. Costs for the existing modalities for the DMC-ODS waiver services are estimated to be:

Services	FY 2016-17		FY 2017-18	
Existing Modalities	Accrual	Cash	Accrual	Cash
IOT	$15,347,000	$8,909,000	$159,947,000	$136,062,000
RTS 3.1, 3.3, 3.5	$13,041,000	$5,807,000	$333,639,000	$277,622,000
NTP	$7,026,000	$2,425,000	$112,675,000	$95,317,000
ODF	$11,223,000	$5,625,000	$153,395,000	$129,912,000
Subtotal	$46,637,000	$22,766,000	$759,656,000	$638,913,000

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.

Services	Cost In Base	
Existing Modalities	FY 2016-17	FY 2017-18
IOT	$326,000	$6,552,000
RTS 3.1, 3.3, 3.5	$13,000	$201,000
NTP	$2,264,000	$91,856,000
ODF	$483,000	$11,476,000
Total	$3,086,000	$110,085,000

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

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FY 2016-17	DMC Waiver - Cash Estimate	Less: Cost in Base	Cash Basis Adjustment
IOT	$8,909,000	$326,000	$8,583,000
RTS 3.1, 3.3, 3.5	$5,807,000	$13,000	$5,794,000
NTP	$2,425,000	$2,264,000	$161,000
ODF	$5,625,000	$483,000	$5,142,000
Total	$22,766,000	$3,086,000	$19,680,000
FY 2017-18			
IOT	$136,062,000	$6,552,000	$129,510,000
RTS 3.1, 3.3, 3.5	$277,622,000	$201,000	$277,421,000
NTP	$95,317,000	$91,856,000	$3,461,000
ODF	$129,912,000	$11,476,000	$118,436,000
Total	$638,913,000	$110,085,000	$528,828,000

Net DMC-ODS Waiver Costs

7. Total net cost for the DMC-ODS waiver services are:

DMC-ODS Waiver Net Cost	FY 2016-17	FY 2017-18
Required Services	$4,291,000	$123,507,000
Optional Services	$534,000	$4,392,000
Existing Services	$19,680,000	$528,828,000
Total	$24,505,000	$656,727,000

FY 2016-17	TF	SF	FFP Title XIX	FFP Title XXI	CF
Regular					
Current	$13,611,000	$3,949,000	$6,750,000	$98,000	$2,814,000
ACA Optional	$10,545,000	$211,000	$10,282,000	$0	$52,000
Perinatal					
Current	$275,000	$0	$135,000	$4,000	$136,000
ACA Optional	$74,000	$2,000	$72,000	$0	$0
Total	$24,505,000	**$4,162,000**	**$17,239,000**	**$102,000**	$3,002,000

FY 2017-18	TF	SF	FFP Title XIX	FFP Title XXI	CF
Regular					
Current	$364,747,000	$111,760,000	$180,891,000	$2,610,000	$69,486,000
ACA Optional	$282,617,000	$12,497,000	$267,071,000	$0	$3,049,000
Perinatal					
Current	$7,381,000	$0	$3,629,000	$108,000	$3,644,000
ACA Optional	$1,982,000	$108,000	$1,874,000	$0	$0
Total	$656,727,000	**$124,365,000**	**$453,465,000**	**$2,718,000**	$76,179,000

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

REGULAR POLICY CHANGE NUMBER: 64

Funding:

FY 2016-17	TF	SF	FFP	CF
50% Title XIX / 50% SF (4260-101-0001/0890)	$7,882,000	$3,941,000	$3,941,000	$0
100% Title XIX FF (4260-101-0890)	$5,887,000	$0	$2,944,000	$2,943,000
100% Title XXI FF (4260-113-0890)	$52,000	$0	$45,000	$7,000
88% Title XXI FF / 12% SF (4260-113-0001/0890)	$65,000	$8,000	$57,000	$0
100% ACA Title XIX FF (4260-101-0890)	$6,355,000	$0	$6,303,000	$52,000
95% ACA Title XIX FF / 5% SF (4260-101-0001/0890)	$4,264,000	$213,000	$4,051,000	$0
Total	$24,505,000	**$4,162,000**	**$17,341,000**	$3,002,000

FY 2017-18	TF	SF	FFP	CF
50% Title XIX / 50% SF (4260-101-0001/0890)	$28,506,000	$14,253,000	$14,253,000	$0
100% Title XIX FF (4260-101-0890)	$243,245,000	$0	$170,267,000	$72,978,000
100% Title XXI FF (4260-113-0890)	$1,269,000	$0	$1,117,000	$152,000
88% Title XXI FF / 12% SF (4260-113-0001/0890)	$1,819,000	$218,000	$1,601,000	$0
100% ACA Title XIX FF (4260-101-0890)	$55,427,000	$0	$52,378,000	$3,049,000
95% ACA Title XIX FF / 5% SF (4260-101-0001/0890)	$114,586,000	$5,730,000	$108,856,000	$0
94% ACA Title XIX FF / 6% SF (4260-101-0001/0890)	$114,586,000	$6,875,000	$107,711,000	$0
Healthcare Treatment Fund (4260-101-3305)	$97,289,000	$97,289,000	$0	$0
Total	$656,727,000	**$124,365,000**	**$456,183,000**	$76,179,000

DRUG MEDI-CAL PROGRAM COST SETTLEMENT

REGULAR POLICY CHANGE NUMBER:	67
IMPLEMENTATION DATE:	1/2013
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1723

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$2,999,000	$0
- STATE FUNDS	$34,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,999,000	$0
STATE FUNDS	$34,000	$0
FEDERAL FUNDS	$2,965,000	$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: 67

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 2016-17, is due to updated final cost settlements for FY 2013-14 which include General Fund (GF) cost settlements for the Affordable Care Act (ACA) optional population. There is no change from the prior estimate for FY 2017-18.

The change from FY 2016-17 to FY 2017-18 in the current estimate, is due to no costs allocated to FY 2017-18.

Methodology:
1. The annual cost settlement is based on a reconciliation of the provider's cost report against the actual expenditures paid by the Department.

2. Final cost settlements are based on comparing actual expenditures against the audited cost reports. If an audit is not conducted within three years of the interim cost settlement, the interim cost settlement becomes the final cost settlement.

3. The FY 2013-14 annual cost settlement will be paid in FY 2016-17.

FY 2013-14 Settlements	TF	FF	GF
Total for FY 2016-17	$2,999,000	$2,965,000	$34,000

Funding:
100% Title XIX (4260-101-0890)
100% GF (4260-101-0001)

DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER:	69
IMPLEMENTATION DATE:	7/2017
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1724

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	$14,189,000
- STATE FUNDS	$0	$536,900
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$14,189,000
STATE FUNDS	$0	$536,900
FEDERAL FUNDS	$0	$13,652,100

DESCRIPTION

Purpose:
This policy change budgets the annual rate adjustment to the Drug Medi-Cal (DMC) rates.

Authority:
Welfare & Institutions Code 14021.51; 14021.6(b)(1); 14021.9(c); and 14105(a)
Title 22, California Code of Regulations, Section 51516.1(a)(g)

Interdependent Policy Changes:
Not Applicable

Background:
Annually, the Department adjusts the DMC rates based on the cumulative growth in the Implicit Price (CIP) Deflator for the Costs of Goods and Services to Governmental Agencies reported by the Department of Finance. The proposed DMC rates are based either on the developed rates for use in FY 2017-18 or the FY 2009-10 Budget Act rates adjusted for the CIP deflator, whichever is lower.

The following DMC rates are adjusted each year:

- Narcotic Treatment Program (NTP) – Dosing
- NTP - Individual Counseling
- NTP - Group Counseling
- Intensive Outpatient Treatment Service (IOTS)
- Naltrexone Treatment Service
- Residential Treatment Service (RTS)
- Outpatient Drug Free (ODF) Treatment Service - Individual Counseling
- ODF- Group Counseling

DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 69

Reason for Change:
This is a new policy change.

FY 2016-17 rates are reflected in the Drug Medi-Cal base estimate. FY 2017-18 rates were adjusted to the lesser of the developed rates or the FY 2009-10 Budget Act rates adjusted for the CIP deflator.

Methodology:
1. The CIP deflator used in the proposed FY 2017-18 DMC rate is based on FY 2009-10 rates adjusted by the CIP deflator. For FY 2017-18, the adjusted rate is 15.6%. This is comprised of:
    - 13.2% for the change from FY 2009-10 to FY 2016-17, and
    - 2.4% for the change from FY 2016-17 to FY 2017-18.

Regular Services	FY 2009-10 UOS Rate	CIP Deflator	FY 2017-18 Rates	FY 2017-18 Developed Rates	FY 2017-18 Required Rates
NTP-Dosing	$11.34	15.60%	$13.11	$13.58	$13.11
NTP-Individual	$13.30	15.60%	$15.37	$17.97	$15.37
NTP- Group	$3.14	15.60%	$3.63	$3.43	$3.43
IOTS	$61.05	15.60%	$70.57	$58.53	$58.53
Naltrexone	$19.07	15.60%	$22.04	$19.06	$19.06
ODF-Individual	$66.53	15.60%	$76.91	$89.87	$76.91
ODF-Group	$28.27	15.60%	$32.68	$30.89	$30.89

Perinatal Services	FY 2009-10 UOS Rate	CIP Deflator	FY 2017-18 Rates	FY 2017-18 Developed Rates	FY 2017-18 Required Rates
NTP-Dosing	$12.21	15.60%	$14.11	$21.42	$14.11
NTP-Individual	$19.04	15.60%	$22.01	$16.39	$16.39
NTP- Group	$6.36	15.60%	$7.35	$4.28	$4.28
IOTS	$73.04	15.60%	$84.43	$94.92	$84.43
RTS	$89.90	15.60%	$103.92	$90.14	$90.14
ODF-Individual	$95.23	15.60%	$110.09	$81.93	$81.93
ODF-Group	$57.26	15.60%	$66.19	$38.56	$38.56

2. The incremental difference between FY 2016-17 required rates and FY 2017-18 required rates are:

Regular Services	FY 2016-17 Required Rates	FY 2017-18 Required Rates	Incremental Difference
NTP-Dosing	$11.95	$13.11	$1.16
NTP- Individual	$13.90	$15.37	$1.47
NTP-Group	$3.05	$3.43	$0.38
Intensive Outpatient	$59.13	$58.53	($0.60)
Naltrexone	$19.06	$19.06	$0.00
ODF-Individual	$69.50	$76.91	$7.41
ODF-Group	$27.46	$30.89	$3.43

DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 69

Perinatal Services	FY 2016-17 Required Rates	FY 2017-18 Required Rates	Incremental Difference
NTP-Dosing	$13.80	$14.11	$0.31
NTP-Individual	$18.43	$16.39	($2.04)
NTP-Group	$6.07	$4.28	($1.79)
Intensive Outpatient	$82.54	$84.43	$1.89
Residential Treatment	$80.92	$90.14	$9.22
ODF-Individual	$92.13	$81.93	($10.20)
ODF-Group	$54.63	$38.56	($16.07)

3. The cost estimate is developed using the following formula:

   Caseload x Units of Service (UOS) x Rates

4. The incremental rate change on an accrual basis is shown below:

Regular	
Narcotic Treatment	$20,663,000
Intensive Outpatient	($92,000)
Outpatient Drug Free	$3,414,000
Naltrexone	$0
Total for Regular	$23,985,000

Perinatal	
Narcotic Treatment	($14,000)
Intensive Outpatient	$15,000
Outpatient Drug Free	($108,000)
Residential Treatment	$227,000
Total for Perinatal	$120,000

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

	Accrual	FY 2017-18	FY 2018-19
Regular	$23,985,000	$17,989,000	$5,996,000
Perinatal	$120,000	$90,000	$30,000
Total	$24,105,000	$18,079,000	$6,026,000

DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 69

6. The annual rate adjustment for FY 2017-18 is:

FY 2017-18	TF	GF	FF (Title XIX)	FF (Title XXI)	County
Regular					
Current	$8,112,000	($9,000)	$3,749,000	$504,000	$3,868,000
ACA Optional	$9,879,000	$543,000	$9,336,000	$0	$0
Perinatal					
Current	$44,000	$0	$22,000	$0	$22,000
ACA Optional	$44,000	$3,000	$41,000	$0	$0
Total	$18,079,000	**$537,000**	**$13,148,000**	**$504,000**	$3,890,000

Funding:
100% Title XIX FF (4260-101-0890)
100% Title XXI FF (4260-113-0890)
88% Title XXI FF / 12% GF (4260-113-001/0890)
95% ACA Title XIX FF / 5% GF (4260-101-001/0890)
94% ACA Title XIX FF / 6% GF (4260-101-001/0890)

SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER:	72
IMPLEMENTATION DATE:	7/2017
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1458

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	$253,505,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$253,505,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$253,505,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental reimbursement based on certified public expenditures for Specialty Mental Health Services (SMHS).

Authority:
ABX4 5 (Chapter 5, Statutes of 2009)
Welfare & Institution Code 14723
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 State Plan Amendment (SPA) 09-004 and Certified Public Expenditure Protocol.

Reason for Change:
The change from the prior estimate, for FY 2016-17, is a decrease due to shifting all FY 2008-09, FY 2009-10, and FY 2010-11 payments for to be paid in FY 2017-18.

The change from the prior estimate, for FY 2017-18, is an increase due to:

- Updating the estimate for FY 2008-09, FY 2010-11, and FY 2011-12 claim payments based on final costs from additional counties, and
- Shifting FY 2008-09, FY 2009-10, and FY 2010-11 payments from FY 2016-17.

SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 72

The change, between FY 2016-17 and FY 2017-18, in the current estimate, is due to shifting all payments to occur in FY 2017-18.

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 48 counties and estimated amounts for the remaining ten 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	$89,679	$81,778	$7,901
FY 2011-12	$83,740	$83,740	$0
Total	**$253,505**	**$239,676**	**$13,829**

Funding:

100% Title XIX FF (4260-101-0890)

MHP COSTS FOR CONTINUUM OF CARE REFORM

REGULAR POLICY CHANGE NUMBER:	73
IMPLEMENTATION DATE:	1/2017
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1957

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	**$7,539,000**	$23,308,000
- STATE FUNDS	**$4,527,000**	$12,423,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	**$7,539,000**	$23,308,000
STATE FUNDS	**$4,527,000**	$12,423,500
FEDERAL FUNDS	**$3,012,000**	$10,884,500

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 specialty mental health services.

MHP COSTS FOR CONTINUUM OF CARE REFORM

REGULAR POLICY CHANGE NUMBER: 73

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 both FY 2016-17 and FY 2017-18, is due to revising the caseload figures to reflect CDSS county workload for CFT.

The change from FY 2016-17 and FY 2017-18, in the current estimate, is due to:

- Updated CDSS caseload assumptions, and
- Updated federal discount percentage applied to training costs in FY 2017-18.

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 60% of Medi-Cal EPSDT eligible children with an open child welfare case will need SMHS. Of the 60%, 10,197 are assumed to be open child welfare cases and currently receiving a CFT.

Caseload	60%	Less: Current Cases	CFT Cases	Hours per Year
Tier 1	1,986	655	1,331	12
Tier 2	3,906	1,288	2,618	10
Tier 3	10,942	3,608	7,334	8
Tier 4	11,986	3,952	8,034	4
Tier 5	2,103	694	1,409	4
Total	30,923	10,197	20,726	

3. Based on filed cost reports for mental health services, the average cost for treatment planning is $3.77 per minute, or $226.20 per hour, for mental health staff to participate in the CFT.

   The estimated cost for participation in a child and family team for 6 months in FY 2016-17 is:

(Rounded)

Caseload	CFT Cases	Cost per Hour	Hours	Cost
Tier 1	1,331	$226.20	6	$1,806,000
Tier 2	2,618	$226.20	6	$3,553,000
Tier 3	7,334	$226.20	4	$6,636,000
Tier 4	8,034	$226.20	2	$3,635,000
Tier 5	1,409	$226.20	2	$637,000
Total	20,726			$16,267,000

MHP COSTS FOR CONTINUUM OF CARE REFORM

REGULAR POLICY CHANGE NUMBER: 73

The estimated cost for participation in a child and family team in FY 2017-18 is:

(Rounded)

Caseload	CFT Cases	Cost per Hour	Hours	Cost
Tier 1	1,331	$226.20	12	$3,613,000
Tier 2	2,618	$226.20	10	$5,922,000
Tier 3	7,334	$226.20	8	$13,271,000
Tier 4	8,034	$226.20	4	$7,269,000
Tier 5	1,409	$226.20	4	$1,275,000
Total	20,726			$31,350,000

Placement Assessments

1. Based on CDSS' estimated number of children currently in a rate classification level (RCL) 10 to 12 residential group homes, assume 16 children would transition to an STRTP in FY 2016-17, and 220 children would transition to an STRTP in FY 2017-18.

2. Assume these children and youth would need to be assessed by county mental health 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.

   FY 2016-17: 16 x $226.20 x 4 = $14,477
   FY 2017-18: 220 x $226.20 x 4 = $199,056

Training

1. CDSS is requesting funds through Federal Title IV-E authority to provide counties with CCR training. The total mental health staff training request is $3,000,000 to be paid at 75% FMAP, and discounted to 66% for FY 2016-17 and 65% for FY 2017-18, 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 2016-17: Federal Share: $3,000,000 x 0.75 x 0.66 = $1,485,000
   GF Match: $3,000,000 x (1 – (0.75 x 0.66)) = $1,515,000

   FY 2017-18*: Federal Share: $3,000,000 x 0.75 x 0.65 = $1,461,000
   GF Match: $3,000,000 x (1 – (0.75 x 0.65)) = $1,539,000

   *Amounts may differ due to rounding

MHP COSTS FOR CONTINUUM OF CARE REFORM

REGULAR POLICY CHANGE NUMBER: 73

Cash Basis Summary

Based on Short Doyle/Medi-Cal paid claims data, the Department will pay 37% of current year claims in the year the services occur and 62% in the following year and 1% in the third year. There is no lag in payment for training costs.

(Dollars in Thousands)

FY 2016-17	TF	GF	FF
CFT	$6,019	$3,010	$3,009
Placement Assessments	$5	$2	$3
Training	$1,515	$1,515	$0
Total	**$7,539**	**$4,527**	**$3,012**

(Dollars in Thousands)

FY 2017-18	TF	GF	FF
CFT	$21,686	$10,843	$10,843
Placement Assessments	$83	$41	$42
Training	$1,539	$1,539	$0
Total	**$23,308**	**$12,423**	**$10,885**

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)
100% GF (4260-101-0001)

PATHWAYS TO WELL-BEING

REGULAR POLICY CHANGE NUMBER:	74
IMPLEMENTATION DATE:	1/2013
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1718

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	**$5,650,000**	$17,201,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	**$5,650,000**	$17,201,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	**$5,650,000**	$17,201,000

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 no longer 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: 74

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 October 2017. 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 2016-17 and FY 2017-18, shifts the costs for TFC, from January 2017 to October 2017 due to a delay in the completion of changes to the claiming system. In addition, a portion of the IHBS and ICC costs have been removed from the estimate as these costs are now captured in the SMHS base policy change.

The change between FY 2016-17 and FY 2017-18 is due to the annual estimated cost for TFC.

Methodology:
1. The Pathways to Well-Being 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 $18,574,000 on an accrual basis. Assume 22% 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 October 1, 2017. Assume costs for TFC services rendered in January 1, 2017 through September 30, 2017 will be paid in FY 2017-18.

4. On an accrual basis, the FY 2016-17 and FY 2017-18 estimated costs are:

(Dollars in Thousands)

Fiscal Year	IHBS and ICC Accrual	TFC Accrual	Total Accrual
2016-17	$18,574	$7,866	**$26,440**
2017-18	$18,574	$15,732	**$34,306**

5. Based on historical claims received, assume 78% of each fiscal year claims will be paid in the year

PATHWAYS TO WELL-BEING

REGULAR POLICY CHANGE NUMBER: 74

the services occur, 21% 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
FY 2016-17	IHBS & ICC	$18,574	0.78	$14,488
Less: % in Base (22%)	IHBS & ICC			($3,188)
Total 2016-17 Cash Estimate				$11,300

(Dollars in Thousands)

Fiscal Year	Service	Total Accrual	Payment Lag	Cash Estimate TF
FY 2016-17	IHBS & ICC	$18,574	0.21	$3,901
Less: % in Base (22%)	IHBS & ICC			($858)
Subtotal				$3,042
FY 2017-18	IHBS & ICC	$18,574	0.78	$14,488
Less: % in Base (22%)	IHBS & ICC			($3,187)
Subtotal				$11,300
FY 2016-17	TFC	$7,866	0.99	$7,787
FY 2017-18	TFC	$15,732	0.78	$12,271
Subtotal				$20,058
Total 2017-18 Cash Estimate				$34,401

(Dollars in Thousands)

Fiscal Year	TF	FF	CF
FY 2016-17	$11,300	**$5,650**	$5,650
FY 2017-18	$34,401	**$17,201**	$17,200

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

LATE CLAIMS FOR SMHS

REGULAR POLICY CHANGE NUMBER:	75
IMPLEMENTATION DATE:	7/2016
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1717

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$24,000	$4,000
- STATE FUNDS	$0	$4,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$24,000	$4,000
STATE FUNDS	$0	$4,000
FEDERAL FUNDS	$24,000	$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:
The change from the prior estimate, for FY 2016-17, is an increase in total funds based on actual payments made to the counties. However, federal funds were available for these payments that were not past the two-year claiming limit and General Funds (GF) were not paid in FY 2016-17.

The change from the prior estimate, for FY 2017-18, decreased due to the payment methodology being revised. Prior to this estimate all late claims were included in the budget. In this estimate, only the late claims that have been adjudicated for payment are budgeted. Only one payment has been adjudicated for payment in FY 2017-18.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is based on claim amounts submitted by counties and finalized for payment.

LATE CLAIMS FOR SMHS

REGULAR POLICY CHANGE NUMBER: 75

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	FF	CF
FY 2016-17	$48,000	**$0**	**$24,000**	$24,000
FY 2017-18	$8,000	**$4,000**	**$0**	$4,000

Funding:

100% Title XIX FFP (4260-101-0890)
100% GF (4260-101-0001)

SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT

REGULAR POLICY CHANGE NUMBER:	76
IMPLEMENTATION DATE:	1/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1660

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	-$315,000	$0
- STATE FUNDS	$270,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$315,000	$0
STATE FUNDS	$270,000	$0
FEDERAL FUNDS	-$585,000	$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 has submitted five payments totaling $1,000,000.

Reason for Change:
The change from the prior estimate, for FY 2016-17, is due to a $315,000 repayment to CMS being recouped and repaid with County Funds, not General Funds (as previously budgeted). There is no change, from the prior estimate, for FY 2017-18.

The change from FY 2016-17 and FY 2017-18, in the current estimate, is due to no CMS repayments scheduled to be paid in FY 2017-18 but continuing to budget the annual County reimbursement.

SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT

REGULAR POLICY CHANGE NUMBER: 76

Methodology:

1. The Department began making repayments to CMS in January 2012 and has repaid CMS overpayments discovered during cost settlements for FY 2006-07 through FY 2010-11 and audit settlements for FY 2005-06 through FY 2010-11.

2. In FY 2016-17, a repayment amount of $315,000 was recouped from the county and repaid to CMS as a result of FY 2009-10 audit findings.

3. Siskiyou County will reimburse the GF $200,000 annually. The total FF repayment due from the County totals $11,268,000. The Department will continue to repay CMS for overpayments. The Department will pay, from the GF, $270,000 in FY 2016-17.

Date of Overpayment Discovery	Due to DHCS	Paid to CMS	FY 2016-17 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	$0	$270,000
4/4/2016	$315,000	$315,000	$315,000
Total	$11,268,000	$10,998,000	$585,000

4. The estimate for FY 2016-17 and FY 2017-18 is as follows:

Fiscal Year	TF	GF	FF	CF*	Reimbursement
FY 2009-10 Audit Finding	($315,000)	$0	($315,000)	$315,000	$0
FY 2016-17 Cost Settlement	$0	$70,000	($270,000)	$0	$200,000
Total for FY 2016-17	**($315,000)**	**$70,000**	**($585,000)**	$315,000	**$200,000**

Fiscal Year	TF	GF	FF	Reimbursement
Total for FY 2017-18	**$0**	**($200,000)**	**$0**	**$200,000**

*County Funds are not included in the total.

Funding:

100% GF (4260-101-0001)
100% Title XIX FF (4260-101-0890)
Reimbursement GF (4260-610-0995)

IMD ANCILLARY SERVICES

REGULAR POLICY CHANGE NUMBER:	77
IMPLEMENTATION DATE:	4/2017
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	35

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$26,632,000	$29,565,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$26,632,000	$29,565,000
FEDERAL FUNDS	-$26,632,000	-$29,565,000

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: 77

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 2016-17 is an increase due to:
- Resolving IMD deferrals for service periods from October 2010 to March 2015 in FY 2016-17.
- Updated IMD FFS repayments based on actual data for dates of service from State Fiscal Year (SFY) 2010-11 Q2 through SFY 2014-15 Q3.

The change from the prior estimate, for FY 2017-18, is an increase due to:
- Resolving IMD FFS deferral repayments for FY 2012-13 Q3 and services periods from April 2015 to June 2016 based on actual data.
- Including FY 2015-16 managed care repayments in FY 2017-18.

The difference in the current estimate, between FY 2016-17 and FY 2017-18, is an increase due to including quarterly IMD deferral repayment amounts and managed care repayments 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 2016-17, the Department will repay FFS IMD deferrals for service periods from October 2010 to March 2015. In FY 2017-18, the Department estimates to repay FFS IMD deferrals through June 2016 and managed care repayments from FY 2011-12 through FY 2015-16.

3. Beginning with the October 2014 to December 2014 quarter (Federal Fiscal Year 2015, Quarter 1), for claims that have been deferred, CMS will require the Department to repay the federal funds while the deferral is being resolved.

IMD ANCILLARY SERVICES

REGULAR POLICY CHANGE NUMBER: 77

4. The estimated IMD repayments are:

(Dollars in Thousands)

FY 2016-17	TF	GF	FF
Fee-For-Service			
FY 2010-11 Q2 (Oct to Dec 10)	$0	$1,597	($1,597)
FY 2010-11 Q3 (Jan to Mar 11)	$0	$1,584	($1,584)
FY 2010-11 Q4 (Apr to Jun 11)	$0	$1,553	($1,553)
Subtotal FY 2010-11	$0	$4,734	($4,734)
FY 2011-12 Q1 (Jul to Sep 11)	$0	$1,260	($1,260)
FY 2011-12 Q2 (Oct to Dec 11)	$0	$1,337	($1,337)
FY 2011-12 Q3 (Jan to Mar 12)	$0	$1,589	($1,589)
FY 2011-12 Q4 (Apr to Jun 12)	$0	$1,688	($1,688)
Subtotal FY 2011-12	$0	$5,874	($5,874)
FY 2012-13 Q1 (Jul to Sep 12)	$0	$2,183	($2,183)
FY 2012-13 Q2 (Oct to Dec 12)	$0	$1,804	($1,804)
FY 2012-13 Q4 (Apr to Jun 13)	$0	$1,274	($1,274)
Subtotal FY 2012-13	$0	$5,261	($5,261)
FY 2013-14 Q1 (Jul to Sep 13)	$0	$759	($759)
FY 2013-14 Q2 (Oct to Dec 13)	$0	$609	($609)
FY 2013-14 Q3 (Jan to Mar 14)	$0	$559	($559)
FY 2013-14 Q4 (Apr to Jun 14)	$0	$161	($161)
Subtotal FY 2013-14	$0	$2,088	($2,088)
FY 2014-15 Q1 (Jul to Sep 14)	$0	$2,103	($2,103)
FY 2014-15 Q2 (Oct to Dec 14) *	$0	$3,141	($3,141)
FY 2014-15 Q3 (Jan to Mar 15) *	$0	$3,431	($3,431)
Subtotal FY 2014-15	$0	$8,675	($8,675)
Total FY 2016-17	**$0**	**$26,632**	**($26,632)**

*Deferrals for service periods from October 2014 to March 2015 will be paid by the required timelines in FY 2016-17.

IMD ANCILLARY SERVICES

REGULAR POLICY CHANGE NUMBER: 77

(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 2014-15 Q4 (Apr to Jun 15) **	$0	$4,351	($4,351)
FY 2015-16 Q1 (Jul to Sep 15) **	$0	$1,060	($1,060)
FY 2015-16 Q2 (Oct to Dec 15) **	$0	$1,045	($1,045)
FY 2015-16 Q3 (Jan to Mar 16) **	$0	$1,232	($1,232)
FY 2015-16 Q4 (Apr to Jun 16) **	$0	$2,569	($2,569)
Subtotal FY 2015-16	$0	$5,906	($5,906)
Subtotal FFS	$0	$11,900	($11,900)
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**	**$29,565**	**($29,565)**

**Deferrals for service periods from April 2015 to June 2016 are estimated to be paid by the required timelines in FY 2017-18.

Funding:
100% General Fund (4260-101-0001)
Title XIX FFP (4260-101-0890)

CHART REVIEW

REGULAR POLICY CHANGE NUMBER:	78
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1714

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	-$1,869,000	-$1,485,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,869,000	-$1,485,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$1,869,000	-$1,485,000

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 for FY 2016-17, from the prior estimate, is based on an increase of estimated recoupments from the FY 2015-16 inpatient and outpatient chart reviews.

The change for FY 2017-18, from the prior estimate, is based on an decrease of estimated recoupments from the FY 2016-17 outpatient chart reviews.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is based on fewer estimated inpatient review recoupments in FY 2017-18.

Methodology:
1. The FY 2016-17 estimate includes recoupments from chart reviews conducted in FY 2014-15 and estimated amounts for FY 2015-16.

CHART REVIEW

REGULAR POLICY CHANGE NUMBER: 78

2. The FY 2017-18 estimate includes estimated recoupments from chart reviews to be conducted in FY 2016-17 and FY 2017-18.

(Dollars in Thousands)

Fiscal Year	TF	FF
FY 2016-17	($1,869)	($1,869)
FY 2017-18	($1,485)	($1,485)

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

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER:	79
IMPLEMENTATION DATE:	7/2015
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1713

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	-$59,037,000	$20,758,000
- STATE FUNDS	$2,655,000	$21,146,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$59,037,000	$20,758,000
STATE FUNDS	$2,655,000	$21,146,000
FEDERAL FUNDS	-$61,692,000	-$388,000

DESCRIPTION

Purpose:
This policy change estimates the interim and final cost settlements for specialty mental health services (SMHS).

Authority:
Welfare & Institution Code 14705(c)
Title 9, California Code of Regulations 1840.105

Interdependent Policy Changes:
Not Applicable

Background:
The Department reconciles interim payments to county cost reports for mental health plans (MHPs) for children, adults, and Healthy Families SMHS. The Department completes interim settlements within two years of the end of the fiscal year. Final settlements are completed within three years of the last amended county cost report the MHPs submit to the Department.

The reconciliation process for each fiscal year may result in an overpayment or underpayment to the county and will be handled as follows:

- For counties that have been determined to be overpaid, the Department will recoup any overpayments.
- For counties that have been determined to be underpaid, the Department will make a payment equal to the difference between the counties cost report and the Medi-Cal payments.

Reason for Change:
There is no change from the prior estimate for FY 2016-17. The change from the prior estimate, for FY 2017-18, is due to the addition of MHP cost settlements for 25 counties. The change from FY 2016-17 and FY 2017-18, in the current estimate, is due to the results of the MHP cost settlements for 26 total counties to be paid in FY 2017-18.

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 79

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 2016-17 and FY 2017-18.

(Dollars in Thousands)

Interim Settlement (FY 2006-07)	Underpaid	Overpaid	Net FF
Children and Adults	$2,396	$0	$2,396
Healthy Families*	$0	($41)	($41)
FY 2006-07 Total	$2,396	($41)	$2,355

(Dollars in Thousands)

Interim Settlement (FY 2009-10)	Underpaid	Overpaid	Net FF
Children and Adults	$422	($74)	$348
ARRA	$97	($17)	$80
BCCTP	$0	($9)	($9)
M-CHIP*	$0	($186)	($186)
Healthy Families*	$0	($151)	($151)
FY 2009-10 Total	$519	($437)	$82

(Dollars in Thousands)

Interim Settlement (FY 2010-11)	Underpaid	Overpaid	Net FF
Children and Adults	$12,554	($92,821)	($80,267)
ARRA	$14,995	$0	$14,995
BCCTP	$1	($8)	($7)
M-CHIP*	$1,233	$0	$1,233
Healthy Families*	$187	($270)	($83)
FY 2010-11 Total	$28,970	($93,099)	($64,129)

(Dollars in Thousands)

Total FY 2016-17	$31,885	($93,577)	($61,692)

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 79

(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	$0	($3,008)	($3,008)
ARRA	$0	($584)	($584)
BCCTP/Pregnancy	$601	($24)	$577
M-CHIP*	$74	$0	$74
Healthy Families*	$0	($74)	($74)
FY 2010-11 Total	$675	($3,690)	($3,015)

(Dollars in Thousands)

Interim Settlement (FY 2011-12)	Underpaid	Overpaid	Net FF
Children and Adults	$2,434	$0	$2,434
BCCTP/Pregnancy	$5	($34)	($29)
M-CHIP*	$18	$0	$18
Healthy Families*	$184	$0	$184
FY 2011-12 Total	$2,641	($34)	$2,607

(Dollars in Thousands)

Total FY 2017-18	$3,347	($3,735)	($388)

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 79

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	$1,914	$0	$1,914
2010-11	$2,564	($1,823)	$741
Total FY 2016-17	$4,478	($1,823)	$2,655

(Dollars in Thousands)

Interim Settlement	GF Underpaid	GF Overpaid	Net GF
2010-11	$22,062	($916)	$21,146
Total FY 2017-18	$22,062	($916)	$21,146

6. The net FF and GF to be paid in FY 2016-17 and FY 2017-18 is:

(Dollars in Thousands)

FY 2016-17 Summary	TF	GF	FF
Children and Adults	($74,868)	$2,655	($77,523)
ARRA	$15,075	$0	$15,075
M-CHIP*	$1,047	$0	$1,047
BCCTP	($16)	$0	($16)
Healthy Families*	($275)	$0	($275)
Total FY 2016-17	**($59,037)**	**$2,655**	**($61,692)**

(Dollars in Thousands)

FY 2017-18 Summary	TF	GF	FF
Children and Adults	$20,563	$21,146	($583)
ARRA	($586)	$0	($586)
M-CHIP*	$106	$0	$106
BCCTP	$548	$0	$548
Healthy Families*	$127	$0	$127
Total FY 2017-18	**$20,758**	**$21,146**	**($388)**

Funding:
Title XIX FFP (4260-101-0890)
Title XXI FFP (4260-113-0890)*
100% GF (4260-101-0001)

PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL

REGULAR POLICY CHANGE NUMBER:	80
IMPLEMENTATION DATE:	8/2016
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1950

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$2,622,000,000	$1,600,000,000
- STATE FUNDS	$1,311,000,000	$800,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,622,000,000	$1,600,000,000
STATE FUNDS	$1,311,000,000	$800,000,000
FEDERAL FUNDS	$1,311,000,000	$800,000,000

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 percent 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 percent by January 2019; and 60 percent 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 percent in the fourth year of the demonstration and by an additional 15 percent in the fifth year of the demonstration.

PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL

REGULAR POLICY CHANGE NUMBER: 80

Reason for Change:
The change in FY 2016-17, from the prior estimate, is due to hospitals not reaching the goals to achieve the full payment in the annual report. There is no change in FY 2017-18 from the prior estimate.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to resuming the two semi-annual report payment schedule.

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. Based on the historical semi-annual report from the Delivery System Reform Incentive Pool, assume 64% of the annual allocation is paid based on the first semi-annual report and the remaining balance is paid based on the annual report.

3. FY 2015-16 payments were delayed to FY 2016-17 based on the timing of the five-year plan approvals.

(Dollars in Thousands)

FY 2016-17	TF	IGT	FF
DY 2015-16			
DPH	$1,400,000	$700,000	$700,000
DMPH	$198,000	$99,000	$99,000
Total	$1,598,000	$799,000	$799,000
DY 2016-17			
DPH	$896,000	$448,000	$448,000
DMPH	$128,000	$64,000	$64,000
Total	$1,024,000	$512,000	$512,000
Total FY 2016-17	**$2,622,000**	**$1,311,000**	**$1,311,000**

(Dollars in Thousands)

FY 2017-18	TF	IGT	FF
DY 2016-17			
DPH	$504,000	$252,000	$252,000
DMPH	$72,000	$36,000	$36,000
Total	$576,000	$288,000	$288,000
DY 2017-18			
DPH	$896,000	$448,000	$448,000
DMPH	$128,000	$64,000	$64,000
Total	$1,024,000	$512,000	$512,000
Total FY 2017-18	**$1,600,000**	**$800,000**	**$800,000**

PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL

REGULAR POLICY CHANGE NUMBER: 80

Funding:
50% Title XIX FF (4260-101-0890)
50% Public Hospital Investment, Improvement, and Incentive Fund (4260-601-3172)

GLOBAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER:	81
IMPLEMENTATION DATE:	12/2015
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1951

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$2,218,904,000	$2,388,446,000
- STATE FUNDS	$1,109,452,000	$1,194,223,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,218,904,000	$2,388,446,000
STATE FUNDS	$1,109,452,000	$1,194,223,000
FEDERAL FUNDS	$1,109,452,000	$1,194,223,000

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 28 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: 81

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 2016-17, is a decrease due to a lower quarter four payment for PY 2015-16. The change from the prior estimate for FY 2017-18, is an increase due to the inclusion of the final reconciliation payment for PY 2015-16.

The change from FY 2016-17 to FY 2017-18, in the current estimate is due to varying DSH allotments by program year, and the inclusion of final reconciliation payment for PY 2015-16 in FY 2017-18.

Methodology:
1. FY 2015-16 assumes federal funding from the DPH portion of the 2015-16 DSH allotment of $868.2 million and Demonstration Year (DY) 2015-16 SNCP funding of $236 million.

2. FY 2016-17 assumes federal funding from the DPH portion of the 2016-17 DSH allotment of $910 million. 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 program year (PY) for the Global Payment Program is from July 1 to June 30, to align with the state fiscal year.

4. Assume payments are made on a quarterly basis. The fourth quarter payment is paid the following fiscal year.

(Dollars in Thousands)

FY 2016-17	TF	IGT	FF
PY 2015-16	$499,892	$249,946	$249,946
PY 2016-17	$1,719,012	$859,506	$859,506
Total	**$2,218,904**	**$1,109,452**	**$1,109,452**

FY 2017-18	TF	IGT	FF
PY 2015-16	$52,182	$26,091	$26,091
PY 2016-17	$573,004	$286,502	$286,502
PY 2017-18	$1,763,260	$881,630	$881,630
Total	**$2,388,446**	**$1,194,223**	**$1,194,223**

Funding:
100% Title XIX FFP (4260-101-0890)
100% Global Payment Program Special Fund (4260-601-8108)

MEDI-CAL 2020 WHOLE PERSON CARE PILOTS

REGULAR POLICY CHANGE NUMBER:	82
IMPLEMENTATION DATE:	7/2016
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1953

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$480,000,000	$720,000,000
- STATE FUNDS	$240,000,000	$360,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$480,000,000	$720,000,000
STATE FUNDS	$240,000,000	$360,000,000
FEDERAL FUNDS	$240,000,000	$360,000,000

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:

- a county,
- a city and county,
- a health or hospital authority,
- a consortium of any of the above entities,
- a Federally Recognized Tribe, or
- a Tribal Health Program

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. Pilots allow county, state, tribal, and federal entities as well as 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.

MEDI-CAL 2020 WHOLE PERSON CARE PILOTS

REGULAR POLICY CHANGE NUMBER: 82

Proposals for WPC Pilots include specific strategies to:

1. 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.

2. Increase coordination and appropriate access to care for the most vulnerable Medi-Cal beneficiaries and reduce inappropriate emergency department utilization.

3. Improve data collection and sharing amongst local entities to support ongoing case management, monitoring, and strategic program improvements.

Pilots may also focus on Housing & Supportive Services which include (but are not limited to):

1. Access to housing

2. Tenancy-based care management services

3. County Housing Pools

In 2017, the Department is conducting a second round for WPC Pilot program applications because an unallocated portion of the allowable funding remained after the first round conducted in 2016. Second round applications were due March 1, 2017. The Department will provide notice of approved applications to the second round applicants by early July 2017.

Reason for Change:
There is no change from the prior estimate for FY 2016-17 or FY 2017-18. The increase from FY 2016-17 to FY 2017-18 in the current estimate is due to a second round of WPC applicants for PY 1 which will be paid in FY 2017-18.

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 are assumed to begin in FY 2016-17 and continue through FY 2020-21.

2. Second Round Lead Entities submitted applications with annual budgets in March 2017. The Department will determine the program awards in the first quarter of FY 2017-18 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. Program years correspond to calendar years. PY 1 began January 1, 2016.

5. First round PY 1 payments are 75% in December 2016 and 25% in April 2017. Second round PY 1 payments will be 13% in September 2017 and 87% in November 2017.

6. PY 2 payments will be 29% in November 2017 and 71% in June 2018.

MEDI-CAL 2020 WHOLE PERSON CARE PILOTS

REGULAR POLICY CHANGE NUMBER: 82

(Dollars in Thousands)

	TF	IGT*	FF
FY 2016-17	$480,000	$240,000	$240,000

(Dollars in Thousands)

	TF	IGT*	FF
FY 2017-18	$720,000	$360,000	$360,000

Funding:
100% FFP Title XIX (4260-101-0890)
Whole Person Care Pilot Special Fund (4260-601-8107)

BTR - LIHP - MCE

REGULAR POLICY CHANGE NUMBER:	83
IMPLEMENTATION DATE:	7/2011
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1578

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$125,692,000	$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	$125,692,000	$198,363,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$125,692,000	$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: 83

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 from the prior estimate, for FY 2016-17, is a decrease due to the delay of the final reconciliations for the LIHP cost report counties to FY 2017-18. The change from the prior estimate, for FY 2017-18, is an increase due to the above shift in costs as well as receiving updated final costs from the counties.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to varying timelines and 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 2016-17, and the reconciliation of LIHP cost report counties occurring in FY 2017-18.

Methodology:
1. Assume the DY 2010-11 through DY 2013-14 final reconciliations for the counties that submitted invoices for payment will occur in FY 2016-17.

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 2017-18.

The estimated MCE payments on a cash basis are:

(Dollars in Thousands)

FY 2016-17	TF	FF
2010-11 (CPEs)	$33,850	$33,850
2011-12 (CPEs)	$30,640	$30,640
2012-13 (CPEs)	$30,593	$30,593
2013-14 (CPEs)	$30,609	$30,609
Total FY 2016-17	**$125,692**	**$125,692**

(Dollars in Thousands)

FY 2017-18	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 2017-18	**$198,363**	**$198,363**

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

LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND

REGULAR POLICY CHANGE NUMBER:	84
IMPLEMENTATION DATE:	7/2017
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1622

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	$232,500,000
- STATE FUNDS	$0	$116,250,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$232,500,000
STATE FUNDS	$0	$116,250,000
FEDERAL FUNDS	$0	$116,250,000

DESCRIPTION

Purpose:
This policy change estimates the funding for the Low Income Health Program (LIHP) Medicaid Coverage Expansion (MCE) Out-of-Network (OON) Emergency Care Services Fund that was created to reimburse out-of-network hospitals for providing certain services to LIHP MCE enrollees.

Authority:
SB 335 (Chapter 286, Statutes of 2011)
SB 920 (Hernandez, Statutes of 2012)
California Bridge to Reform (BTR) Section 1115(a) Medicaid Demonstration

Interdependent Policy Changes:
Not Applicable

Background:
SB 335 establishes the LIHP MCE Out-of-Network Emergency Care Services Fund, effective July 1, 2011 to December 31, 2013. Moneys shall be allocated from the fund by the Department to be matched with federal funds in accordance with the Special Terms and Conditions for the BTR. The Department shall disburse moneys from the fund to the LIHPs solely for the purposes of funding the out-of-network hospital emergency care services for emergency medical conditions and required post stabilization care provided by private hospitals that are outside the LIHP coverage network. SB 920 changes the amount transferred from the Hospital Quality Assurance Revenue Fund (HQARF) and subsequent payments. SB 920 further removes the non-designated public hospitals eligibility for this program.

Reason for Change:
The change from the prior estimate, for FY 2016-17 and FY 2017-18, is due to a shift in payments from FY 2016-17 to FY 2017-18. The change from FY 2016-17 to FY 2017-18 in the current estimate, is an increase due to ongoing negotiations with CMS for the approval of the payment methodology for the QAF III LIHP MCE OON payments.

LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND

REGULAR POLICY CHANGE NUMBER: 84

Methodology:

1. IGT funds are to be used in their entirety before HQARF funds are used.

2. SB 920 authorizes HQARF funds to be transferred to LIHP MCE Out-of-Network Emergency Care Services Fund.

3. Current HQARF collections and disbursements project that $75.6 million is available for transfer from the HQARF funds for FY 2011-12, 2012-13, and FY 2013-14. Additional funds of approximately $50 million are available for transfer from the HQAF collection withhold account.

4. HQARF transfers are estimated to be $83.7 million in FY 2017-18.

5. LIHPs will provide utilization data for FY 2011-12, FY 2012-13, and FY 2013-14 to the Department after the fiscal year. The LIHP ended on December 31, 2013. The Department will calculate the payments based on the data and make payments to the LIHPs within 60 days of completing the calculations.

6. The LIHP funds will be used to reimburse private out-of-network hospitals.

7. IGTs will be deposited into and paid from the LIHP MCE Out-of-Network Emergency Care Services Fund. IGT amounts are estimated to total $32.577 million in FY 2017-18.

(Dollars in Thousands)

FY 2017-18	LIHP	IGT	HQARF
2011-12	$28,055	$12,162	$15,893
2012-13	$44,995	$10,415	$34,580
2013-14	$43,200	$10,000	$33,200
Total FY 2017-18	$116,250	$32,577	$83,673

(Dollars in Thousands)

FY 2017-18	**TF**	**FF**	**LIHP**
2011-12	$56,110	$28,055	$28,055
2012-13	$89,990	$44,995	$44,995
2013-14	$86,400	$43,200	$43,200
Total FY 2017-18	**$232,500**	**$116,250**	**$116,250**

Funding:

50% LIHP MCE OON Emergency Care Services Fund (4260-610-3201)/
50% Title XIX FFP (4260-101-0890)

BTR - LOW INCOME HEALTH PROGRAM - HCCI

REGULAR POLICY CHANGE NUMBER:	85
IMPLEMENTATION DATE:	11/2010
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1572

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$44,037,000	$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	$44,037,000	$231,547,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$44,037,000	$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: 85

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 from the prior estimate, for FY 2016-17, is a decrease due to the delay of the final reconciliations for the LIHP cost report counties to FY 2017-18. The change from the prior estimate, for FY 2017-18, is an increase due to the above shift in costs as well as receiving updated final costs from the counties.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to varying timelines and 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 2016-17, and the reconciliation of LIHP cost report counties occurring in FY 2017-18.

Methodology:
1. Assume the DY 2010-11 through DY 2013-14 final reconciliations for the counties that submitted invoices for payment will occur in FY 2016-17.

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 2017-18.

The estimated HCCI payments on a cash basis are:

(Dollars in Thousands)

FY 2016-17	TF	FF
DY 2010-11	$14,547	$14,547
DY 2011-12	$10,426	$10,426
DY 2012-13	$11,754	$11,754
DY 2013-14	$7,310	$7,310
Total FY 2016-17	**$44,037**	**$44,037**

BTR - LOW INCOME HEALTH PROGRAM - HCCI

REGULAR POLICY CHANGE NUMBER: 85

(Dollars in Thousands)

FY 2017-18	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 2017-18	**$231,547**	**$231,547**

Funding:
Health Care Support Fund (4260-601-7503)

MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE

REGULAR POLICY CHANGE NUMBER:	86
IMPLEMENTATION DATE:	1/2017
ANALYST:	Nikaela Ratliff
FISCAL REFERENCE NUMBER:	1954

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$46,216,000	$141,905,000
- STATE FUNDS	$23,108,000	$70,952,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$46,216,000	$141,905,000
STATE FUNDS	$23,108,000	$70,952,500
FEDERAL FUNDS	$23,108,000	$70,952,500

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 the form of semi-annual incentive payments to dental provider service office locations that provide

MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE

REGULAR POLICY CHANGE NUMBER: 86

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 overall decrease from the prior estimate for FY 2016-17 is due to the implementation date of Domain 4 shifting to no sooner than April 15, 2017 as well as the updating of Domain 4 costs to reflect actual proposals from the LDPPs.

The overall increase from the prior estimate for FY 2017-18 is due to updated data trends for Domain 1 based on actuals received thus far.

The change from FY 2016-17 to FY 2017-18 in the current estimate is due to updated data showing an overall increase in expenses due to the number of expected services based on updated actuals.

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

MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE

REGULAR POLICY CHANGE NUMBER: 86

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.

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 is 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 2016-17 includes incentive payments for CY 2016 and FY 2017-18 includes incentive payments for CY 2017 and the remainder of CY 2016.

6. Based on preliminary data from the Fiscal Intermediary (FI), assume 10% of service office locations will not meet the benchmark.

7. The FQHC population is estimated as 10% of the combined FFS and DMC population.

Total Domain 1 costs are estimated to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2016-17	$21,985	$10,993	$10,993
FY 2017-18	$43,332	$21,666	$21,666

Domain 2: Caries Risk Assessment and Disease Management

8. This four year incentive program implements January 1, 2017 and will only be available for services performed on child beneficiaries six years of age and under. Assume that 40 percent 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%.

9. 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.

10. 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.

11. Payments will be made on a monthly basis starting in January 2017. Therefore, FY 2016-17 will include incentive payments for the first six months of CY 2017 and FY 2017-18 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.

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Total Domain 2 costs are estimated to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2016-17	$23,480	$11,740	$11,740
FY 2017-18	$47,254	$23,627	$23,627

Domain 3: Increase the Continuity of Care

12. The implementation date for Domain 3 is July 1, 2016; however, 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 2016.

13. 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.

14. Medi-Cal eligibles are expected to grow by 1% annually.

15. 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 85% from the previous year for year one, 75% of the previous year for year two, 65% of the previous year for year three, 55% of the previous year for year four and 45% of the previous year for year five.

16. There will be a projected 2.25% increase in exams utilization each year for newly entering Domain 3 participants.

17. 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:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2017-18	$21,318	$10,659	$10,659

Domain 4: Local Dental Pilot Program

18. The expected implementation for this domain is no sooner than April 15, 2017. Payments will be made twice a year starting in June 2017. Therefore, FY 2016-17 will include incentive payments for half of CY 2017 and FY 2017-18 will include incentive payments for half of CY 2017 and half of CY 2018.

19. Fifteen LDPPs were approved.

MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE

REGULAR POLICY CHANGE NUMBER: 86

20. 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).

21. Assume incentive payments will be reviewed, approved, and payable to selected pilots that target an identified population of Medi-Cal eligible child beneficiaries in accordance with the requirements established jointly by the Department and CMS and deemed appropriate to fulfill specific strategies linked to one or more of the domains delineated above.

    Total Domain 4 costs are estimated to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2016-17	$750	$375	$375
FY 2017-18	$30,000	$15,000	$15,000

22. On a cash basis, the FY 2016-17 and FY 2017-18 total demonstration costs are:

(Dollars in Thousands)

FY 2016-17	TF	GF	FF
Domain 1	$21,985	$10,993	$10,993
Domain 2	$23,480	$11,740	$11,740
Domain 3	$0	$0	$0
Domain 4	$750	$375	$375
Total	**$46,216**	**$23,108**	**$23,108**

FY 2017-18	TF	GF	FF
Domain 1	$43,332	$21,666	$21,666
Domain 2	$47,254	$23,627	$23,627
Domain 3	$21,318	$10,659	$10,659
Domain 4	$30,000	$15,000	$15,000
Total	**$141,905**	**$70,953**	**$70,953**

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

MH/UCD—HEALTH CARE COVERAGE INITIATIVE

REGULAR POLICY CHANGE NUMBER:	87
IMPLEMENTATION DATE:	9/2007
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1154

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	**$1,343,000**	$23,509,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	**$1,343,000**	$23,509,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	**$1,343,000**	$23,509,000

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: 87

Reason for Change:
The change from the prior estimate, for FY 2016-17, is a decrease due to the delay of the final reconciliations for the HCCI cost report counties to FY 2017-18. The change from the prior estimate, for FY 2017-18, is an increase due to the above shift in costs as well as receiving updated final costs from the counties.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due varying timelines and 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 2016-17, and the reconciliation of HCCI cost report counties occurring in FY 2017-18.

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. Reconciliation payment for DY 2007-08 under the MH/UCD HCCI for the counties that submitted invoices for payment will occur in FY 2016-17.

3. Assume DY 2007-08 through DY 2009-10 final reconciliations for the counties that submitted cost reports for payment will occur in FY 2017-18.

The estimated HCCI reconciliation payments on a cash basis are:

FY 2016-17	TF	FF
DY 2007-08	$1,343,000	$1,343,000
Total FY 2016-17	**$1,343,000**	**$1,343,000**

FY 2017-18	TF	FF
DY 2007-08	$19,272,000	$19,272,000
DY 2008-09	$698,000	$698,000
DY 2009-10	$3,539,000	$3,539,000
Total FY 2017-18	**$23,509,000**	**$23,509,000**

Funding:
Health Care Support Fund (4260-601-7503)

MH/UCD—STABILIZATION FUNDING

REGULAR POLICY CHANGE NUMBER:	88
IMPLEMENTATION DATE:	7/2006
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1153

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$33,686,000	$55,400,000
- STATE FUNDS	$33,686,000	$55,400,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$33,686,000	$55,400,000
STATE FUNDS	$33,686,000	$55,400,000
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: 88

Stabilization for NDPHs and private hospitals is calculated; however, pursuant to AB 1467, the Department redirected the stabilization funding available to the NDPHs and private hospitals that was not paid for FY 2005-06 through FY 2009-10 to the GF. This policy change budgets the stabilization payments available for DPHs and Distressed Hospitals payments.

Reason for Change:
The change in FY 2016-17, from the prior estimate, is due to updated payment amounts based on updated audited cost reports for DY 2007-08. There is no change in FY 2017-18 from the prior estimate.

The change from FY 2016-17 to FY 2017-18, 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 2007-08 final reconciliation for DPHs and Distressed Hospitals will be completed in FY 2016-17.

10. The DY 2008-09 final reconciliation for DPHs and Distressed Hospitals will be completed in FY 2017-18.

MH/UCD—STABILIZATION FUNDING

REGULAR POLICY CHANGE NUMBER: 88

The estimated stabilization payments are:

(Dollars in Thousands)

FY 2016-17	TF	GF	FF
DY 2007-08 DPHs	$33,686	$33,686	$0
Total	**$33,686**	**$33,686**	**$0**

FY 2017-18	TF	GF	FF
DY 2008-09 DPHs	$55,400	$55,400	$0
Total	**$55,400**	**$55,400**	**$0**

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

MH/UCD—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER:	89
IMPLEMENTATION DATE:	9/2005
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1072

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$7,844,000	-$6,723,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$7,844,000	-$6,723,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$7,844,000	-$6,723,000

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: 89

If the DPHs require more of the SNCP funds than what is available after the Department utilizes the CPEs from the four state-funded programs to draw down FFP, the DPHs will be paid GF which will be budgeted in the Stabilization policy change. The FFP paid to the DPHs and SLAMSP, and drawn down by the state-funded programs cannot exceed $586 million.

SB 1100 authorized the establishment of the Health Care Support Fund (HCSF), Item 4260-601-7503. Funds that pass through the HCSF are to be paid in the following order:

- Meeting the baseline of the DPHs.
- Federalizing the four state-only programs, and
- Providing stabilization funding.

The reconciliation process for each DY may result in an overpayment or underpayment to a DPH, which will be handled as follows:

- For DPHs that have been determined to be overpaid, the Department will recoup any overpayments.
- For DPHs that have been determined to be underpaid, the Department will make a payment equal to the difference between the SNCP payments that the DPHs have received and the SNCP payments estimated in the interim reconciliation process.

The MH/UCD was extended for two months, until October 31, 2010. The Centers for Medicare and Medicaid Services (CMS) approved the California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) effective November 1, 2010. Funding for the two-month extension of the prior MH/UCD SNCP is included in the BTR demonstration. A modified SNCP was continued in the BTR demonstration.

Reason for Change:
The change in FY 2016-17, from the prior estimate, and from FY 2016-17 to FY 2017-18, in the current estimate, is due to updated audited cost reports for DY 2007-08. There is no change for FY 2017-18 from the prior estimate.

Methodology:
1. The final reconciliation for DY 2007-08 will occur in FY 2016-17.

2. The final reconciliation for DY 2008-09 will occur in FY 2017-18.

The estimated payments to the DPHs on a cash basis are:

(Dollars in Thousands)

FY 2016-17	FF
DY 2007-08	$7,844
Total	**$7,844**

FY 2017-18	FF
DY 2008-09	($6,723)
Total	**($6,723)**

Funding:
100% Health Care Support Fund (4260-601-7503)

MH/UCD & BTR—CCS AND GHPP

REGULAR POLICY CHANGE NUMBER:	90
IMPLEMENTATION DATE:	9/2005
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1108

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$6,025,000	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$6,025,000	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$6,025,000	$0

DESCRIPTION

Purpose:
This policy change reflects the federal reimbursement received by the Department for a portion of the California Children Services (CCS) Program and Genetically Handicapped Persons Program (GHPP) claims based on the certified public expenditures (CPEs).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.22
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
PC 93 BTR—Designated State Health Programs

Background:
Effective September 1, 2005, based on the Special Terms and Conditions of the MH/UCD, the Department may claim federal reimbursement for the CCS and GHPP from the Safety Net Care Pool (SNCP) funding established by the MH/UCD. The CCS program provides diagnostic and treatment services, medical case management, and physical and occupational therapy health care services to children under 21 years of age with CCS-eligible conditions in families unable to afford catastrophic health care costs. The GHPP program provides comprehensive health care coverage for persons over 21 with specified genetic diseases including: cystic fibrosis; hemophilia; sickle cell disease and thalassemia; and chronic degenerative neurological diseases, including phenylketonuria.

The MH/UCD was extended for two months until October 31, 2010. Effective November 1, 2010, the Centers for Medicare & Medicaid Services (CMS) approved a five-year demonstration, the BTR. The Special Terms and Conditions of the BTR allow the State to claim federal financial participation (FFP) using the CPEs of approved Designated State Health Programs (DSHP). The CCS and GHPP programs are included in the list of DSHP. Funding for the two-month extension of the prior MH/UCD SNCP is included in the BTR. This policy change includes the impact of the BTR.

MH/UCD & BTR—CCS AND GHPP

REGULAR POLICY CHANGE NUMBER: 90

The BTR was extended for two months, until December 31, 2015. Funding for the two-month extension of the prior BTR CCS and GHPP is included in the Medi-Cal 2020 Designated State Health Program policy change.

Reason for Change:
The change in FY 2016-17, from the prior estimate, is due to a decrease in the claimed amount for the DY 2010-11 final reconciliation.

Methodology:
1. Total eligible expenditures have been reduced by 17.79% under the MH/UCD and 13.95% under the BTR to adjust for services provided to undocumented persons. The FFP received for CCS and GHPP will be deposited in the Health Care Support Fund, Item 4260-601-7503. These funds are transferred to the Family Health Estimate. The GF impact is reflected in the Family Health Estimate.

2. The final reconciliation for DY 2010-11 has been updated and the Department claimed an additional $6.025 million in federal funds in FY 2016-17.

3. The estimated CCS/GHPP federal reimbursements are:

(Dollars in Thousands)

Fiscal Year	CCS FF	GHPP FF	Total
FY 2005-06	$15,523	$8,485	$24,008
FY 2006-07	$46,856	$15,300	$62,156
FY 2007-08	$18,000	$8,000	$26,000
FY 2008-09	$20,958	$19,096	$40,054
FY 2009-10	$114,023	$43,313	$157,336
FY 2010-11	$96,910	$53,578	$150,488
FY 2011-12	$65,095	$30,351	$95,446
FY 2012-13	$67,718	$34,811	$102,529
FY 2013-14	$83,621	$47,438	$131,059
FY 2014-15	$39,558	$47,363	$86,920

(Dollars in Thousands)

FY 2016-17	CCS FF	GHPP FF	Total
DY 2010-11 Final Reconciliation	$6,025	$0	$6,025
Total	**$6,025**	**$0**	**$6,025**

Funding:
100% Health Care Support Fund (4260-601-7503)

BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER:	91
IMPLEMENTATION DATE:	3/2011
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1570

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$2,913,000	$0
- STATE FUNDS	$1,456,500	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,913,000	$0
STATE FUNDS	$1,456,500	$0
FEDERAL FUNDS	$1,456,500	$0

DESCRIPTION

Purpose:
This policy change estimates the intergovernmental transfers (IGTs) and the federal funds for the Delivery System Reform Incentive Pool (DSRIP) to support California's Designated Public Hospitals' (DPH) efforts in enhancing the quality of care and the health of the patients and families they serve.

Authority:
AB 1066 (Chapter 86, Statutes of 2011), Welfare & Institutions Code 14166.77
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
Not Applicable

Background:
The Centers for Medicare and Medicaid Services (CMS) approved the BTR effective November 1, 2010. The BTR establishes the DSRIP. AB 1066 provides the authority for the Department to implement payment methodologies under the BTR to determine DSRIP payments to DPHs.

There are five categories for which funding is available under the DSRIP in the Medi-Cal program:

(1) Infrastructure Development
(2) Innovation and Redesign
(3) Population-focused Improvement
(4) Urgent Improvement in Care
(5) HIV Transition Projects

Category 5 payments have been completed and are not budgeted in this policy change. DPHs submitted their DSRIP proposal for approval and are paid based on meeting milestones. DPHs provide the non-federal share of their DSRIP through IGTs.

BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER: 91

The total federal funding for DSRIP for categories 1-4 shall not exceed total computable expenditures of $6.506 billion over the five Demonstration Years (DYs). Annual federal funds available will be the applicable Federal Medical Assistance Percentage (FMAP) of annual total computable expenditure limits as follows:

(Dollars in Thousands)

Demonstration Year	Total Computable	DSRIP
2010-11	$1,006,880	$591,601
2011-12	$1,300,000	$650,000
2012-13	$1,400,000	$700,000
2013-14	$1,400,000	$700,000
2014-15	$1,400,000	$700,000

The BTR waiver was extended two months, until December 31, 2015. Effective January 1, 2016, incentive payments that are made under the authority of the California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration will be budgeted in the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) policy change.

Reason for Change:
The increase from the prior estimate, for FY 2016-17, is due to the updated final review of the Santa Clara Valley Medical Center DY 2013-14 annual report, and the inclusion of the approved DY 2014-15 annual report for Alameda Health System. There is no change for FY 2017-18 from the prior estimate.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to the final DSRIP payments made in FY 2016-17.

Methodology:
1. The final annual DSRIP reports for DY 2013-14 and DY 2014-15 were approved and paid in FY 2016-17, which concludes the program.

2. On a cash basis, DSRIP payments are estimated to be:

FY 2016-17	TF	IGT	FF
DY 2013-14	$3,767,000	$1,883,500	$1,883,500
DY 2014-15	($854,000)	($427,000)	($427,000)
Total	**$2,913,000**	**$1,456,500**	**$1,456,500**

Funding:
50% Title XIX FF (4260-101-0890)
50% Public Hospital Investment, Improvement, and Incentive Fund (4260-601-3172)

UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

REGULAR POLICY CHANGE NUMBER:	92
IMPLEMENTATION DATE:	7/2013
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1769

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	**$1,463,000**	**$1,060,000**
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	**$1,463,000**	**$1,060,000**
STATE FUNDS	$0	$0
FEDERAL FUNDS	**$1,463,000**	**$1,060,000**

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: 92

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***
- Audiology
- Chiropractic
- Dental*
- Incontinence creams and washes
- Optician/optical lab
- Podiatry
- Psychology**
- Speech therapy

*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.

**SBX1 1 (Chapter 4, Statutes of 2013) restores psychology services, effective January 1, 2014.

***SB 833 (Chapter 30, Statutes of 2016) restores acupuncture services, effective July 1, 2016.

Reason for Change:
The change in FY 2016-17, from the prior estimate, is due to:

- Revised Calendar Year (CY) 2015 claims.
- Decreased estimated encounters for CY 2016 and CY 2017, and
- Updated encounter rate for CY 2017.

UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

REGULAR POLICY CHANGE NUMBER: 92

The change in FY 2017-18, from the prior estimate, is due to a decrease in the estimated encounters for CY 2017 and CY 2018, and updated encounter rates for CY 2017 and CY 2018.

The change from FY 2016-17 and FY 2017-18, in the current estimate, is due to a higher encounters for CY 2016, and all four quarters for CY 2016 expected to be paid in FY 2016-17.

Methodology:

1. Additional CY 2015 claims in the amount of $56,000 TF will be paid in FY 2016-17.

2. Assume all of CY 2016 will be paid in FY 2016-17.

3. Assume the first quarter of CY 2017 will be paid in FY 2016-17.

4. Assume the remaining three quarters of CY 2017 will be paid in FY 2017-18.

5. Assume the first quarter of CY 2018 will be paid in FY 2017-18.

6. The IHS global encounter rate is updated on the Federal Register for each CY. For CY 2016, the rate is $368, and $391 for CY 2017. Assume the rate is $391 for CY 2018.

7. IHS claims are paid for each encounter. Assume the encounters for CY 2016 are 3,104, CY 2017 are 2,710, and CY 2018 are 2,710.

Calendar Year 2016	3,104 encounters X	$368 =	$1,142,272 FF
Calendar Year 2017	2,710 encounters X	$391 =	$1,059,610 FF
Calendar Year 2018	2,710 encounters X	$391 =	$1,059,610 FF

8. Assume IHS payments will be made as follows on a cash basis:

FY 2016-17	TF	FF
Calendar Year 2015	$56,000	$56,000
Calendar Year 2016	$1,142,000	$1,142,000
Calendar Year 2017	$265,000	$265,000
Total	**$1,463,000**	**$1,463,000**

FY 2017-18	TF	FF
Calendar Year 2017	$795,000	$795,000
Calendar Year 2018	$265,000	$265,000
Total	**$1,060,000**	**$1,060,000**

Funding:

100% Health Care Support Fund (4260-601-7503)

BTR—DESIGNATED STATE HEALTH PROGRAMS

REGULAR POLICY CHANGE NUMBER:	93
IMPLEMENTATION DATE:	11/2010
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1571

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$50,518,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$50,518,000	$0
FEDERAL FUNDS	-$50,518,000	$0

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 California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR).

Authority:
SB 208 (Chapter 71, Statutes 2009), Welfare & Institutions Code 14182.3
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)
Interagency Agreement 10-87249 A 03
AB 1467 (Chapter 23, Statutes of 2012)

Interdependent Policy Changes:
PC 90 MH/UCD & BTR —CCS and GHPP

Background:
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 CPEs of approved Designated State Health Programs (DSHP) listed below (exceptions as noted):

BTR—DESIGNATED STATE HEALTH PROGRAMS

REGULAR POLICY CHANGE NUMBER: 93

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)
Expanded Access to Primary Care (EAPC)
County Mental Health Services Program
Department of Developmental Services (DDS)
Every Woman Counts (EWC)
Prostate Cancer Treatment Program (PCTP)
Workforce Development Programs
Office of Statewide Health Planning & Development (OSHPD) • Song-Brown Health Care Workforce Training • Steven M. Thompson Physician Corps Loan Repayment Program • Mental Health Loan Assumption Program
County Medical Services Program (CMSP); effective 11/01/10 to 12/31/11.

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 (SNCP) funds. In addition to the above programs, AB 1467 allows the Designated Public Hospitals (DPHs) to voluntarily provide excess CPEs as necessary for the State to claim the full $400 million.

The BTR was extended for two months, until December 31, 2015. Funding for the two-month extension of the prior BTR DSHP is included in the Medi-Cal 2020 Designated State Health Program policy change.

Reason for Change:
There is no change for FY 2016-17 and FY 2017-18, from the prior estimate. The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to no anticipated reconciliations in FY 2017-18.

Methodology:
1. The additional FFP received for MIA-LTC and BCCTP are used to offset General Fund expense in Item 4260-101-0001. The additional FFP received for CPEs using the CCS and GHPP programs are budgeted in the MH/UCD & BTR —CCS and GHPP policy change. The FFP received for CCS and GHPP will be deposited in the Health Care Support Fund, Item 4260-601-7503. These funds are transferred to the Family Health Estimate and the GF impact is reflected in that estimate.

2. In prior years, the CPEs available from DSHP programs have not been sufficient to claim the $400 million FFP for each DY. AB 1467 permits the State to use DPH CPEs, as a condition for DPHs receiving Health Care Coverage Initiative rollover payments, to claim up to the $400 million limit. See “Reserved SNCP Fund for DSHP” in the table below.

BTR—DESIGNATED STATE HEALTH PROGRAMS

REGULAR POLICY CHANGE NUMBER: 93

3. The estimated BTR DSHP federal reimbursements are as follows:

(Dollars in Thousands)

	(Cash Basis)
	FF
	FY 2016-17
CCS (PC 90)	$6,025
GHPP (PC 90)	$0
MIA-LTC	$0
BCCTP	$0
DHCS Total	$6,025
ADAP	($5,601)
Co. Mental Health	($15,072)
DDS	($30,977)
EWC	$0
PCTP	$0
OSHPD	$1,132
Reserved SNCP fund for DSHP	$0
Other Programs Total (PC 93)	**($50,518)**
Grand Total	($44,493)

Funding:
100% GF (4260-101-0001)
100% Health Care Support Fund (4260-601-7503)

MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP

REGULAR POLICY CHANGE NUMBER:	94
IMPLEMENTATION DATE:	7/2010
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1459

	FY 2016-17	FY 2017-18
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 from the prior estimate, for FY 2016-17, is to correct a technical error from the November 2016 Estimate in which a number was transposed. The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to the anticipated completion of the CMHS reconciliation in FY 2016-17.

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).

MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP

REGULAR POLICY CHANGE NUMBER: 94

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. The Department is assuming completion of the CMHS reconciliation in FY 2016-17.

The General Fund savings resulting from the federal flexibilities are expected to be:

(Dollars in Thousands)

FY 2016-17	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:	95
IMPLEMENTATION DATE:	10/2016
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1952

	FY 2016-17	FY 2017-18
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 86 Medi-Cal 2020 Dental Transformation Initiative

Background:
The Centers for Medicare & Medicaid Services (CMS) approved the State to claim FFP using the CPEs of approved Designated State Health Programs (DSHP) listed below:

State Only Medical Programs
California Children Services (CCS)
Genetically Handicapped Persons Program (GHPP)
Medically Indigent Adult Long Term Care (MIA-LTC)
Breast & Cervical Cancer Treatment Program (BCCTP)
AIDS Drug Assistance Program (ADAP)
Department of Developmental Services (DDS)
Prostate Cancer Treatment Program (PCTP)
Workforce Development Programs
Office of Statewide Health Planning & Development (OSHPD) • Song-Brown Health Care Workforce Training • Steven M. Thompson Physician Corp Loan Repayment Program (STLRP) • Mental Health Loan Assumption Program (MHLAP)

MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM

REGULAR POLICY CHANGE NUMBER: 95

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 2016-17 and FY 2017-18 from the prior estimate. The FY 2016-17 and FY 2017-18 DSHP claiming allocations, however, have changed from the prior estimate based on actual expenditure data for each program. ADAP, DDS, and PCTP claiming is not needed to reach the annual claiming limit.

There is no change to the total claims from FY 2016-17 to FY 2017-18 in the current estimate. The claiming allocations by DSHP have changed based on updated expenditure data for each DSHP.

Methodology:
1. Assume DTI will claim the maximum $75 million FFP annually for FY 2016-17 and FY 2017-18.

2. Program allocations are updated based on actual claims.

3. For FY 2016-17 and FY 2017-18, the $75 million FFP annual claiming limit will be achieved without ADAP, DDS, and PCTP claims.

4. On a cash basis, the total DSHP payments are estimated to be:

FY 2016-17	TF	GF	FF
CCS	$0	($30,260,000)	$30,260,000
GHPP	$0	($28,950,000)	$28,950,000
MIA-LTC	$0	($8,420,000)	$8,420,000
BCCTP	$0	($1,000,000)	$1,000,000
ADAP	$0	$0	$0
DDS	$0	$0	$0
PCTP	$0	$0	$0
Song-Brown	$0	($4,390,000)	$4,390,000
STLRP	$0	($830,000)	$830,000
MHLAP	$0	($1,150,000)	$1,150,000
Total	**$0**	**($75,000,000)**	**$75,000,000**

MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM

REGULAR POLICY CHANGE NUMBER: 95

FY 2017-18	TF	GF	FF
CCS	$0	($35,000,000)	$35,000,000
GHPP	$0	($30,000,000)	$30,000,000
MIA-LTC	$0	($5,000,000)	$5,000,000
BCCTP	$0	($500,000)	$500,000
ADAP	$0	$0	$0
DDS	$0	$0	$0
PCTP	$0	$0	$0
Song-Brown	$0	($2,500,000)	$2,500,000
STLRP	$0	($1,000,000)	$1,000,000
MHLAP	$0	($1,000,000)	$1,000,000
Total	**$0**	**($75,000,000)**	**$75,000,000**

Funding:
100% GF (4260-101-0001)
100% Health Care Support Fund (4260-601-7503)

CCI-MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER:	98
IMPLEMENTATION DATE:	4/2014
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1766

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$10,042,736,000	$9,936,539,000
- STATE FUNDS	$5,021,368,000	$4,968,269,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	54.35 %	54.47 %
APPLIED TO BASE		
TOTAL FUNDS	$4,584,509,000	$4,524,106,200
STATE FUNDS	$2,292,254,490	$2,262,053,100
FEDERAL FUNDS	$2,292,254,490	$2,262,053,100

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 197 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 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

CCI-MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 98

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 an overall net increase in FY 2016-17 from the previous estimate due to the following:

- Overall increase in all CCI member months – 328,000
  - Decrease in CMC – 101,000
  - Increase in MLTSS Full Dual – 263,000
  - Increase in MLTSS Non-Full Dual – 166,000
- Percent of opt-ins (out of all full duals) dropped from 19% to 17%
- Opt-in rates increased from $518.74 to $525.14
- The MLTSS Full Dual weighted average rate decreased by approximately $0.83
- IHSS portion of opt-in rates decreased from $196.65 to $178.59
- IHSS portion of MLTSS Full Dual rates increased from $307.11 to $333.77

There is an overall net increase in FY 2017-18 from the previous estimate due to the following:

- Increase in all CCI member months – 291,000
  - Decrease in CMC – 163,000
  - Increase in MLTSS Full Dual – 170,000
  - Increase in Non-Full Dual – 284,000
- Percent of opt-ins (out of all full duals) dropped from 18% to 16%
- Opt-in rates decreased from $530.37 to $528.50
- The MLTSS Full Dual weighted average rate increased from $725.76 to $861.37
- IHSS portion of opt-in rates increased from $201.54 to $215.37
- IHSS portion of MLTSS Full Dual rates increased from $315.51 to $403.38

FY 2017-18 costs decreased from FY 2016-17 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 – 710,000
  - Increase in CMC – 7,000
  - Increase in MLTSS Full Dual – 648,000
  - Increase in MLTSS Non-Full Dual – 55,000
- Percent of opt-ins (out of all full duals) dropped from 17% to 16%
- Opt-in rates increased from $525.14 to $528.50
- The MLTSS weighted average rate increased from $708.00 to $861.37

CCI-MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 98

- IHSS portion of opt-in rates increased from $178.59 to $215.37
- IHSS portion of MLTSS Full Dual rates increased from $333.77 to $403.38

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. Orange began August 1, 2015.

3. The Department performs reconciliation of IHSS category of service to actual IHSS expenditures paid out to providers by the California Department of Social Services (CDSS) for the same quarter. The Department will determine the appropriate amount of reimbursement during reconciliation which will identify IHSS over/underpayments to CDSS or the managed care plans. Reconciliation was operationalized in the capitated payment system in January 2016.

4. The Department re-casted capitation rates for plans participating in the CCI for full-benefit dual eligible beneficiaries. Preliminary data suggests the department will recoup the difference between the paid capitation rate and the re-casted rate from plans participating in CCI. The recoupment of payments in excess of plans re-casted capitation payments is for the period of April 2014 through December 2014. The recasts will continue to occur through the CCI demonstration period.

5. FY 2016-17 rates are based on current paid rates, which are blended from previous demonstration year re-casted rates. FY 2017-18 rates are based on CY 2016 draft rates with a growth assumption of 1%.

6. Estimated below is the overall impact of the CCI demonstration in FY 2016-17 and FY 2017-18.

CCI-MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 98

(Dollars in Thousands)

FY 2016-17	TF	GF	FFP	Reimb.
CCI-Managed Care Payments (PC 98):				
Base managed care payments	$6,163,115	$3,081,557	$3,081,557	$0
Base managed care payments for add'l enrollment	$135,799	$67,899	$67,899	
Transfer of IHSS Costs to CDSS	$3,622,356	$1,811,178	$1,811,178	$0
Transfer of IHSS Costs to CDSS for add'l enrollment	$121,466	$60,733	$60,733	
Total Managed Care Payments	**$10,042,736**	**$5,021,368**	**$5,021,368**	**$0**
CCI-Savings and Deferral :				
Total Savings (In the Base)	($6,190,790)	($3,095,395)	($3,095,395)	$0
FFS Savings for Additional Enrollment (PC 210):	($94,594)	($47,297)	($47,297)	$0
Defer Managed Care Payment (In the Base)	$32,477	$16,239	$16,239	$0
Total	($6,252,907)	($3,126,453)	($3,126,453)	$0
IHSS Savings (In the Base)	($1,871,911)	$0	($1,871,911)	$0
Delay 1 Checkwrite (In the Base)	$56,580	$28,290	$28,290	$0
CCI-Transfer of IHSS Costs to DHCS (PC 197)	$0	($1,871,911)	$0	$1,871,911
CCI-Admin Costs, HCO Costs (OA 13, 17, 72)	$25,737	$12,869	$12,869	$0
Retro MC Rate Adjustments (PC 124)	$312,427	($193,737)	$156,214	$349,950
CCI-Quality Withhold Repayments (PC 220)	$1,353	$676	$677	$0
Total of CCI PCs including pass through	$2,314,014	($128,899)	$221,053	$2,221,861

CCI-MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 98

(Dollars in Thousands)

FY 2017-18	TF	GF	FFP	Reimb.
CCI-Managed Care Payments (PC 98):				
Base managed care payments	$7,094,234	$3,547,117	$3,547,117	$0
Base managed care payments for add'l enrollment	$346,790	$173,395	$173,395	
Transfer of IHSS Costs to CDSS	$2,333,595	$1,166,798	$1,166,798	$0
Transfer of IHSS Costs to CDSS for add'l enrollment	$161,921	$80,960	$80,960	
Total Managed Care Payments	**$9,936,539**	**$4,968,270**	**$4,968,270**	**$0**
CCI-Savings and Deferral :				
Total Savings (In the Base)	($7,131,022)	($3,565,511)	($3,565,511)	$0
FFS Savings for Additional Enrollment (PC 210):	($332,853)	($166,427)	($166,427)	$0
Defer Managed Care Payment (In the Base)	($11,375)	($5,687)	($5,687)	$0
Total	($7,475,250)	($3,737,625)	($3,737,625)	$0
IHSS Savings (In the Base)	($1,247,758)	$0	($1,247,758)	$0
Delay 1 Checkwrite (In the Base)	$17,212	$8,606	$8,606	$0
CCI-Transfer of IHSS Costs to DHCS (PC 197)	$0	($1,247,758)	$0	$1,247,758
CCI-Admin Costs, HCO Costs (OA 13, 17, 72)	$26,423	$13,212	$13,212	$0
Retro MC Rate Adjustments (PC 124)	$1,234,221	$191,375	$617,110	$425,736
CCI-Quality Withhold Repayments (PC 220)	$9,000	$4,500	$4,500	$0
Health Insurer Fee (PC 19)	$5,724	$2,862	$2,862	$0
Total of CCI PCs including pass through	$2,506,111	$203,441	$629,176	$1,673,494

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

MANAGED CARE PUBLIC HOSPITAL IGTS

REGULAR POLICY CHANGE NUMBER:	100
IMPLEMENTATION DATE:	5/2013
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1588

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$247,118,000	$2,880,095,000
- STATE FUNDS	$123,559,000	$471,745,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$247,118,000	$2,880,095,000
STATE FUNDS	$123,559,000	$471,745,000
FEDERAL FUNDS	$123,559,000	$2,408,350,000

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 119 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: 100

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.

Reason for Change:
The change from the prior estimate, for FY 2016-17, is a decrease due to:

- ACA OE payments for FY 2015-16 and FY 2016-17 are expected to occur in FY 2017-18 and have been updated based on actuarial estimates.

The change from the prior estimate, for FY 2017-18, is an increase due to:

- A shift in ACA OE payments for FY 2015-16 and FY 2016-17 from FY 2016-17, and
- The addition of SPD and ACA OE payments for FY 2017-18.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to:

- Timing of payments for both SPD and ACA OE payments, and
- ACA OE payments are not expected to be paid until FY 2017-18.

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 SPD FY 2014-15 IGTs occurred in FY 2016-17. The FY 2013-14 DPH unexpended amounts of $665,426 was applied against the FY 2014-15 IGT collection.
10. The FY 2015-16, FY 2016-17, and FY 2017-18 payments are expected to occur in FY 2017-18. The actual IGTs have not yet been determined; therefore placeholders have been budgeted.

MANAGED CARE PUBLIC HOSPITAL IGTS

REGULAR POLICY CHANGE NUMBER: 100

DPH – OE

1. FY 2015-16 payments are expected to occur in FY 2017-18. $0 has been budgeted as the IGT amount as this rating period is funded solely by federal funds.
2. FY 2016-17 and FY 2017-18 payments are expected to occur in FY 2017-18. The final reimbursement has not yet been calculated, therefore, actuarial estimates have been budgeted. Estimated IGT amounts have been budgeted for these time periods to account for the cost based and rate range reimbursements.

(Dollars in Thousands)

FY 2016-17	TF	IGT	FF	ACA
SPD FY 2013-14	*($665)	($333)	($333)	$0
SPD FY 2014-15	$247,784	$123,892	$123,892	$0
Total FY 2016-17	**$247,118**	**$123,559**	**$123,559**	**$0**

FY 2017-18	TF	IGT	FF	ACA
SPD FY 2015-16	$260,173	$130,086	$130,086	$0
SPD FY 2016-17	$273,182	$136,591	$136,591	$0
SPD FY 2017-18	*$286,841	$143,420	$143,420	$0
ACA OE FY 2015-16	$518,700	$0	$0	$518,700
ACA OE FY 2016-17	$770,600	$19,265	$0	$751,335
ACA OE FY 2017-18	$770,600	$42,383	$0	$728,217
Total FY 2017-18	***$2,880,095**	**$471,745**	***$410,098**	**$1,998,252**

*Difference due to rounding.

Funding:
100% Title XIX FFP (4260-101-0890)
Reimbursement GF (4260-610-0995)
100% Title XIX ACA (4260-101-0890)
95% Title XIX ACA FF / 5% GF (4260-101-0890)
94% Title XIX ACA FF / 6% GF (4260-101-0890)

MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.RATES

REGULAR POLICY CHANGE NUMBER:	101
IMPLEMENTATION DATE:	4/2017
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1961

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$1,849,578,000	$2,131,736,000
- STATE FUNDS	$521,681,640	$612,223,010
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,849,578,000	$2,131,736,000
STATE FUNDS	$521,681,640	$612,223,010
FEDERAL FUNDS	$1,327,896,360	$1,519,512,990

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 2016-17 nor FY 2017-18.

The change from FY 2016-17 to FY 2017-18, 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: 101

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 2016-17	**$1,849,578**	$521,682	$1,327,895
FY 2017-18	**$2,131,736**	$612,223	$1,519,513

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

MANAGED CARE RATE RANGE IGTS

REGULAR POLICY CHANGE NUMBER:	103
IMPLEMENTATION DATE:	7/2005
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1054

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$870,681,000	$3,143,888,000
- STATE FUNDS	$385,658,000	$1,372,668,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$870,681,000	$3,143,888,000
STATE FUNDS	$385,658,000	$1,372,668,000
FEDERAL FUNDS	$485,023,000	$1,771,220,000

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 118 Managed Care IGT Admin. And Processing Fee
PC 96 Two Plan Model
PC 97 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. New federal regulations require development of a single rate, rather than a rate range, for rating periods beginning July 1, 2018. To comply with these regulations, the Department plans to move to a prospective rate-setting process as of FY 2017-18 rating period.

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.

MANAGED CARE RATE RANGE IGTS

REGULAR POLICY CHANGE NUMBER: 103

Reason for Change:
The change from the prior estimate, for FY 2016-17, is a decrease due to incorporating FY 2014-15 actuals in FY 2016-17.

The change from the prior estimate, for FY 2017-18, is an increase due to adding FY 2017-18 amounts to budget year and updated based on expected participation.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to ongoing efforts to move to a prospective rate setting. FY 2016-17 budgets one year of IGTs. FY 2017-18 budgets three years of IGTs (FY 2015-16, FY 2016-17, and FY 2017-18).

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. The IGT will continue on an ongoing basis.

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 IGTs will continue on an ongoing basis.

The COHS expansion counties (Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity) were effective retroactive to September 1, 2013. The IGTs will continue on an ongoing basis.

Two Plan Model:
An IGT for Los Angeles County was effective October 2006 and will continue on an ongoing basis.

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. The IGTs will continue on an ongoing basis.

Geographic Managed Care:
The IGTs for Sacramento and San Diego Counties were retroactive to January 2012. The IGTs will continue on an ongoing basis.

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. The IGT will continue on an ongoing basis.

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: 103

(Dollars in Thousands)

FY 2016-17	IGT*	T19 FF	T21 FF	Family Planning FF	Total FF	TF
FY 2014-15	$385,658	$368,043	$93,004	$23,976	$485,023	$870,681
Total FY 2016-17	**$385,658**	$368,043	$93,004	$23,976	**$485,023**	**$870,681**

FY 2017-18	IGT*	T19 FF	T21 FF	Family Planning FF	Total FF	TF
FY 2015-16	$390,808	$372,958	$96,776	$24,296	$494,030	$884,838
FY 2016-17	$490,930	$468,506	$139,569	$30,520	$638,595	$1,129,525
FY 2017-18	$490,930	$468,506	$139,569	$30,520	$638,595	$1,129,525
Total FY 2017-18	**$1,372,668**	$1,309,970	$375,914	$85,336	**$1,771,220**	**$3,143,888**

Funding:
100% Title XIX FFP (4260-101-0890)
100% Title XXI FFP (4260-113-0890)
Reimbursement (4260-610-0995)*

HQAF RATE RANGE INCREASES

REGULAR POLICY CHANGE NUMBER:	105
IMPLEMENTATION DATE:	12/2015
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1895

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$125,000,000	$232,000,000
- STATE FUNDS	$62,500,000	$116,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$125,000,000	$232,000,000
STATE FUNDS	$62,500,000	$116,000,000
FEDERAL FUNDS	$62,500,000	$116,000,000

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.

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 2016-17, is a decrease due to a shift in FY 2015-16 and FY 2016-17 (July-December 2016) payments from FY 2016-17 to FY 2017-18.

The change from the prior estimate, for FY 2017-18, is an increase due to a shift in FY 2015-16 and FY 2016-17 (July-December 2016) payments from FY 2016-17 to FY 2017-18.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to budgeting 18 months of Hospital QAF payments in FY 2017-18. FY 2016-17 budgets 12 months.

HQAF RATE RANGE INCREASES

REGULAR POLICY CHANGE NUMBER: 105

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 Department paid the FY 2014-15 rate range increases using the corresponding withhold amounts in the second quarter of FY 2016-17. The FY 2015-16 and FY 2016-17 (July – December 2016) rate range increases will be paid in FY 2017-18.

The following rate ranges increases were made in FY 2016-17:

(Dollars in Thousands)

FY 2016-17	TF	SF (HQARF)*	Regular FFP	Title 21 FFP	Family Planning FFP	Total FFP
FY 2014-15 Increases	$125,000	$62,500	$59,645	$2,423	$432	$62,500
Total	**$125,000**	**$62,500**	**$59,645**	**$2,423**	**$432**	**$62,500**

The rate range increases to be made in FY 2017-18 are expected to be:

(Dollars in Thousands)

FY 2016-17	TF	SF (HQARF)*	Regular FFP	Title 21 FFP	Family Planning FFP	Total FFP
FY 2015-16 Increases	$148,000	$74,000	$70,620	$2,869	$511	$74,000
FY 2016-17 Increases (July-Dec 2016)	$84,000	$42,000	$40,082	$1,628	$290	$42,000
Total	**$232,000**	**$116,000**	**$110,702**	**$4,497**	**$801**	**$116,000**

Funding:

*Hospital Quality Assurance Revenue Fund (4260-611-3158)
Title XIX FFP (4260-611-0890)
Title XXI FFP (4260-611-0890)

PALLIATIVE CARE SERVICES IMPLEMENTATION

REGULAR POLICY CHANGE NUMBER:	111
IMPLEMENTATION DATE:	6/2017
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1947

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$10,000	$2,977,000
- STATE FUNDS	$5,000	$1,334,530
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$10,000	$2,977,000
STATE FUNDS	$5,000	$1,334,530
FEDERAL FUNDS	$5,000	$1,642,470

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)

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: 111

Reason for Change:
The change from the prior estimate, for FY 2016-17, is a decrease due to an implementation delay to FY 2017-18.

The change from the prior estimate, for FY 2017-18, is a decrease due to an implementation delay to January 2018.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to:

- Implementation in January 2018,
- Full year of costs for training, and
- Costs for managed care plan program development to occur in FY 2017-18.

Methodology:

1. Assume palliative care training will begin in June 2017.

2. The Department estimates initial training of providers will cost $10,000 TF in FY 2016-17 and $244,000 TF in FY 2017-18.

3. Assume implementation of palliative care services will begin January 2018.

4. FY 2016-17 and FY 2017-18 costs for this program are estimated to be:

	TF	GF	FF
FY 2016-17	**$10,000**	**$5,000**	**$5,000**
FY 2017-18	**$2,977,000**	**$1,335,000**	**$1,642,000**

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)

CAPITATED RATE ADJUSTMENT FOR FY 2017-18

REGULAR POLICY CHANGE NUMBER:	112
IMPLEMENTATION DATE:	7/2017
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1338

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
The policy change estimates the increase for the Managed Care capitation rates for fiscal year (FY) 2017-18.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
Managed care capitation rates will be rebased in FY 2017-18 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 2016-17 to FY 2017-18.

Reason for Change:
The change in classic capitation rates from FY 2016-17 to FY 2017-18 is a 3.69% average rate increase, excluding Optional Expansion (OE) rates. OE rates are held constant from FY 2016-17 to FY 2017-18.

CAPITATED RATE ADJUSTMENT FOR FY 2017-18

REGULAR POLICY CHANGE NUMBER: 112

Methodology:

(Rounded)	Rate Adjustment (without OE rates)	Rate Adjustment (with OE rates)
Two Plan	5.35%	3.06%
COHS	0.90%	0.20%
GMC	0.51%	2.31%
Regional	4.29%	0.52%
Total	**3.69%**	**2.09%**

Funding:
Not Applicable

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 2016-17	FY 2017-18
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 101: 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 2016-17 and for FY 2017-18, is due to an updated funding allocation based on recent payment data.

The change from FY 2016-17 to FY 2017-18, 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 2016-17	**$0**	($521,682)	$521,682
FY 2017-18	**$0**	($612,223)	$612,223

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 2016-17	FY 2017-18
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 101: MCO Enrollment Tax Mgd. Care Plans-Incr. Cap. Rates
PC 114: MCO Enrollment Tax Mgd. Care Plans-Funding Adj.

Background:
SBx2 2 was signed by the Governor on March 1, 2016, and provides for a statewide tax on managed care plans based on reported enrollment into these plans during the 12-month period between October 1, 2014 and September 30, 2015. The tax is tiered based on whether the enrollee is a Medi-Cal, alternate health care service plans, or other enrollee.

The MCO Enrollment tax is effective July 1, 2016 through July 1, 2019. This policy change estimates GF savings resulting from the imposition of the MCO enrollment tax.

Reason for Change:
The change from the prior estimate, for FY 2016-17 and for FY 2017-18, is due to an updated funding allocation based on more recent payment data.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to the quarterly cash collection schedule. MCO enrollment tax collections begin in the second quarter of FY 2016-17. There are three collection periods in FY 2016-17 and four collection periods in FY 2017-18.

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 2016-17:

Medi-Cal			
Enrollees	**Rate**	**Average Enrollment/Entity**	
0-2,000,000	$40.00	39,161,300	$1,566,451,000*
2,000,001-4,000,000	$19.00	21,181,000	$402,439,000
Over 4,000,000	$1.00	48,831,000	$48,831,000

*Difference due to rounding.

Non-Medi-Cal (including AHCSP)			
Enrollees	**Rate**	**Average Enrollment/Entity**	
0-4,000,000	$7.50	25,648,000	$192,360,000
4,000,001-8,000,000	$2.50	17,175,200	$42,938,000
Over 8,000,000	$1.00	30,244,000	$30,244,000

The total FY 2016-17 Medi-Cal and Non-Medi-Cal MCO Enrollment Tax is: $2,283,263,000

4. 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 is: $2,428,921,000

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 2016-17	**$0**	($1,190,766)	$1,190,766
FY 2017-18	**$0**	($1,780,284)	$1,780,284

Funding:
MCO Tax 2016 (Non-GF) (4260-601-3293)

MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER:	116
IMPLEMENTATION DATE:	7/2016
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1782

	FY 2016-17	FY 2017-18
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 122 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 117 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. One half 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 2016-17, is a funding transfer increase due to updated tax revenues based on managed care premiums.

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.

MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 116

The change from FY 2016-17 to FY 2017-18, decreases savings in the current estimate due the timing of retro payments.

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. Total tax revenue was multiplied by 50% to determine the share that offsets GF cost for the Medi-Cal program.

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 2016-17	$0	($128,145)	$128,145
FY 2017-18	$0	($13,631)	$13,631

Funding:

100% State GF (4260-101-0001)
*3156 MCO (Non-GF) (4260-601-3156)

MCO TAX MANAGED CARE PLANS

REGULAR POLICY CHANGE NUMBER:	117
IMPLEMENTATION DATE:	7/2013
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1783

	FY 2016-17	FY 2017-18
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 122 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 116 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. One half 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:
There is no change from the prior estimate for FY 2016-17.

MCO TAX MANAGED CARE PLANS

REGULAR POLICY CHANGE NUMBER: 117

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 2016-17 to FY 2017-18, is an increase in GF transfers in the current estimate due to the timing of retro payments.

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. Total tax revenue was multiplied by 50% to determine the share that offsets GF cost for the Medi-Cal program.

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 2016-17	($184,621)	$184,621
FY 2017-18	($414,386)	$414,386

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:	118
IMPLEMENTATION DATE:	7/2012
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1601

	FY 2016-17	FY 2017-18
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: 118

The 20% assessment fees are collected at the same time as the rate range IGTs. New federal regulations require development of a single rate, rather than a rate range, for rates beginning July 1, 2018. To comply with these regulations, the Department plans to move to a prospective rate-setting proves as of the FY 2017-18 rating period; therefore, any applicable fees will also be calculated prospectively.

The Department will make new Medi-Cal Graduate Medical Education (GME) supplemental payments, pending CMS approval of State Plan Amendment (SPA) 17-009, to Designated Public Hospitals (DPHs) systems participating in the Medi-Cal managed care program. The SPA will be submitted to CMS in the third quarter of FY 2016-17 with an anticipated CMS approval by June 30, 2017 for an effective date of January 1, 2017. The Department will budget the Graduate Medical Education Payments to DPHs and their affiliated governmental entities, whereby IGTs will fund the nonfederal share of the cost. A 5% administrative fee will be assessed for the IGTs related to direct and indirect GME payments 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 2016-17, is a decrease due to updating the estimate using actual FY 2014-15 IGTs.

The change from the prior estimate, for FY 2017-18, is an increase due to:

- Updating the estimate based on expected participation levels,
- Adding FY 2017-18 IGTs to FY 2017-18, and
- Adding the 5% GME administrative fee.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to ongoing efforts to move to a prospective rate setting. FY 2016-17 only budgets one year of IGTs. FY 2017-18 budgets three years of IGTs (FY 2015-16, 2016-17, and FY 2017-18). The 5% GME administrative fee assessment is expected to begin in FY 2017-18.

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.

(Dollars in Thousands)

FY 2016-17	IGT amount subject to the fee	20% Admin. & Processing Fee	Support Cost Reimbursement to GF	Local Assistance Reimbursement to GF
FY 2014-15	$347,275	$69,455	$251	$69,204
Total FY 2016-17	$347,275	$69,455	$251	**$69,204**

MANAGED CARE IGT ADMIN. & PROCESSING FEE

REGULAR POLICY CHANGE NUMBER: 118

(Dollars in Thousands)

FY 2017-18	IGT amount subject to the fee	20% Admin. & Processing Fee	5% GME Admin Fee	Support Cost Reimbursement to GF	Local Assistance Reimbursement to GF
FY 2015-16	$363,690	$72,738	$0	$251	$72,487
FY 2016-17	$435,730	$87,146	$0	$251	$86,895
FY 2017-18	$435,730	$87,146	$0	$251	$86,895
FY 2016-17 GME	$237,500	$0	$11,875	$0	$11,875
FY 2017-18 GME	$356,250	$0	$17,813	$0	$17,813
Total FY 2017-18	$1,235,150	$247,030	$29,688	$753	**$275,965**

Funding:
100% State GF (4260-101-0001)
Reimbursement (4260-610-0995)

GENERAL FUND REIMBURSEMENTS FROM DPHS

REGULAR POLICY CHANGE NUMBER:	119
IMPLEMENTATION DATE:	5/2013
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1605

	FY 2016-17	FY 2017-18
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: 119

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.

New federal regulations require development of a single rate, rather than a rate range, for rating periods beginning July 1, 2018. To comply with these regulations, the Department plans to move to a prospective rate-setting process as of the FY 2017-18 rating period.

Reason for Change:
The change from the prior estimate, for FY 2016-17, is a decrease due to:

- The shift of ACA OE payments for FY 2015-16 and FY 2016-17 from FY 2016-17 to FY 2017-18.

The change from the prior estimate, for FY 2017-18, is an increase due to:

- The shift of ACA OE payments for FY 2015-16 and FY 2016-17 from FY 2016-17 to FY 2017-18, and
- The addition of SPD and OE payments for FY 2017-18.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to:

- Timing of payments for SPD and ACA OE payments, and
- ACA OE payments are not expected to be paid until FY 2017-18.

Methodology:
DPH – SPD

1. Determine the baseline of DPH inpatient services/costs in FFS that are subject to transition into managed care.

2. Account for managed care factors applied in the capitation rate development process.

3. Calculate the expected DPH inpatient cost per day for applicable SPDs. Divide the total costs by the total utilization, which yields the calculated historical DPH allowable cost per day and related utilization.

4. Calculate the DPH utilization and costs that have already been built into the baseline managed care capitation rate for transitioned members.

5. Calculate the amount of funding (IGT) needed from DPHs for the state/local match related to the inpatient portion of services included in the transitioned SPD members' baseline capitation rates.

GENERAL FUND REIMBURSEMENTS FROM DPHS

REGULAR POLICY CHANGE NUMBER: 119

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 2013-14 DPH unexpended amounts of $332,712 was applied against the FY 2014-15 IGT collection.

9. The FY 2015-16, FY 2016-17, and FY 2017-18 reimbursements are expected to occur in FY 2017-18. The reimbursement has not yet been calculated; therefore, placeholders have been budgeted.

DPH – OE

1. FY 2015-16 payments are expected to occur in FY 2017-18. $0 has been budgeted as the IGT amount as this rating period is funded solely by federal funds.
2. FY 2016-17 and FY 2017-18 payments are expected to occur in FY 2017-18. The final reimbursements have not yet been calculated, therefore, estimated IGT amounts have been budgeted for these time periods.
3. The finalized OE rate development methodology will account for the cost-based reimbursement for the OE population.

(Dollars in Thousands)

	FY 2016-17
SPD - FY 2013-14	($332)
SPD - FY 2014-15	$48,867
Total Reimbursement	$48,535
GF	($48,535)
Net Impact	**$0**

	FY 2017-18
SPD - FY 2015-16	$51,310
SPD - FY 2016-17	$53,876
SPD - FY 2017-18	$56,570
ACA OE - FY 2015-16	$0
ACA OE - FY 2016-17	$28,589
ACA OE - FY 2017-18	$62,896
Total Reimbursement	$253,242
GF	($253,242)
Net Impact	**$0**

Funding:
Reimbursement (4260-610-0995)
100% State GF (4260-101-1001)

CENCAL HEALTH PLAN-ADDITION OF CHDP

REGULAR POLICY CHANGE NUMBER:	120
IMPLEMENTATION DATE:	7/2016
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1968

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	-$2,574,000	-$3,329,000
- STATE FUNDS	-$1,287,000	-$1,664,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	77.39 %	71.74 %
APPLIED TO BASE		
TOTAL FUNDS	-$582,000	-$940,800
STATE FUNDS	-$290,990	-$470,390
FEDERAL FUNDS	-$290,990	-$470,390

DESCRIPTION

Purpose:
This policy change estimates the cost of shifting the Child Health and Disability Prevention (CHDP) benefit from Fee-For-Service (FFS) to Managed Care for CenCal Health Plan in San Luis Obispo and Santa Barbara Counties.

Authority:
Welfare & Institutions Code 14087.3

Interdependent Policy Changes:
Not Applicable

Background:
CHDP provides early screening, preventative care, and treatment of childhood illnesses and disabilities. Prior to July 1, 2016, San Luis Obispo and Santa Barbara counties remained the only counties in the State in which a managed care health plan did not provide CHDP benefits.

Effective July 1, 2016, the CHDP benefit transitioned from FFS to Managed Care. CHDP coverage in San Luis Obispo and Santa Barbara counties mirrors coverage in all other managed care counties. Implementing CHDP services in the Managed Care program for San Luis Obispo and Santa Barbara counties simplified the billing and administrative process for providers while still maintaining local program compliance.

Reason for Change:
The change from the prior estimate, for FY 2016-17 and FY 2017-18, is a decrease in savings reflected in the policy change due to updating the payment lag and the savings percentage captured in the base.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to applying a payment lag.

Methodology:
1. There will not be additional managed care members transferring from FFS.

CENCAL HEALTH PLAN-ADDITION OF CHDP

REGULAR POLICY CHANGE NUMBER: 120

2. The payments under capitation are assumed to be equal to the costs under FFS, except for the remaining FFS claims to be paid.

FY 2016-17	TF	GF	FF
FFS Savings	($3,450,000)		
FFS Payment Lag	0.746		
FFS Lagged Savings	($2,574,000)		
FY 2016-17 Savings	**($2,574,000)**	**($1,287,000)**	**($1,287,000)**

FY 2017-18	TF	GF	FF
FFS Savings	($3,450,000)		
FFS Payment Lag	0.965		
FFS Lagged Savings	($3,329,000)		
FY 2017-18 Savings	**($3,329,000)**	**($1,665,000)**	**($1,664,000)**

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

FORMER AGNEWS' BENEFICIARIES RECOUPMENT

REGULAR POLICY CHANGE NUMBER:	121
IMPLEMENTATION DATE:	12/2016
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1935

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	-$6,477,000	$0
- STATE FUNDS	-$3,238,500	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$6,477,000	$0
STATE FUNDS	-$3,238,500	$0
FEDERAL FUNDS	-$3,238,500	$0

DESCRIPTION

Purpose:
This policy change estimates the recoupment of supplemental payments for the former Agnews' beneficiaries who have transitioned into managed care plans.

Authority:
Title 42, United States Code (USC) 1396b (d)(2)(C)

Interdependent Policy Changes:
Not Applicable

Background:
Between July 2007 and April 2009, a total of 327 residents of the Agnews' Development Center were transitioned by the California Department of Developmental Services (CDDS) from residence in the Agnews' Developmental Center to living arrangements in the community.

Pursuant to the Agnews' Closure Plan, the Department developed agreements with Health Plan of San Mateo, Santa Clara Family Health Plan and Alameda Alliance for Health to accept Agnews' beneficiaries who chose to enroll in managed care. These three plans received a supplemental payment in excess of the regular capitation rates for each of the Agnews' beneficiaries.

In December 2010, the Department implemented capitation rates for Agnews' beneficiaries retroactively to July 1, 2008 for the Health Plan of San Mateo and January 1, 2008 for Santa Clara Family Health Plan and the Alameda Alliance for Health. The capitation payment for these beneficiaries was originally based on the capitation rate for the beneficiary's assigned aid code and then a supplemental payment was made for the remainder of the Agnews' rate.

Although this process was necessary when these beneficiaries were new to managed care, over time, their costs have been included into the health plans' regular capitation rates and the supplemental payment was no longer necessary.

FORMER AGNEWS' BENEFICIARIES RECOUPMENT

REGULAR POLICY CHANGE NUMBER: 121

Reason for Change:
The change from the prior estimate, for FY 2016-17, is due to updated recoupment amounts from the health plans.

There is no change from the prior estimate for FY 2017-18.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to this policy change being a one-time recoupment.

Methodology:

1. Actuaries from the Department determined the overlap of reported data for rate development purposes began for rate years in FY 2012-13.

2. Agnews' supplemental payments to plans beginning July 1, 2012 (Health Plan of San Mateo) and October 1, 2012 (Santa Clara Family Health Plan and Alameda Alliance for Health) were extracted from plan payment data and summarized.

3. Total recoupment is $6,476,500.

4. A one-time recoupment occurred in December 2016. Ongoing Agnews' supplemental payments have been discontinued.

FY 2016-17	TF	GF	FF
Alameda Alliance for Health	($1,495,000)	($747,000)	($748,000)
Health Plan of San Mateo	($842,000)	($421,000)	($421,000)
Santa Clara Family Health Plan	($4,140,000)	($2,070,000)	($2,070,000)
Total	**($6,477,000)**	**($3,238,000)**	**($3,239,000)**

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

MCO TAX MGD. CARE PLANS - INCR. CAP. RATES

REGULAR POLICY CHANGE NUMBER:	122
IMPLEMENTATION DATE:	7/2014
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1781

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$25,332,000	$21,304,000
- STATE FUNDS	$12,666,000	$10,464,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$25,332,000	$21,304,000
STATE FUNDS	$12,666,000	$10,464,000
FEDERAL FUNDS	$12,666,000	$10,840,000

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 116 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 117 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 2016-17, is an increase due to updated tax revenues based on managed care premiums.

MCO TAX MGD. CARE PLANS - INCR. CAP. RATES

REGULAR POLICY CHANGE NUMBER: 122

The change from the prior estimate, for FY 2017-18, is an increase due to retro payments from the applicable period scheduled to be paid in FY 2017-18.

The change from FY 2016-17 to FY 2017-18 is a decrease in the current estimate due to the timing of retro payments.

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 2016-17	**$25,332**	**$12,666**	**$12,666**
FY 2017-18	**$21,304**	**$10,464**	**$10,840**

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)
100% Title XIX FFP (4260-101-0890)

MANAGED CARE DRUG REBATES

REGULAR POLICY CHANGE NUMBER:	123
IMPLEMENTATION DATE:	4/2013
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1585

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	-$2,146,160,000	-$1,066,751,000
- STATE FUNDS	-$606,546,680	-$345,951,190
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$2,146,160,000	-$1,066,751,000
STATE FUNDS	-$606,546,680	-$345,951,190
FEDERAL FUNDS	-$1,539,613,320	-$720,799,810

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) and Two-Plan 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.

Retroactive adjustments will be made for the ACA optional rebates. See the Drug Rebates — Retroactive ACA Adjustments policy change for more information.

Reason for Change:
The change from the prior estimate, for FY 2016-17, is the result of revised collection projections based on the net result of the following:

- The addition of three quarters of actual Managed Care rebate collections from July 2016 through March 2017 which were significantly higher than previously estimated;
- Increased ACA optional and Title XXI rebates based on data through March 2017
- Increased ACA Offset rebates based on data through March 2017; and
- Increased Medi-Cal Managed Care eligibles data used to project the estimated rebates.

There is no change from the prior estimate for FY 2017-18.

MANAGED CARE DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 123

The change from FY 2016-17 to FY 2017-18, in the current estimate, is a decrease due to higher estimated FY 2016-17 rebate collections that include actual collections from the October 2016 to March 2017 quarter which were higher than previously estimated. The ongoing projected average quarterly Managed Care rebate collections are lower than the most recent quarter's increase.

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 related drug rebate collections are estimated to be $64,169,000 TF in FY 2016-17 and $34,977,000 TF in FY 2017-18. Beginning October 2015, these rebates are funded at 88% FF / 12% GF.

4. Collections for the optional expansion ACA population are estimated to be $823,317,000 TF for FY 2016-17, funded at 100% FF and $358,773,000 TF for FY 2017-18, funded with 95% FF and 5% GF.

5. The ongoing additional FF claimed by CMS (ACA Offset) is fully reflected in this policy change. The additional FF is $60,214,000 TF for FY 2016-17 and $24,688,000 TF for FY 2017-18.

(Dollars in Thousands)

FY 2016-17	TF	GF	FF
50% Title XIX / 50% GF	($1,197,501)	($598,751)	($598,750)
100% ACA Title XIX FF	($823,317)	$0	($823,317)
90% Title XIX / 10% GF	($959)	($96)	($863)
ACA Offset	($60,214)	$0	($60,214)
88% Title XXI / 12 % GF	($64,169)	($7,700)	($56,469)
Total	**($2,146,160)**	**($606,547)**	**($1,539,613)**

(Dollars in Thousands)

FY 2017-18	TF	GF	FF
50% Title XIX / 50% GF	($647,460)	($323,730)	($323,730)
95% Title XIX/ 5% GF	($358,773)	($17,939)	($340,834)
90% Title XIX / 10% GF	($853)	($85)	($768)
ACA Offset	($24,688)	$0	($24,688)
88% Title XXI / 12 % GF	($34,977)	($4,197)	($30,780)
Total	**($1,066,751)**	**($345,951)**	**($720,800)**

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)
100% ACA Title XIX (4260-101-0890)
95% ACA Title XIX FF / 5% GF (4260-101-0001/0890)
88% Title XXI / 12% GF (4260-113-0001/0890)

RETRO MC RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER:	124
IMPLEMENTATION DATE:	1/2016
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1788

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$331,083,000	-$4,048,269,000
- STATE FUNDS	$208,758,900	$617,110,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$331,083,000	-$4,048,269,000
STATE FUNDS	$208,758,900	$617,110,000
FEDERAL FUNDS	$122,324,100	-$4,665,379,000

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:

- Managed care rate adjustments for FY 2015-16 base rates and Hepatitis C recoupments,
- AB 97 recoupments from FY 2014-15,
- Martin Luther King, Jr. (MLK) rate adjustments,
- Optional Expansion recoupment, and
- The Coordinated Care Initiative (CCI) full dual and non-full dual payments.

This policy change also includes the California Department of Social Services (CDSS) Coordinated Care Initiative (CCI) calendar year (CY) 2014 In-Home Supportive Services (IHSS) reconciliation.

Reason for Change:
The change from the prior estimate, for FY 2016-17 and FY 2017-18, is an increase in cost due to:

- A delay in ACA optional expansion (OE) recoupment from FY 2016-17 to FY 2017-18,
- A delay in MLK payments associated with OE for FY 2015-16 from FY 2016-17 to FY 2017-18,
- The addition of MLK payments associated with OE for FY 2016-17 (July to December 2016) to be paid in FY 2017-18, and

RETRO MC RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 124

- Adjusted CCI retro amounts for the following reasons:
  - CY 2015 estimates were updated using final recast totals. Timing of payments and recoupments were also updated,
  - CY 2016 estimates were updated using draft CY 2016 rates, and
  - CY 2017 estimates used CY 2016 draft rates with a 1% growth factor.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to updating payments and recoupment timeframes.

Methodology:

1. The Department estimates the following retroactive managed care capitation rate adjustments in FY 2016-17 and FY 2017-18:

(Dollars in Thousands)

FY 2016-17	TF	GF	FF	Reimbursement
Retro Base Payment (FY 2015-16)	$42,247	$5,229	$37,018	$0
MLK SPD Payments (FY 2015-16)	$9,659	$4,829	$4,830	$0
CCI Full Duals (CY 2014)				
CMC	($60,590)	($30,295)	($30,295)	$0
CMC Reimb	$0	$14,209	$0	($14,209)
MLTSS	($152,144)	($76,072)	($76,072)	$0
MLTSS Reimb	$0	($16,138)	$0	$16,138
CCI Full Duals (CY 2015)				
CMC	($55,732)	($27,866)	($27,866)	$0
CMC Reimb	$0	$10,018	$0	($10,018)
MLTSS	$266,136	$133,068	$133,068	$0
MLTSS Reimb	$0	($160,378)	$0	$160,378
CCI Full Duals (CY 2016)				
CMC	$11,970	$5,985	$5,985	$0
CMC Reimb	$0	($250)	$0	$250
MLTSS	$32,204	$16,102	$16,102	$0
MLTSS Reimb	$0	($4,565)	$0	$4,565
CCI Non-Full Duals				
FY 2015-16	$270,584	$135,292	$135,292	$0
FY 2015-16 Reimb.	$0	($192,846)	$0	$192,846
AB 97 Recoupment (FY 2014-15)	($22,675)	($11,338)	($11,337)	$0
Hepatitis C Recoupment (FY 2015-16)	($78,296)	($13,898)	($64,398)	$0
CDSS Reconciliation (CY 2014)	$67,721	$0	$0	$67,721
Total FY 2016-17	**$331,083**	**($208,915)**	**$122,327**	**$417,671**

RETRO MC RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 124

(Dollars in Thousands)

FY 2017-18	TF	GF	FF	Reimbursement
MLK Payments				
MLK OE Payments (FY 2015-16)	$9,177	$0	$9,177	$0
MLK OE Payments (July – December 2016)	$4,637	$0	$4,637	$0
CCI Full Duals (CY 2015)				
CMC	($181,976)	($90,988)	($90,988)	$0
CMC Reimb.	$0	$26,435	$0	($26,435)
MLTSS	$23,498	$11,749	$11,749	$0
MLTSS Reimb.	$0	($11,053)	$0	$11,053
CCI Full Duals (CY 2016)				
CMC	($117,642)	($58,821)	($58,821)	$0
CMC Reimb.	$0	($14,287)	$0	$14,287
MLTSS	$956,166	$478,083	$478,083	$0
MLTSS Reimb.	$0	($299,989)	$0	$299,989
CCI Full Duals (CY 2017, 6 mons.)				
CMC	$16,890	$8,445	$8,445	$0
CMC Reimb.	$0	($7,856)	$0	$7,856
MLTSS	$362,544	$181,272	$181,272	$0
MLTSS Reimb.	$0	($52,307)	$0	$52,307
CCI Non-Full Duals (FY 2016-17)				
SFY 2016-17	$174,740	$87,370	$87,370	$0
SFY 2016-17 Reimb.	$0	($66,679)	$0	$66,679
ACA Optional Recoupment				
ACA Optional Recoupment (FY 2015-16)	($3,115,256)	$0	($3,115,256)	$0
ACA Optional Recoupment (July-Dec 2016)	($2,181,048)	$0	($2,181,048)	$0
Total FY 2017-18	**($4,048,271)**	**$191,375**	**($4,665,380)**	**$425,736**

Funding:
50% Title XIX FF / 50% GF (4260-101-0001/0890)
65% Title XXI FF / 35% GF (4260-113-0001/0890)
88% Title XXI FF / 12% GF (4260-113-0001/0890)
100% Title XIX Federal Share Only (4260-101-0890)
90% Family Planning / 10% GF (4260-101-0001/0890)
100% Reimbursement GF (4260-610-0995)

MEDICARE PART B ADJUSTMENT

REGULAR POLICY CHANGE NUMBER:	125
IMPLEMENTATION DATE:	7/2016
ANALYST:	Humei Wang
FISCAL REFERENCE NUMBER:	1939

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$23,423,000	-$160,682,000
- STATE FUNDS	$11,711,500	-$88,557,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	50.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$11,711,500	-$160,682,000
STATE FUNDS	$5,855,750	-$88,557,500
FEDERAL FUNDS	$5,855,750	-$72,124,500

DESCRIPTION

Purpose:
This policy change estimates the Medicare Part B premium and deductible change expected in Calendar Year 2017 and 2018.

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

Interdependent Policy Changes:
Not Applicable

Background:
This policy change estimates the Medicare Part B premium and deductible change for Part B dual eligibles (those Medi-Cal eligibles who also eligible for Medicare Part B). For these dual eligibles, Medi-Cal pays the full Part B monthly premium and the annual deductible. The Medicare Part B premium and deductible are determined by the Centers for Medicare and Medicaid (CMS) based on the projected increase in expenditures for Medicare Part B.

Reason for Change:
The change from the prior estimate for FY 2016-17 is due to:
1. The actual 2017 Part B premium now being reflected in the Medicare Pmnts – Buy-In Part A & B Premiums policy change.
2. Lower estimate of Part B enrollment.

The change from the prior estimate for FY 2017-18 is due to:
1. Projecting the 2018 premium reduction of $9.60 due to the 2017 premium increase now being reflected in the Medicare Pmnts – Buy-In Part A & B Premiums policy change.
2. Lower estimate of Part B enrollment.

MEDICARE PART B ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 125

The change from FY 2016-17 to FY 2017-18 in the current estimate is due to:
1. Lower 2018 premium rate starting January 2018, there is no FY 2016-17 impact.
2. Lower estimate of 2018 deductible rate.

Methodology:
1. The 2017 premium was set by CMS at $134.00. The 2018 premium is estimated to be $124.40. It is assumed the 2018 Social Security increase will allow the growth in Part B costs to be spread to the entire Part B premium population and lower the 'hold harmless' populations' premium.

Fiscal Year	Total
2016-17	$ 0
2017-18	$ -166,328,000

2. The 2017 deductible was set by CMS at $183.00. The 2018 deductible is estimated to decrease to $170.00, still higher than the 2016 level at $166.00.

Fiscal Year	Total
2016-17	$ 23,423,000
2017-18	$ 5,646,000

3. The estimated total expenditure changes are:

Fiscal Year	Total
2016-17	$ 23,423,000
2017-18	$ -160,682,000

(Dollars in Thousands)

FY2016-17	TF	GF	FF
Part B Premium	-	-	-
Part B Deductible	$23,423	$11,711	$11,712
Total	**$23,423**	**$11,711**	**$11,712**

FY 2017-18	TF	GF	FF
Part B Premium	-$166,328	-$91,381	-$74,947
Part B Deductible	$5,646	$2,823	$2,823
Total	**$160,682**	**-$88,558**	**-$72,124**

MEDICARE PART B ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 125

Funding:

(Dollars in Thousands)

FY 2016-17	TF	GF	FF
100% GF (4260-101-0001)	-	-	-
100% Title XIX (4260-101-0890)	-	-	-
50% Title XIX / 50% GF (4260-101-0001/0890)	$23,423	$11,711	$11,712
Total	**$23,423**	**$11,711**	**$11,712**

FY 2017-18	TF	GF	FF
100% GF (4260-101-0001)	-$19,377	-$19,377	-
100% Title XIX (4260-101-0890)	-$2,944	-	-$2,944
50% Title XIX / 50% GF (4260-101-0001/0890)	-$138,361	-$69,181	-$69,180
Total	**-$160,682**	**-$88,558**	**-$72,124**

DENTAL RETROACTIVE RATE CHANGES

REGULAR POLICY CHANGE NUMBER:	126
IMPLEMENTATION DATE:	7/2014
ANALYST:	Nikaela Ratliff
FISCAL REFERENCE NUMBER:	1185

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$131,542,000	$23,693,000
- STATE FUNDS	$42,416,380	$9,095,270
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$131,542,000	$23,693,000
STATE FUNDS	$42,416,380	$9,095,270
FEDERAL FUNDS	$89,125,620	$14,597,730

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 Denti-Cal or a prepaid health plan and 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 2016-17, is a decrease due to a revision of the timing of when retroactive payments will be received and the Health Insurance Provider Fee being budgeted through the Dental Services policy change for Fee-For-Service and through the Dental Manage Care policy change for Dental Managed care instead of as a retroactive adjustment. The change from the prior estimate, for FY 2017-18, is a decrease due to a revision of the timing of when retroactive payments will be received. The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to the timing of when retroactive payments will be received.

DENTAL RETROACTIVE RATE CHANGES

REGULAR POLICY CHANGE NUMBER: 126

Methodology:

1. Assume the following retroactive rate adjustments are to be made in FY 2016-17:

Delta Dental Rate Period	**Existing Rate**	**New Rate**	**Change**	**Eligible Months**	**Dental Retro Rate Adjustment**
Regular					
07/01/2015 – 06/30/2016	$7.81	$8.32	$0.51	122,317,972	$62,382,000
07/01/2016 – 04/30/2017	$7.81	$8.32	$0.51	135,824,560	$69,271,000
Refugees					
07/01/2015 – 06/30/2016	$5.81	$0.00	($5.81)	19,092	($111,000)
07/01/2016 – 04/30/2017	$5.81	$0.00	($5.81)	0	
Total Dental Retroactive Adjustments for Delta Dental (CO 26)					$131,542,000

FY 2016-17 (cash basis)	**Dental Retro Rate Adjustment**
Delta Dental FY 2015-16	**$62,271,000**
Delta Dental FY 2016-17	**$69,271,000**
Total FY 2016-17	**$131,542,000**

2. Assume the following retroactive rate adjustments are to be made in FY 2017-18:

GMC and PHP Dental Rate Period	**Existing Rate**	**New Rate**	**Change**	**Eligible Months**	**Dental Retro Rate Adjustment**
GMC <21					
07/01/2015 – 06/30/2016	$11.45	$11.86	$0.41	2,812,031	$1,153,000
07/01/2016 – 06/30/2017	$11.45	$11.86	$0.41	2,543,916	$1,043,000
07/01/2017 – 09/30/2018	$11.45	$11.86	$0.41	635,979	$261,000
21+					
07/01/2015 – 06/30/2016	$8.42	$8.71	$0.29	2,474,943	$718,000
07/01/2016 – 06/30/2017	$8.42	$8.71	$0.29	2,632,524	$763,000
07/01/2017 – 09/30/2018	$8.42	$8.71	$0.29	658,131	$191,000
PHP <21					
07/01/2015 – 06/30/2016	$12.95	$13.50	$0.55	3,802,091	$2,091,000
07/01/2016 – 06/30/2017	$12.95	$13.50	$0.55	2,942,640	$1,618,000
07/01/2017 – 09/30/2018	$12.95	$13.50	$0.55	735,660	$405,000
21+					
07/01/2015 – 06/30/2016	$7.80	$9.31	$1.51	6,063,992	$9,157,000
07/01/2016 – 06/30/2017	$7.80	$9.31	$1.51	3,334,548	$5,035,000
07/01/2017 – 09/30/2018	$7.80	$9.31	$1.51	833,637	$1,258,000
Total Dental Retroactive Adjustments for GMC and PHP					$23,693,00

DENTAL RETROACTIVE RATE CHANGES

REGULAR POLICY CHANGE NUMBER: 126

FY 2017-18 (cash basis)	Dental Retro Rate Adjustment
GMC and PHP Dental FY 2015-16	**$13,119,000**
GMC and PHP Dental FY 2016-17	**$8,459,000**
GMC and PHP Dental FY 2017-18	**$2,115,000**
Total FY 2017-18	**$23,693,000**

Funding:

FY 2016-17		TF	GF	FF
65% Title XXI / 35% GF	4260-101-0001/0890	$2,060,000	$721,000	$1,339,000
88% Title XXI / 12% GF	4260-101-0001/0890	$12,904,000	$1,548,480	$11,355,520
65% Title XIX / 35% GF	4260-101-0001/0890	$81,000	$28,350	$52,650
100% GF	4260-101-0001	$5,000	$5,000	$0
50% Title XIX / 50% GF	4260-101-0001/0890	$79,137,000	$39,568,500	$39,568,500
100% Title XIX ACA	4260-101-0890	$26,454,000	$0	$26,454,000
95% Title XIX ACA FF / 5% GF		$10,901,000	$545,050	$10,355,950
Total		**$131,542,000**	**$42,416,380**	**$89,125,620**

FY 2017-18		TF	GF	FF
88% Title XXI / 12% GF	4260-101-0001/0890	$446,000	$53,520	$392,480
65% Title XIX / 35% GF	4260-101-0001/0890	$300	$105	$195
50% Title XIX / 50% GF	4260-101-0001/0890	$17,963,000	$8,981,500	$8,981,500
100% Title XIX ACA	4260-101-0890	$4,076,000	$0	$4,076,000
95% Title XIX ACA FF / 5% GF		$1,208,000	$60,400	$1,147,600
Total		**$23,693,000**	**$9,095,525**	**$14,597,775**

FQHC/RHC/CBRC RECONCILIATION PROCESS

REGULAR POLICY CHANGE NUMBER:	127
IMPLEMENTATION DATE:	7/2008
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1329

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$200,634,000	$204,397,000
- STATE FUNDS	$74,548,250	$77,604,240
PAYMENT LAG	0.9816	0.9757
% REFLECTED IN BASE	21.07 %	13.92 %
APPLIED TO BASE		
TOTAL FUNDS	$155,446,600	$171,669,500
STATE FUNDS	$57,758,260	$65,178,450
FEDERAL FUNDS	$97,688,320	$106,491,030

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). This policy change also estimates the cost to provide a rate increase to Cost-Based Reimbursement Clinics (CBRCs) after the Department completes a reconciliation audit.

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 2011-12 audited levels were used to update the CBRC rates as of July 1, 2016. The Department is scheduled to complete the CBRC reconciliation audit for FY 2012-13 in FY 2017-18 and will complete FY 2014-15 in FY 2016-17. 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. Interim rates will be adjusted to the FY 2012-13 audited levels beginning in FY 2018-19, to the FY 2013-14 audited levels in FY 2016-17, and to the FY 2014-15 audit levels in FY 2017-18.

Currently, there are 1008 active FQHCs, 342 active RHCs, 25 active CBRCs, and 59 active Indian Health Services.

FQHC/RHC/CBRC RECONCILIATION PROCESS

REGULAR POLICY CHANGE NUMBER: 127

Reason for Change:
The increase from the prior estimate for FY 2016-17 is due to adjustments from the interim to the final rates. The increase from the prior estimate, for FY 2017-18, is due to an increased number of completed FQHC and RHC reconciliations than previously estimated. The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to an increase in actual settlements and the addition of tentative settlements in the estimated costs for FY 2017-18.

Methodology:
1. FY 2016-17 FQHC and RHC reconciliations are based on a three-year average of actual settlements from July 2014 through June 2016. FY 2017-18 reconciliations are also based on a three-year average and based on actual and reported settlements from July 2015 through June 2017.

2. The estimated FQHC retroactive rate adjustment for FY 2016-17 of $17,439,000 and $14,280,000 for FY 2017-18 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 2014-15, 2015-16, and 2016-17. 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 2016-17 is based on the settlement of 91.2% of 2014 audited settlements, while the FY 2017-18 reconciliation is based on settlement of 95% of the 2015 reported settlements. Based on reported costs for fiscal years 2007-2016, reconciliations are expected to increase by 5.13% thereafter. The change from the prior year estimate is due to an increase in reported revenues and reported payments.

   Hospital closures and/or ancillary facilities no longer utilizing the hospitals' PPS rate may have attributed to the LA CBRC reconciliation decrease between FY 2016-17 and FY 2017-18.

4. The July 1, 2016 CBRC rate increase of $27,757,000 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 payment and the total payments per the Paid Claims Summary Reports for FY 2015-16.

5. 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 payment and the total payments per the Paid Claims Summary reports for FY 2015-16.

FQHC/RHC/CBRC RECONCILIATION PROCESS

REGULAR POLICY CHANGE NUMBER: 127

(Dollars in Thousands)	FY 2016-17	FY 2017-18
FQHCs Reconciliation	$75,481	$86,339
RHCs Reconciliation	$10,933	$13,234
FQHC Retroactive Rate Adjustment	$17,439	$14,280
LA CBRCs Reconciliation	$69,024	$25,503
July 2016 LA CBRC Rate Increase	$27,757	$27,757
July 2017 LA CBRC Rate Increase	$0	$37,284
Total	**$200,634**	**$204,397**

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

AB 1629 ANNUAL RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER:	128
IMPLEMENTATION DATE:	8/2014
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1508

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$100,677,000	$180,813,000
- STATE FUNDS	$50,338,500	$90,406,500
PAYMENT LAG	0.9253	0.9670
% REFLECTED IN BASE	5.66 %	17.07 %
APPLIED TO BASE		
TOTAL FUNDS	$87,883,800	$144,999,900
STATE FUNDS	$43,941,890	$72,499,960
FEDERAL FUNDS	$43,941,890	$72,499,960

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 193 Funding Adjust.—ACA Opt. Expansion
PC 194 Funding Adjust.—OTLICP

Background:
AB 1629 requires the Department to implement a facility-specific rate methodology and impose a QAF on NF-Bs, including adult and pediatric subacute facilities. The QAF is used to offset the 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: 128

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 program (QASP) for freestanding nursing facilities (NF-Bs). The QASP will be 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 skilled nursing facilities 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 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 in FY 2016-17, effective August 1, 2017, for federal approval.

Reason for Change:

The change from the prior estimate, for FY 2016-17, is a decrease due to:

- Delayed implementation of the 2016-17 rate from December 1, 2016, to March 27, 2017,
- Revised Fee-for-Service (FFS) utilization based on data through January 2017,
- Updated 2016-17 rates based on decreased QAF rates,
- Updated 2015-16 erroneous payment correction (EPC) based on actual data.

The change from the prior estimate, for FY 2017-18, is an increase due to:

- An increase in the 2016-17 retroactive payment amount,
- Revised FFS utilization based on data through January 2017, and
- Updated 2017-18 rates based on decreased QAF rates.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to:

- Including eight months of the 2015-16 rate in FY 2016-17 and 12 months in FY 2017-18;
- Including three months of the 2016-17 rate in FY 2016-17 and 12 months in FY 2017-18;
- The 2015-16 retroactive payment being implemented in FY 2016-17;
- The 2016-17 and 2017-18 retroactive payments being implemented in FY 2017-18.

AB 1629 ANNUAL RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 128

Methodology:

1. The effective date for the rate increase and add-ons is August 1st.

2. Assume a 3.62% rate increase for the 2016-17 rate year, and a 3.62% rate increase for the 2017-18 rate year.

3. The 2015-16 final rates and add-ons were implemented in October 24, 2016. The 2015-16 retroactive rate payments that covered August 1, 2015, through October 23, 2016, were implemented on March 21, 2017 for Freestanding Subacute facilities and March 28, 2017 for NF-Bs.

4. 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 will be implemented in September 2017.

5. The 2017-18 rates and add-ons will be implemented in December 2017. The 2017-18 retroactive rate payment will cover August 1, 2017, through November 30, 2017, and will be implemented in March 2018.

6. The estimated managed care rate adjustment impact for 2016-17 and 2017-18 is included in the 2016-17 and 2017-18 managed care capitation rates, respectively.

AB 1629 ANNUAL RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 128

7. The add-on descriptions are listed below:

Add-On	FY 2016-17	FY 2017-18
FUTA – 2015-16: Effective August 1, 2015, the FUTA add-on increases annually and provides LTC facilities FUTA tax credit.	$0.11	
FUTA – 2016-17: Effective August 1, 2016, the FUTA add-on increases annually and provides LTC facilities FUTA tax credit.	$0.11	$0.11
FUTA – 2017-18: Effective August 1, 2016, the FUTA add-on increases annually and provides LTC facilities FUTA tax credit.		$0.11
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.	$0.35	
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.	$2.11	
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	
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.	$0.54	
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.	$0.10	$0.17
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.		$0.10
Payroll-Based Journal: Effective July 1, 2016, CMS requires facilities to submit direct care staffing information based on payroll data.	$0.13	$0.13

AB 1629 ANNUAL RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 128

8. The estimated payments on a cash basis are:

(Dollars in Thousands)

FY 2016-17	TF	GF	FFP
FFS (Rate Increase)	$19,962	$9,981	$9,981
RY 2015-16 Retro	$63,674	$31,837	$31,837
Add-Ons	$17,041	$8,520	$8,521
Managed Care	$0	$0	$0
Total	**$100,677**	**$50,338**	**$50,339**

FY 2017-18	TF	GF	FFP
FFS (Rate Increase)	$126,080	$63,040	$63,040
RY 2016-17 Retro	$53,469	$26,734	$26,735
RY 2017-18 Retro	$10,358	$5,179	$5,179
Add-Ons	($9,094)	($4,547)	($4,547)
Managed Care	$0	$0	$0
Total	**$180,813**	**$90,406**	**$90,407**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
ACA Optional Expansion funding identified in PC 189 Funding Adjust.—ACA Opt. Expansion
OTLICP funding identified in PC 190 Funding Adjust.—OTLICP

QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	129
IMPLEMENTATION DATE:	4/2014
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1563

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$82,670,000	$86,243,000
- STATE FUNDS	$41,335,000	$43,121,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$82,670,000	$86,243,000
STATE FUNDS	$41,335,000	$43,121,500
FEDERAL FUNDS	$41,335,000	$43,121,500

DESCRIPTION

Purpose:
This policy change estimates:

- Transfer from the General Fund (GF) to a Skilled Nursing Facility Quality and Accountability Special Fund (Special Fund), and
- Supplemental payments to freestanding nursing facilities (NF-Bs) through the Special Fund.

Authority:
SB 853 (Chapter 717, Statutes of 2010)
AB 1489 (Chapter 631, Statutes of 2012)
AB 119 (Chapter 17, Statutes of 2015)

Interdependent Policy Changes:
Not Applicable

Background:
SB 853 implemented a quality and accountability supplemental payments (QASP) program for NF-Bs. The supplemental payments are tied to demonstrated quality of care improvements. Supplemental payments began April 2014 and are paid through the Special Fund. The Special Fund is comprised of penalties collected from skilled nursing facilities that do not meet minimum staffing requirements, one-third of the AB 1629 facilities reimbursement rate increase for rate year 2014-15 (up to a maximum of 1% of the overall rate), and the savings achieved from setting the professional liability insurance (PLI) cost category at the 75th percentile.

AB 1489 implemented a 3% increase to the AB 1629 facilities weighted average Medi-Cal reimbursement rate for the 2013-14 and 2014-15 rate years, and also extended the quality assurance fee (QAF) and the QASP at 1% of the overall rate level until July 31, 2015.

QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS
REGULAR POLICY CHANGE NUMBER: 129

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 QASP will continue at FY 2014-15 levels, rather than setting aside a portion of the annual rate increase. Additionally, beginning fiscal year 2015-16, the legislation requires the Department to incorporate direct care staff retention as a performance measure into the QASP Program.

The California Department of Aging (CDA) has direct appropriation authority of $1.9 million from the Special Fund to pay for the Ombudsman costs that are not matched with Federal Financial Participation (FFP).

The Department reimburses the California Department of Public Health (CDPH) administrative costs from the Special Fund. See the FFP for Department of Public Health Support Cost other administration policy change.

Reason for Change:
The change from the prior estimate, for FY 2016-17 and FY 2017-18, is due to estimating payments without a fund balance reserve and updated CDPH administrative costs.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to updated CDPH administrative costs.

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 2016-17	FY 2017-18
Penalties on Nursing Facilities	$210,000	$210,000
AB 1629 QAF Set Aside	$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 $7,860,000 TF ($3,930,000 Special Fund) for FY 2016-17 and $7,814,000 TF ($3,907,000 Special Fund) for FY 2017-18.

5. The QASP funding will continue at FY 2014-15 levels, instead of setting aside a portion of the annual increase.

6. A repayment to the GF in the amount of $45,000,000 was made in FY 2016-17, due to the FY 2015-16 supplemental payment being made from the GF.

QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS
REGULAR POLICY CHANGE NUMBER: 129

7. The FY 2015-16 transfer from the GF to SF in the amount of $43,236,000 was made in FY 2016-17.

8. Supplemental payments are estimated to be:

(Dollars in Thousands)

FY 2016-17	TF	GF	SF	FF
FY 2015-16 Supplemental Payments***	$90,000	$0	$45,000	$45,000
FY 2016-17 Supplemental Payments***	$82,670	$0	$41,335	$41,335
FY 2015-16 Transfer from GF* to SF**	$0	$43,236	($43,236)	$0
FY 2016-17 Transfer from GF* to SF**	$0	$48,928	($48,928)	$0
GF Repayment****	($90,000)	($45,000)	$0	($45,000)
Total	**$82,670**	**$47,164**	**($5,829)**	**$41,335**

FY 2017-18	TF	GF	SF	FF
FY 2017-18 Supplemental Payments***	$86,243	$0	$43,121	$43,122
FY 2017-18 Transfer from GF* to SF**	$0	$48,928	($48,928)	$0
Total	**$86,243**	**$48,928**	**($5,807)**	**$43,122**

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

DPH INTERIM & FINAL RECONS

REGULAR POLICY CHANGE NUMBER:	130
IMPLEMENTATION DATE:	12/2016
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1152

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$81,174,000	$137,004,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$81,174,000	$137,004,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$81,174,000	$137,004,000

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 2552-96 or 2552-10 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: 130

Reason for Change:
The change from the prior estimate, for FY 2016-17, is due to the final review of the FY 2013-14 cost reports. The change for FY 2017-18, from the prior estimate, is due to the revised FY 2008-09 interim reconciliations.

The change from FY 2016-17 to FY 2017-18, 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 2016-17	TF	FF	ACA FF
2007-08 Final Reconciliation	$85,321	$85,321	$0
2013-14 Final Reconciliation	($4,147)	($11,812)	$7,665
Total	**$81,174**	**$73,509**	**$7,665**

FY 2017-18	TF	FF	ACA FF
2008-09 Final Reconciliation	$137,004	$137,004	$0
Total	**$137,004**	**$137,004**	**$0**

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

DPH INTERIM RATE GROWTH

REGULAR POLICY CHANGE NUMBER:	131
IMPLEMENTATION DATE:	7/2017
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1162

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	$55,831,000
- STATE FUNDS	$0	$27,915,500
PAYMENT LAG	1.0000	0.6792
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$37,920,400
STATE FUNDS	$0	$18,960,210
FEDERAL FUNDS	$0	$18,960,210

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 142 DPH Interim Rate
PC 193 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 hospital's costs. This growth increase is expected to be different from the Selective Provider Contracting Program (SPCP) negotiated rate trend for some DPHs and requires an adjustment to the Medi-Cal Estimate base. The interim per diem rate consists of 100% federal funding.

Reason for Change:
The change in FY 2016-17, from the prior estimate, is due to the FY 2016-17 rate growth removed from this policy change as the fee-for-service (FFS) base trends include the full impact of the FY 2016-17 rate increase.

The change in FY 2017-18, from the prior estimate is due to an increased growth rate from 3.92% to 4.37%, and a decrease in estimated users based on updated DPH actual data through January 2017.

In the current estimate, costs are only included for the FY 2017-18 rate increase.

DPH INTERIM RATE GROWTH

REGULAR POLICY CHANGE NUMBER: 131

Methodology:

1. The DPHs received new FY 2016-17 interim rates as of July 1, 2016. These rates were based on FY 2014-15 costs trended to FY 2016-17.

2. For FY 2016-17:
   - The rate increase is 100% captured in the FFS base trends.

3. For FY 2017-18:
   - Assume an average interim rate increase of 4.37%.
   - An additional cost of $55,831,000 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 $37,920,400 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 193 Funding Adjust. — ACA Opt. Expansion

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER:	132
IMPLEMENTATION DATE:	8/2007
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1046

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$15,685,000	$34,003,000
- STATE FUNDS	$7,842,500	$17,001,500
PAYMENT LAG	0.8565	0.9328
% REFLECTED IN BASE	13.38 %	7.28 %
APPLIED TO BASE		
TOTAL FUNDS	$11,636,700	$29,408,900
STATE FUNDS	$5,818,350	$14,704,460
FEDERAL FUNDS	$5,818,350	$14,704,460

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 193 Funding Adjust. – ACA Opt. Expansion
PC 194 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.

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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 2016-17, is due to the following costs being being fully captured in the Fee-for-Service (FFS) base trends and no longer budgeted in this policy change:

- 2016-17 ICF-DD rates;
- 2015-16 retroactive payments for DP/NF-Bs, Rural Swing Beds, ICF-DDs, DP Pediatric Subacutes, and FS Pediatric Subacutes, and
- 2016-17 ICF-DD retroactive payment.

The change from the prior estimate, for both FY 2016-17 and FY 2017-18, is due to:

- Revised FFS utilization based on data through January 2017, including a significant decrease in NF-A utilization resulting from an audit in 2016-17;

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- The 2016-17 and 2017-18 DP/NF-B rates being established at a higher rate based on less facilities meeting the 20% Medi-Cal utilization requirement. DP/NF-B rates are established as the lower of the facility's cost or the projected median rate. As the projected median rate increases, DP/NF-B rates are also projected to increase;
- Delays in the implementation of the 2016-17 DP/NF-B, Rural Swing Bed, and DP Pediatric Subacute rates, and 2016-17 DP Pediatric Subacute retroactive payments due to system delays;
- The implementation of the 2016-17 retroactive payments for DP/NF-Bs, Rural Swing Beds, DP Adult Subacutes, and NF-As occurring sooner than expected;
- Decreased FS Pediatric Subacute QAF amounts for FY 2016-17 and FY 2017-18; and
- Decreased ACA Employer Mandate add-ons for FY 2016-17 and FY 2017-18.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to:

- The impact of the 2016-17 rate adjustments being included in FY 2017-18; and
- Updates to the applicable add-ons in FY 2017-18.

Methodology:

1. Effective date for the FS rate adjustments begins August 1. Implementation dates for 2016-17 and 2017-18 rates are as follows:

Facility	Rate Year 2016-17	Rate Year 2017-18
DP/NF-B	11/22/2016	11/1/2017
Rural Swing Beds (non-exempt)	11/22/2016	11/1/2017
Rural Swing Beds (exempt)	11/22/2016	11/1/2017
DP Adult Subacute	10/25/2016	11/1/2017
NF-A	10/25/2016	11/1/2017
ICF/DDs	8/18/2016	11/1/2017
DP Pediatric Subacute	6/1/2017	9/1/2017
FS Pediatric Subacute	9/1/2016	9/1/2017

2. Payments in FY 2016-17 include retroactive payments for 2015-16 and 2016-17. Payments for FY 2017-18 include retroactive payments for 2016-17 and 2017-18.

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.

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6. **DP/NF-B facilities**: Effective August 1, 2016, ABX2 1 requires the Department to forgo the AB 97 retroactive recoupment for the rate reduction and rate freeze that would have been applied to the reimbursement for services provided by DP/NF-Bs between June 1, 2011 and September 30, 2013. The repayment of federal funds for the lost savings is budgeted in the DP/NF-B Retroactive Recoupment Forgiveness policy change.

7. **Rural Swing Bed Rates**: The impact of the rate freeze and exemption for Rural Swing Beds in DP/NF-B facilities located in designated rural and frontier areas is captured in the FFS base trends.

8. **ICF/DD, ICF/DD-H, and ICF/DD-N facilities**: Effective August 1, 2016, ABX2 1 requires the Department to restore the AB 97 payment reduction and reimburse ICF/DDs at the 2008-09 rate levels, increased by 3.7%.

Restore AB 97	Increase 3.7%	Total
$5,791,000	$19,330,000	$25,121,000

9. ABX1 19 requires FS Pediatric Subacute Care facilities to pay a QA fee (QAF) beginning January 1, 2012. Effective October 1, 2011, the QA fee cap is 6% of total gross revenues. The fee is used to draw down Federal Financial Participation (FFP) and fund rate increases.

10. AB 119 extends the FS Pediatric Subacute Facilities QAF sunset from July 31, 2015 to July 31, 2020.

11. The estimated managed care rate adjustment impacts for rate year 2016-17 and rate year 2017-18 are included in the managed care capitation rates.

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12. The add-on descriptions are listed below:

Add-On	Rate Year 2016-17	Rate Year 2017-18
FUTA – 2015-16: Effective August 1, 2015, the FUTA add-on increases annually and provides LTC facilities FUTA tax credit.	$0.11 - $0.15	
FUTA – 2016-17: Effective August 1, 2016, the FUTA add-on increases annually and provides LTC facilities FUTA tax credit.	$0.11 - $0.15	
FUTA – 2017-18: Effective August 1, 2017, the FUTA add-on increases annually and provides LTC facilities FUTA tax credit.		$0.11 - $0.15
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.	$0.07 - $7.41	
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.	$0.10 - $0.82	$0.10 - $0.82
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	
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.	$0.54 - $0.62	
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 - $2.29	$0.17 - $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.		$0.10 - $2.29
Payroll-Based Journal: Effective July 1, 2016, CMS requires facilities to submit direct care staffing information based on payroll data.	$0.13	$0.13 - $0.26

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13. The costs below reflect the incremental rate adjustments and add-ons for each facility type:

Fee-for-Service	FY 2016-17	FY 2017-18
Rate Adjustment (16-17)		
DP/NF-B	$9,381,000	$16,081,000
Rural Swing Beds (non-exempt)	($1,000)	($1,000)
Rural Swing Beds (exempt)	($96,000)	($165,000)
DP Adult Subacute	$747,000	$1,120,000
NF-A	$16,000	$23,000
ICF/DDs	$0	$0
DP Pediatric Subacute	$34,000	$415,000
FS Pediatric Subacute	($9,000)	($10,000)
Rate Adjustment (17-18)		
DP/NF-B	$0	$6,281,000
Rural Swing Beds (non-exempt)	$0	$1,000
Rural Swing Beds (exempt)	$0	($32,000)
DP Adult Subacute	$0	$881,000
NF-A	$0	$31,000
ICF/DDs	$0	$4,843,000
DP Pediatric Subacute	$0	$138,000
FS Pediatric Subacute	$0	$22,000
Retro Rate Adjustments		
DP/NF-B	$5,360,000	$2,355,000
Rural Swing Beds (non-exempt)	$0	$0
Rural Swing Beds (exempt)	($29,000)	($6,000)
DP Adult Subacute	$280,000	$331,000
NF-A	$3,000	$6,000
ICF/DDs	$0	$1,327,000
DP Pediatric Subacute	$0	$360,000
FS Pediatric Subacute	($1,000)	$2,000
Total FFS	$15,685,000	$34,003,000
Managed care	$0	$0
Total Cost	**$15,685,000**	**$34,003,000**

Funding:
50% Title XIX / 50% Title GF (4260-101-0001/0890)
ACA Optional Expansion funding identified in PC 193 Funding Adjust. – ACA Opt. Expansion
OTLICP funding identified in PC 194 Funding Adjust. – OTLICP

ANNUAL MEI INCREASE FOR FQHCS/RHCS

REGULAR POLICY CHANGE NUMBER:	133
IMPLEMENTATION DATE:	10/2005
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	88

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$42,712,000	$56,022,000
- STATE FUNDS	$15,869,750	$21,270,140
PAYMENT LAG	0.9079	0.9176
% REFLECTED IN BASE	100.00 %	57.92 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$21,631,600
STATE FUNDS	$0	$8,212,960
FEDERAL FUNDS	$0	$13,418,600

DESCRIPTION

Purpose:
This policy change estimates the annual Medicare Economic Index (MEI) increase for all Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) under the prospective payment system (PPS) reimbursement methodology.

Authority:
Section 1833 of the Social Security Act

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 MEI and is effective October 1st of each year.

Reason for Change:
The change from the prior estimate is a decrease due to 100% of FY 2016-17 costs and 57.92% of FY 2017-18 costs being included in the base. However, the overall expenditures increased due to an increased number of actual and projected visits from newly eligible beneficiaries. The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to increased projected visits with the addition of actual data from FY 2015-16, an increase in the MEI, and fewer FY 2017-18 costs in the base.

Methodology:
1. The projected visits are based on the average percent increase of the last 3 years actual visit counts.

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2. The annual MEI increase will be used as a trend factor to calculate the estimated cost per visit rate. The MEI increase percent for calendar year 2015 was 0.8%, 1.1% for calendar year 2016, and 1.2% for calendar year 2017.

Rate Year	Projected Visits	Rate without MEI	Rate with MEI
2015	16,651,381	$152.21	$152.21 x (1+0.8%) = $153.43
2016	17,670,575	$153.43	$153.43 x (1+1.1%) = $155.12
2017	18,752,153	$155.12	$155.12 x (1+1.2%) = $156.98

3. The estimated expenditures are the estimated rate multiplied by the estimated visits. The annual expenditures due to MEI increase are:

(Dollars in Thousands)

Rate Year	Expenditures without MEI	Expenditures with MEI	MEI Increase
2015	$2,534,507	$2,554,821	$20,315
2016	$2,711,196	$2,741,060	$29,863
2017	$2,908,834	$2,943,713	$34,879

(Dollars in Thousands)

	TF	GF	FF
FY 2016-17	**$42,712**	**$15,869**	**$26,843**
FY 2017-18	**$56,022**	**$21,271**	**$34,751**

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)

EMERGENCY MEDICAL AIR TRANSPORTATION ACT

REGULAR POLICY CHANGE NUMBER:	134
IMPLEMENTATION DATE:	11/2012
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1612

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$11,188,000	$11,000,000
- STATE FUNDS	$5,594,000	$5,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$11,188,000	$11,000,000
STATE FUNDS	$5,594,000	$5,500,000
FEDERAL FUNDS	$5,594,000	$5,500,000

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)
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.

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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.

SB 326 extended the sunset date for the assessment of penalties to January 1, 2018. Penalties assessed before this date will continue to be collected and administered, and augmentation payments will be made until June 30, 2019. The Department will provide 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).

Reason for Change:
The change from the prior estimate, for FY 2016-17, is a decrease due to actual augmentation payments and revised GF offset amounts.

The change from the prior estimate, for FY 2017-18, is an increase in GF offset amounts.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is a decrease due to:

- Decreased augmentation payment amounts expected in FY 2017-18 based on the assessments ending December 31, 2017, and
- Decreased GF offset amounts in FY 2017-18 compared to FY 2016-17.

Methodology:

1. Implementation date began November 2012.

2. The FY 2016-17 estimated payments include:
    - FFS augmentation payments based on fees collected from the second half of FY 2015-16 and the first half of FY 2016-17,
    - GF transfer from the second half of FY 2015-16 collections of $1,456,000, and
    - GF transfer from the first half of FY 2016-17 collections is expected to be $1,066,000.

3. 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 $1,172,000, and
    - GF transfer from the first half of FY 2017-18 collections is expected to be $1,218,000.

EMERGENCY MEDICAL AIR TRANSPORTATION ACT

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4. Based on estimated fee collections, the estimated payments on a cash basis are:

(Dollars in Thousands)

FY 2016-17	TF	GF	EMATA	FFP
GF Offset	$0	($2,522)	$2,522	$0
Augment Payment	$11,188	$0	$5,594	$5,594
Total	**$11,188**	**($2,522)**	**$8,116**	**$5,594**

FY 2017-18	TF	GF	EMATA	FFP
GF Offset	$0	($2,390)	$2,390	$0
Augment Payment	$11,000	$0	$5,500	$5,500
Total	**$11,000**	**($2,390)**	**$7,890**	**$5,500**

Funding:
100% GF (4260-101-0001)
Title XIX FFP (4260-101-0890)
EMATA Fund (4260-101-3168)

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER:	135
IMPLEMENTATION DATE:	10/2006
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	96

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$2,638,000	$24,014,000
- STATE FUNDS	$1,319,000	$12,007,000
PAYMENT LAG	0.7971	0.8945
% REFLECTED IN BASE	70.34 %	7.26 %
APPLIED TO BASE		
TOTAL FUNDS	$623,700	$19,921,000
STATE FUNDS	$311,840	$9,960,520
FEDERAL FUNDS	$311,840	$9,960,520

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 193 Funding Adjust.—ACA Opt. Expansion
PC 194 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 affiliated 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.

   Pursuant to ABX4 5 (Chapter 5, Statutes of 2009), hospice room and board rates were frozen to 2008-09 levels for rate years 2009-10 and 2010-11, in those cases where the facility's per-diem rate was frozen. AB 97 (Chapter 3, Statutes of 2011) allows the Department to decide whether to

HOSPICE RATE INCREASES

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implement further rate freezes and payment reductions for long-term care (LTC) facilities, effective June 1, 2011. The Department removed the rate freeze for certain LTC facilities.

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. Hospice room and board rates will increase based on the nursing facility rate increases.

Reason for Change:

The change from the prior estimate, for FY 2016-17, is due to:

- Updated FY 2015-16 retroactive Erroneous Payment Correction (EPC) amount based on actuals provided by CA-MMIS;
- Shifts in rate and retroactive payment implementation dates due to system delays; and
- Revised Routine Home Care (RHC) estimates based on updated utilization through January 2017.

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

- Shifts in rate and retroactive payment implementation dates due to system delays; and
- Revised Routine Home Care (RHC) estimates based on updated utilization through January 2017.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to:

- The impact of the FY 2015-16 RHC rates and FY 2016-17 hospice rate increases being budgeted in FY 2017-18;
- The FY 2016-17 hospice services retroactive EPC being implemented in FY 2017-18; and
- The implementation of the FY 2017-18 hospice rates in FY 2017-18.

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, tobacco products, 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. Effective June 1, 2011, AB 97 allows the Department to implement rate freezes at the 2008-09 levels for all LTCs other than Freestanding Skilled Nursing and Freestanding Adult Subacute Nursing Facilities.

   The Department received approval from the Centers of Medicare and Medicaid Services (CMS) to implement a rate freeze on NF-As and DP NF-Bs, and Freestanding Pediatric Subacute rates.

   The Department elected to not implement the rate freeze for some LTC facility types based on its access and utilization analyses. CMS approved the Department's request to not implement a rate freeze on DP Adult and Pediatric Subacute rates.

   Effective June 2014, 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

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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.

SB 239 (Chapter 657, Statutes of 2013) required the Department to remove prospectively the DP/NF-B providers from the rate freeze and payment reductions.

2. The estimated weighted increase for hospice service rates for FY 2016-17 and FY 2017-18 is 1.97%.

3. 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. Based on utilization trends, it is assumed that 54.1% of beneficiaries have hospice stays of 60 days or less and 45.9% have hospice stays of 61 days or more.

   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.

4. The 2015-16 RHC rates and SIA are expected to be implemented December 2017, with the retroactive payment for the period of January 2016 through November 2017 expected to be implemented in May 2018.

5. The 2016-17 RHC rates and SIA are expected to be implemented March 2018, with the retroactive payment for the period of October 2016 through February 2018 expected to be implemented in August 2018.

6. The 2017-18 RHC rates and SIA are expected to be implemented September 2018, with the retroactive payment for the period of October 2017 through August 2018 expected to be implemented in FY 2018-19.

7. 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 FY 2016-17 and FY 2017-18 is estimated to be 2.53%.

Cash Basis	FY 2016-17	FY 2017-18
FY 2015-16 - RHC Hospice Services	$0	$3,852,000
FY 2015-16 - Retroactive Payments	$139,000	$0
FY 2016-17 - Hospice Services	$73,000	$2,016,000
FY 2016-17 - Room & Board	$2,426,000	$2,647,000
FY 2016-17 - Retroactive Payments	$0	$12,801,000
FY 2017-18 - Hospice Services	$0	$210,000
FY 2017-18 - Room & Board	$0	$2,488,000
TOTAL	**$2,638,000**	**$24,014,000**

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 135

8. Of the nonfederal share for this policy change in 2017-18, $4.12 million in new growth as compared to the 2016 Budget Act will be funded with Proposition 56 revenue.

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
Healthcare Treatment Fund (4260-101-3305)
ACA Optional Expansion funding identified in PC 193 Funding Adjust.—ACA Opt. Expansion
OTLICP funding identified in PC 194 Funding Adjust.—OTLICP

DISCONTINUE PHARMACY RATE REDUCTIONS

REGULAR POLICY CHANGE NUMBER:	136
IMPLEMENTATION DATE:	4/2017
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1999

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	**$5,644,000**	$22,577,000
- STATE FUNDS	**$2,822,000**	$11,288,500
PAYMENT LAG	0.8030	0.9980
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	**$4,532,100**	$22,531,800
STATE FUNDS	**$2,266,070**	$11,265,920
FEDERAL FUNDS	**$2,266,070**	$11,265,920

DESCRIPTION

Purpose:
This policy change estimates the costs to discontinue the Fee-for-Service (FFS) 10% pharmacy provider payment reductions for drug products when the Department moves to an actual acquisition cost (AAC) and dispensing fee reimbursement methodology.

Authority:
AB 102 (Chapter 29, Statutes of 2011)
State Plan Amendment (SPA) 12-014

Interdependent Policy Changes:
PC 146 10% Provider Payment Reduction
PC 193 Funding Adjust.—ACA Opt. Expansion
PC 194 Funding Adjust.—OTLICP

Background:
Effective June 1, 2011, AB 97 (Chapter 3, Statutes of 2011) required the Department to implement 10% provider payment reductions to most categories of services in Medi-Cal FFS as well as actuarially equivalent reductions in Medi-Cal managed care, including pharmacy providers.

Prospective FFS pharmacy reductions were implemented beginning February 2014. Recoupments for the retroactive period from June 2011 to January 2014 were implemented in March 2016. Per SPA 12-014, certain drugs were exempt from the payment reductions if the state determines that such a reduction would result in reimbursement less than actual acquisition costs or if beneficiary access issues arise. The AB 97 reductions were not implemented for managed care pharmacy providers.

Per Welfare and Institutions (W&I) Code, Section 14105.45(i), AB 97 payment reductions to pharmacy drug products shall no longer apply when the department determines that the average acquisition cost methodology has been fully implemented.

DISCONTINUE PHARMACY RATE REDUCTIONS

REGULAR POLICY CHANGE NUMBER: 136

The 10% payment reductions for non-exempt, pharmacy non-drug products, however, will continue. The ongoing prospective reduction for the pharmacy non-drug products are fully captured in the FFS base trends but are displayed in the 10% Provider Payment Reduction policy change for informational purposes.

The Department will end the prospective FFS 10% pharmacy provider reductions for dates of service on and after April 1, 2017. Per the Centers for Medicare and Medicaid Services (CMS), as directed in the Outpatient Drug Final Rule, the effective date of the new AAC and dispensing fee reimbursement methodology will be April 1, 2017.

Reason for Change:
The change from the prior estimate, for both FY 2016-17 and FY 2017-18, is a decrease due to updated FY 2015-16 pharmacy expenditures data that reflects the restoration costs for pharmacy drug products only. The prior estimate for the AB 97 pharmacy rate restoration included costs for both drug and non-drug products. In addition, the updated FY 2015-16 data includes additional AB 97 pharmacy exemptions.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to three months of the restoration costs in FY 2016-17 compared with a full year of costs in FY 2017-18.

Methodology:
1. Assume the FFS pharmacy rate reduction to drug products will end beginning April 1, 2017.

2. The annual savings for the AB 97 pharmacy drug products reductions are estimated at $22.58 million TF.

3. The estimated costs to restore the pharmacy drug products rates are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2016-17	$5,644	$2,822	$2,822
FY 2017-18	$22,577	$11,288	$11,289

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
ACA Optional Expansion funding identified in PC 193 Funding Adjust.—ACA Opt. Expansion
OTLICP funding identified in PC 194 Funding Adjust.—OTLICP

GDSP NEWBORN SCREENING PROGRAM FEE INCREASE

REGULAR POLICY CHANGE NUMBER:	137
IMPLEMENTATION DATE:	4/2017
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1938

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	**$1,465,000**	$19,743,000
- STATE FUNDS	$732,500	**$9,871,500**
PAYMENT LAG	0.4440	0.9859
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$650,500	$19,464,600
STATE FUNDS	$325,230	**$9,732,310**
FEDERAL FUNDS	$325,230	**$9,732,310**

DESCRIPTION

Purpose:
This policy change estimates the costs associated with a fee increase for newborn screening provided to Medi-Cal beneficiaries under the California Department of Public Health (CDPH) Genetic Disease Screening Program (GDSP).

Authority:
Health & Safety Code Section 124977
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 the 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 will be implemented retroactive to January 2012 in FY 2016-17 and FY 2017-18.

AB 1559 requires GDSP to expand statewide screening of newborns to include screening for adrenoleukodystrophy (ALD). Effective July 1, 2016, the 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 necessitates a fee increase of $17.55 per specimen, effective July 1, 2016.

GDSP NEWBORN SCREENING PROGRAM FEE INCREASE

REGULAR POLICY CHANGE NUMBER: 137

Reason for Change:
The change from the prior estimate, for FY 2016-17, is due to:

- The delay in implementation for the fee $17.55 increase from December 2016 to April 2017;
- The addition of the AB 395 $9.95 fee increase in April 2017; and
- Updated GDSP newborn screening data.

The change from the prior estimate, for FY 2017-18, is an increase due to the Erroneous Payment Corrections (EPCs) for both the $9.95 fee increase and $17.55 fee increase being implemented in August 2017.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to only three months of the $9.95 and $17.55 fee increases in FY 2016-17 and 12 months in FY 2017-18. Additionally, the EPCs for both fee increases are being implemented in August 2017.

Methodology:

1. The Department will implement 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 August 2017.

2. The Department will implement 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 August 2017.

3. The estimated number of births in California is 488,146 in FY 2016-17 and 483,601 in FY 2017-18. GDSP assumes approximately 99.00% of newborns will be screened by the NBS Program each year.

4. Assume approximately 45% of newborns screened are from the Medi-Cal population.

5. Assume 98% of claims submitted are paid.

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 2016-17	488,146	99.00%	45.00%	98.00%	$9.95	$2,121,000
FY 2016-17	488,146	99.00%	45.00%	98.00%	$17.55	$3,740,000
FY 2017-18	483,601	99.00%	45.00%	98.00%	$9.95	$2,101,000
FY 2017-18	483,601	99.00%	45.00%	98.00%	$17.55	$3,705,000

6. The estimated annual costs are:

Fee Increase	FY 2016-17 Annual Cost	FY 2017-18 Annual Cost
$9.95 fee increase	$2,120,541	$2,100,797
$17.55 fee increase	$3,740,250	$3,705,426

GDSP NEWBORN SCREENING PROGRAM FEE INCREASE

REGULAR POLICY CHANGE NUMBER: 137

7. The estimated costs for FY 2016-17 and FY 2017-18 are:

FY 2016-17	TF	GF	FF
$9.95 Rate Increase	$530,000	$265,000	$265,000
$17.55 Rate Increase	$935,000	$467,000	$468,000
Total	**$1,465,000**	**$732,000**	**$733,000**

FY 2017-18	TF	GF	FF
$9.95 Rate Increase	$2,101,000	$1,050,000	$1,051,000
$9.95 Rate Increase – Retro	$11,132,000	$5,566,000	$5,566,000
$17.55 Rate Increase	$3,705,000	$1,852,000	$1,853,000
$17.55 Rate Increase – Retro	$2,805,000	$1,402,000	$1,403,000
Total	**$19,743,000**	**$9,870,000**	**$9,873,000**

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

GDSP PRENATAL SCREENING FEE INCREASE

REGULAR POLICY CHANGE NUMBER:	138
IMPLEMENTATION DATE:	7/2017
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1974

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	**$4,508,000**
- STATE FUNDS	$0	**$2,254,000**
PAYMENT LAG	1.0000	0.9069
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	**$4,088,300**
STATE FUNDS	$0	**$2,044,150**
FEDERAL FUNDS	$0	**$2,044,150**

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 193 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: 138

Reason for Change:
The change from the prior estimate, for FY 2016-17, is a decrease due to:

- A delay in the new rate implementation from December 2016 to July 2017, and
- A shift in the retroactive recoupment implementation from April 2017 to November 2017.

The change from the prior estimate, for FY 2017-18, is an increase due to updated caseload for FY 2016-17 and FY 2017-18, and including the retroactive recoupment in FY 2017-18 instead of FY 2016-17.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to the shift of the new rate implementation from December 2016 to July 2017 and the retroactive recoupment from FY 2016-17 to FY 2017-18.

Methodology:

1. The Department will implement a $14.60 fee increase for the GDSP PNS program in July 2017, retroactive to July 2016.

2. The Erroneous Payment Correction (EPC) for the period of July 2016 through June 2017 is expected to be implemented in November 2017.

3. Assume 351,711 women will have prenatal screening in FY 2016-17 and 348,437 women in FY 2017-18. Approximately 45% of them are Medi-Cal beneficiaries.

   351,711 x 45% = 158,270 Medi-Cal caseload in FY 2016-17

   348,437 x 45% = 156,797 Medi-Cal caseload in FY 2017-18

4. Assume 98% of claims are paid.

   158,270 x 98% = 155,105 claims paid in FY 2016-17

   156,797 x 98% = 153,661 claims paid in FY 2017-18

5. The estimated annual costs are:

   155,105 x $14.60 = $2,265,000 TF in FY 2016-17 (rounded)

   153,661 x $14.60 = $2,243,000 TF in FY 2017-18 (rounded)

(Dollars in Thousands)

FY 2017-18	TF	GF	FF
Fee Increase	$2,243	$1,121	$1,122
Retro	$2,265	$1,132	$1,133
Total	**$4,508**	**$2,253**	**$2,255**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
ACA Optional Expansion funding identified in PC 193 Funding Adjust.—ACA Opt. Expansion

ALAMEDA HOSP & SAN LEANDRO HOSP INTERIM RATE

REGULAR POLICY CHANGE NUMBER:	139
IMPLEMENTATION DATE:	5/2017
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1996

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$334,000	$2,001,000
- STATE FUNDS	-$256,200	-$1,608,540
PAYMENT LAG	0.0960	0.7754
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$32,100	$1,551,600
STATE FUNDS	-$24,600	-$1,247,260
FEDERAL FUNDS	$56,660	$2,798,840

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)

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 Department submitted a State Plan Amendment (SPA) in September 2016 to the Centers for Medicare & Medicaid Services to request the two hospitals' designations be changed to DPHs.

Reason for Change:
The change in FY 2016-17, from the prior estimate, is due to a delay in the expected implementation date by seven months.

The change in FY 2017-18, from the prior estimate, is due to the updated DPH CPE interim rate growth percentage from 3.92% to 4.37%.

ALAMEDA HOSP & SAN LEANDRO HOSP INTERIM RATE

REGULAR POLICY CHANGE NUMBER: 139

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to FY 2016-17 includes two months of payments, while FY 2017-18 includes a full year of payments.

Methodology:

1. Assume the FY 2017-18 DPH CPE interim rate will increase by 4.37% and DRG rates will increase by 3.59%.

2. The DRG payment methodology is paid at 50% GF and 50% FFP.

3. The cost based CPE payment methodology is paid at 50% FFP and 50% CPE.

4. Assume the net ACA optional population adjustments are included in FY 2016-17 and FY 2017-18. 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 will be reduced to 95% FFP / 5% GF. Beginning January 2018, the FFP will further be reduced to 94% FFP / 6% GF.

5. Assume the change in payment methodology from DRG to cost based CPEs will occur in May 2017. The GF savings as a result of the change in payment methodology is expected to be $256,000 in FY 2016-17, and $1,608,000 in FY 2017-18.

6. The funding adjustment on an annual basis is estimated as follows:

FY 2016-17	TF	GF	FF	ACA FF
Alameda Hospital				
DRG	($230,000)	($98,000)	($96,000)	($36,000)
CPE	$353,000	$0	$236,000	$117,000
Alameda Hospital Total	$123,000	($98,000)	$140,000	$81,000
San Leandro Hospital				
DRG	($430,000)	($158,000)	($152,000)	($120,000)
CPE	$641,000	$0	$357,000	$284,000
San Leandro Hospital Total	$211,000	($158,000)	$205,000	$164,000
FY 2016-17 Total	**$334,000**	**($256,000)**	**$345,000**	**$245,000**

FY 2017-18	TF	GF	FF	ACA FF
Alameda Hospital				
DRG	($1,442,000)	($614,000)	($601,000)	($227,000)
CPE	$2,183,000	$0	$1,471,000	$712,000
Alameda Hospital Total	$741,000	($614,000)	$870,000	$485,000
San Leandro Hospital				
DRG	($2,690,000)	($994,000)	($951,000)	($745,000)
CPE	$3,950,000	$0	$2,226,000	$1,724,000
San Leandro Hospital Total	$1,260,000	($994,000)	$1,275,000	$979,000
FY 2017-18 Total	**$2,001,000**	**($1,608,000)**	**$2,145,000**	**$1,464,000**

ALAMEDA HOSP & SAN LEANDRO HOSP INTERIM RATE

REGULAR POLICY CHANGE NUMBER: 139

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)

ALTERNATIVE BIRTHING CENTER REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER:	140
IMPLEMENTATION DATE:	10/2017
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	2000

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	$51,000
- STATE FUNDS	$0	$25,500
PAYMENT LAG	1.0000	0.8703
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$44,400
STATE FUNDS	$0	$22,190
FEDERAL FUNDS	$0	$22,190

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)

Interdependent Policy Changes:
PC 193 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 is currently amending 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: 140

Reason for Change:
There is no material change for FY 2017-18 from the prior 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 is expected to be implemented October 2017.

2. Retroactive payments for the period of July 1, 2017 through September 30, 2017, are expected to be implemented December 2017.

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	$38,000	$19,000	$19,000
Retro	$13,000	$6,500	$6,500
Total	**$51,000**	**$25,500**	**$25,500**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
ACA Optional Expansion funding identified in PC 193 Funding Adjust.—ACA Opt. Expansion

DP/NF-B RETROACTIVE RECOUPMENT FORGIVENESS

REGULAR POLICY CHANGE NUMBER:	141
IMPLEMENTATION DATE:	9/2016
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1964

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$104,415,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$104,415,000	$0
FEDERAL FUNDS	-$104,415,000	$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: 141

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:
There is no change from the prior estimate for both FY 2016-17 and FY 2017-18. The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to completing the one-time repayment in FY 2016-17.

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 estimated GF cost to repay the federal share of the loss of savings is:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2016-17	**$0**	**$104,415**	($104,415)

Funding:
100% GF (4260-101-0001)
100% Title XIX FF (4260-101-0890)

DPH INTERIM RATE

REGULAR POLICY CHANGE NUMBER:	142
IMPLEMENTATION DATE:	7/2005
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1161

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$350,932,550	-$391,438,740
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$350,932,550	-$391,438,740
FEDERAL FUNDS	$350,932,550	$391,438,740

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 131 DPH Interim Rate Growth

Background:
As approved on April 25, 2006 through SPA 05-21, effective July 1, 2005, DPHs no longer receive the negotiated per diem rates under the Selective Provider Contracting Program (SPCP) for inpatient hospital costs for services rendered to Medi-Cal beneficiaries on and after July 1, 2005. Instead, 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 and 6% GF / 94% FFP to 100% FFP beginning January 2018.

DPH INTERIM RATE

REGULAR POLICY CHANGE NUMBER: 142

Reason for Change:
The change in FY 2016-17 and FY 2017-18, from the prior estimate, is due to a decrease in estimated users based on actual data through January 2017, which is mainly a result of users shifting from FFS to managed care.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to the FY 2017-18 rate increase of 4.37%.

Methodology:
1. The funding adjustment is estimated at:

(Dollars in Thousands)

	Expenditures	GF to FF shift
FY 2016-17	**$1,231,587**	**$350,933**
FY 2017-18	**$1,315,514**	**$391,439**

Funding:
(Dollars in Thousands)

FY 2016-17	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890 / 0001)	($673,985)	($336,993)	($336,993)
100% Title XIX FF (4260-101-0890)	$1,231,587	$0	$1,231,587
100% Title XIX ACA (4260-101-0890)	($278,801)	$0	($278,801)
95% Title XIX ACA / 5% GF (4260-101-0890 / 0001)	($278,801)	($13,940)	($264,861)
***Total Funds**	**$0**	**($350,933)**	**$350,933**

FY 2017-18	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890 / 0001)	($717,046)	($358,523)	($358,523)
100% Title XIX FF (4260-101-0890)	$1,315,514	$0	$1,315,514
95% Title XIX ACA / 5% GF (4260-101-0890 / 0001)	($299,234)	($14,962)	($284,272)
94% Title XIX ACA / 6% GF (4260-101-0890 / 0001)	($299,234)	($17,954)	($281,280)
***Total Funds**	**$0**	**($391,439)**	**$391,439**

*Amounts may differ due to rounding

LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES

REGULAR POLICY CHANGE NUMBER:	143
IMPLEMENTATION DATE:	8/2013
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1784

	FY 2016-17	FY 2017-18
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: 143

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 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 both FY 2016-17 and FY 2017-18, is due to:

- Revised ICF-DD and nursing facility growth rates based on updated FFS utilization data,
- Revised average annual LTC QA fee revenue based on updated collection data, and
- Updated collections and transfer data through February 2017.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to the estimated increase in collections based on previous collection growth trends.

Methodology:
1. Based on LTC QA fee collection data from July 2014 through February 2017, the average annual LTC QA fee revenue on a cash basis is $477,251,000. Based on the most recent four years of FFS utilization data, the average growth rate for ICF-DDs and nursing facilities is 0.71% and 1.50%, respectively.

2. Based on FY 2014-15 and FY 2015-16 actual QA fee transfer data, 90.48% of the current year's fee collection is transferred to the GF in the current year, and 95.58% 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:

FY 2016-17	TF	GF	LTCQAF
FY 2014-15	$0	($35,804)	$35,804
FY 2015-16	$0	($140,890)	$140,890
FY 2016-17	$0	($304,754)	$304,754
Total	**$0**	**($481,448)**	**$481,448**

FY 2017-18	TF	GF	LTCQAF
FY 2015-16	$0	($7,804)	$7,804
FY 2016-17	$0	($30,650)	$30,650
FY 2017-18	$0	($444,521)	$444,521
Total	**$0**	**($482,975)**	**$482,975**

Funding:
Long Term Care Quality Assurance Fund (4260-601-3213)
100% GF (4260-101-0001)

LABORATORY RATE METHODOLOGY CHANGE

REGULAR POLICY CHANGE NUMBER:	144
IMPLEMENTATION DATE:	2/2016
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1703

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	-$3,090,000	-$24,403,000
- STATE FUNDS	-$1,545,000	-$12,201,500
PAYMENT LAG	0.7484	0.9827
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$2,312,600	-$23,980,800
STATE FUNDS	-$1,156,280	-$11,990,410
FEDERAL FUNDS	-$1,156,280	-$11,990,410

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 193 Funding Adjust.—ACA Opt. Expansion
PC 194 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.

LABORATORY RATE METHODOLOGY CHANGE

REGULAR POLICY CHANGE NUMBER: 144

Reason for Change:
The change from the prior estimate, for FY 2016-17, is due to:

- The 2015-16 rate year savings being captured in the Fee-for-Service (FFS) base trends and no longer in this policy change;
- Delayed implementation of the prospective 2016-17 rate year adjustment from November 2016 to February 2017; and
- Only one month of the 2016-17 rate year retroactive recoupment, based on a revised recoupment schedule beginning June 2017, compared to a lump sum in the previous estimate.

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

- Increased AB 1494 10% retroactive savings amount based on CA-MMIS updates;
- A delay in implementation of the AB 1494 10% retroactive recoupment from July 2017 to January 2018;
- A delay in implementation of the retroactive recoupment for the 2015-16 rate change from July 2017 to January 2018; and
- 11 months of the 2016-17 rate year retroactive recoupment shifted to FY 2017-18.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to:

- Five months of the prospective 2016-17 rate year adjustment in FY 2016-17 and 12 months in FY 2017-18;
- The AB 1494 10% retroactive recoupments beginning in FY 2017-18;
- One month of the 2016-17 rate year retroactive recoupment being budgeted in FY 2016-17 and 11 months in FY 2017-18; and
- The prospective 2017-18 rate year adjustment being budgeted 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 is expected to be implemented February 2017. The recoupment of retroactive savings from July 2016 through January 2017 is expected to be implemented in June 2017.

7. Effective July 1, 2017, the laboratory rate change savings is projected to be $2,378,000 TF for the 2017-18 rate year and is expected to be implemented August 2017. The recoupment of retroactive savings from July 2017 is expected to be implemented in December 2017.

LABORATORY RATE METHODOLOGY CHANGE

REGULAR POLICY CHANGE NUMBER: 144

FY 2016-17	TF	GF	FF
New Rate Methodology Savings	($2,767,000)	($1,384,000)	($1,383,000)
New Rate Methodology Retro Savings	($323,000)	($161,000)	($162,000)
Total	**($3,090,000)**	**($1,545,000)**	**($1,545,000)**

FY 2017-18	TF	GF	FF
New Rate Methodology Savings	($8,821,000)	($4,410,000)	($4,411,000)
AB 1494 Retro Savings	($2,810,000)	($1,405,000)	($1,405,000)
New Rate Methodology Retro Savings	($12,773,000)	($6,387,000)	($6,386,000)
Total	**($24,404,000)**	**($12,202,000)**	**($12,202,000)**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
ACA Optional Expansion funding identified in PC 193 Funding Adjust.—ACA Opt. Expansion
OTLICP funding identified in PC 194 Funding Adjust.—OTLICP

REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER:	145
IMPLEMENTATION DATE:	8/2015
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1505

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	-$16,013,000	-$26,973,000
- STATE FUNDS	-$8,006,500	-$13,486,500
PAYMENT LAG	1.0000	0.8420
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$16,013,000	-$22,711,300
STATE FUNDS	-$8,006,500	-$11,355,630
FEDERAL FUNDS	-$8,006,500	-$11,355,630

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 193 Funding Adjust.—ACA Opt. Expansion
PC 194 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 2016-17, is a decrease due to:

- The October 2014 rate adjustment being fully captured in the Fee-for-Service (FFS) base trends and no longer being budgeted in this policy change;
- Delayed implementation of the 2015 and 2016 rate adjustments from February 2017 to January 2018; and

REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER: 145

- Delayed implementation of the 2015 and 2016 retroactive recoupments from June 2017 to May 2018.

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

- The October 2014 rate adjustment being fully captured in the FFS base trends and no longer being budgeted in this policy change;
- Revised 2015 and 2016 rate adjustment amounts based on updated utilization data and updated Medicare rates;
- The removal of the 2017 rate adjustment based on a revised amount that is considered to have an insignificant impact to this policy change; and
- Delayed implementation of the 2015 and 2016 retroactive recoupments from June 2017 to May 2018.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to:

- The delay of the 2015 and 2016 rate adjustments from FY 2016-17 to FY 2017-18; and
- The delay of the 2015 and 2016 retroactive recoupments from FY 2016-17 to FY 2017-18.

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 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 within five years.

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.

REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER: 145

5. Rate adjustment based on the October 2016 Medicare Rates:

   a. The Department will submit a State Plan Amendment (SPA) in May 2017 to receive federal approval to adjust radiology reimbursement rates exceeding 80% of Medicare rates, effective April 1, 2017, and annual the first day of each calendar year thereafter, beginning with January 1, 2018.

   b. The adjusted rates based on the October 2016 Medicare rates will be effective April 1, 2017, through December 31, 2017, with an annual FFS savings of $568,000 TF. These rates are expected to be implemented in January 2018.

   c. The total recoupment of retroactive savings from April 1, 2017, through December 31, 2017, is estimated to be $426,000 TF and is expected to be implemented in May 2018 over 12 months.

(Dollars in Thousands)

FY 2016-17	TF	GF	FF
Recoupment of Retro Savings	($16,013)	($8,006)	($8,007)
Total	**($16,013)**	**($8,006)**	**($8,007)**

(Dollars in Thousands)

FY 2017-18	TF	GF	FF
Prospective Savings	($11,594)	($5,797)	($5,797)
Recoupment of Retro Savings	($15,379)	($7,690)	($7,689)
Total	**($26,973)**	**($13,487)**	**($13,486)**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
ACA Optional Expansion funding identified in PC 193 Funding Adjust.—ACA Opt. Expansion
OTLICP funding identified in PC 194 Funding Adjust.—OTLICP

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER:	146
IMPLEMENTATION DATE:	12/2011
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1580

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	-$197,626,000	-$205,136,000
- STATE FUNDS	-$98,813,000	-$102,568,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	91.32 %	87.98 %
APPLIED TO BASE		
TOTAL FUNDS	-$17,153,900	-$24,657,300
STATE FUNDS	-$8,576,970	-$12,328,670
FEDERAL FUNDS	-$8,576,970	-$12,328,670

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 194 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: 146

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 2016-17, is due to:

- A shift in the implementation of the DME/Medical Supplies recoupment from February 2017 to July 2017 based on system delays; and
- Revised prospective pharmacy reductions based on updated FY 2015-16 pharmacy expenditures data. The prospective pharmacy reductions are displayed in this policy change but are fully incorporated in the FFS base trends.

The change from the prior estimate, for FY 2017-18, is due to revised prospective pharmacy reductions based on updated data. The prospective pharmacy reductions are displayed in this policy change but are fully incorporated in the FFS base trends.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to a shift in the implementation of the DME/Medical Supplies retroactive savings from FY 2016-17 to FY 2017-18.

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.

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 146

- Genetic disease screening program, administered by California Department of Public Health, is not subject to the 10% payment reduction. The Department stopped the 10% payment reduction in December 2013 and refunded the payment reduction for the period June 1, 2011 through November 30, 2013 in August 2014.

- **Phase II**: Phase II includes all the previously enjoined providers.
  - DME/Medical Supplies payment reduction recoupment for dates of service from June 1, 2011 to October 24, 2013.
  - Nonprofit dental pediatric surgery centers that provide at least 99% of their services under general anesthesia to children with severe dental disease under age of 21 are exempt from the 10% payment reduction effective August 31, 2013.
  - For-profit dental pediatric surgery centers that provide services to at least 95% of their Medi-Cal beneficiaries under the age of 21 are exempt from the 10% payment reduction effective December 1, 2013.
  - 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 will be discontinued once the Department moves to an actual acquisition cost (AAC) and dispensing fee reimbursement methodology. Refer to the Discontinue Pharmacy Rate Reductions policy change for the costs to restore the pharmacy drug products reductions.

    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 in PC 136)	($22,577,000)
Pharmacy non-drug products (prospective reductions shown in PC 146)	($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: 146

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	7/1/2017	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: 146

4. The estimated savings (TF) from AB 97 payment reduction are:
(Dollars in Thousands)

Provider Type		FY 2016-17	FY 2017-18	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	$0	($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)	($17,148)	($17,148)
	FFS	($131,241)	($131,241)	($131,241)
	FFS Retro	($17,148)	($24,658)	($24,658)
	Phase II Total	($148,389)	($155,899)	($155,898)
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	($17,148)	($24,658)	($24,658)
	Managed Care	$0	$0	$0
Grand Total	**Grand Total**	**($197,626)**	**($205,136)**	($205,136)

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
OTLICP funding identified in PC 194 Funding Adjust.—OTLICP

EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	147
IMPLEMENTATION DATE:	3/2015
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1761

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$7,022,721,000	$15,569,513,000
- STATE FUNDS	$2,874,729,000	$5,239,840,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$7,022,721,000	$15,569,513,000
STATE FUNDS	$2,874,729,000	$5,239,840,000
FEDERAL FUNDS	$4,147,992,000	$10,329,673,000

DESCRIPTION

Purpose:
This policy change estimates the payments hospitals will receive from the extension of the quality assurance fee (QAF) program.

Authority:
SB 239 (Chapter 657, Statutes of 2013)
AB 1607 (Chapter 27, Statutes of 2016)
Proposition 52 (2016)

Interdependent Policy Changes:
PC 105 HQAF Rate Range Increases

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 and received approval for these SPAs in December 2014.

SB 239 also requires the Department to increase capitation payments for the actuarial equivalent of AB 113 (Chapter 20, Statutes of 2011) payments to non-designated public hospitals (NDPH).

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.

EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 147

Reason for Change:
The change from the prior estimate, for FY 2016-17, is a decrease due to:
- FFS: No change
- Managed Care:
  - Totals have been updated to actuals for FY 2014-15, and
  - For the FY 2015-16 and July 1, 2016 to December 31, 2016 period of FY 2016-17, the managed care payments and NDPH IGTS are delayed to FY 2017-18.

The change from the prior estimate, for FY 2017-18, is a net increase due to:
- FFS:
  - Projecting payments for the HQAF program period from January 1, 2017 to June 30, 2019 (HQAF V), calculated using a draft fee/payment model with projected FFS and Grant payments,
  - The addition of FFS Affordable Care Act (ACA) projected payments for FYs 2013-14 and 2014-15, and
  - One quarter of FY 2017-18 FFS payments was shifted to the subsequent fiscal year due to the timing of collections.
- Managed Care:
  - For the FY 2015-16 and July 1, 2016 to December 31, 2016 period of FY 2016-17, the managed care payments and NDPH IGTS have shifted from FY 2016-17.
  - Payments pertaining to the HQAF V program period have been revised based on the draft fee/payment model.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to:
- FFS:
  - Projecting payments for HQAF V, calculated using a draft fee/payment model with projected FFS and Grant payments in FY 2017-18.
  - The addition of FFS ACA projected payments for FYs 2013-14 and 2014-15 in FY 2017-18.
- Managed Care:
  - FY 2016-17 and FY 2017-18 have been updated based on revised projections.

Methodology:
1. Per SB 239, the Hospital QAF program was extended from January 1, 2014 through December 31, 2016.

2. The first FFS payment was made in March 2015. This includes Designated Public Hospital and NDPH grant amounts.

3. The first managed care payment was made in August 2015.

4. 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

EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 147

5. 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.

6. 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.

7. Increased capitation payments under Section 14165.58 are the actuarial equivalent to AB 113 payments previously made to NDPHs. In FY 2015-16, the Department has collected $12 million IGTs for FY 2013-14 from NDPHs. The Department will collect the following amounts from NDPHs:
    - To be collected in FY 2016-17:
        - $28.05 million for FY 2014-15
    - To be collected in FY 2017-18:
        - $25.36 million for FY 2015-16
        - $28.58 million for FY 2016-17
        - $30.37 million for FY 2017-18

8. Payments associated with HQAF V are preliminary estimates at this time. Calculations are based on a draft fee/payment model and subject to change

9. Due to anticipated delays in implementing HQAF V, all associated HQAF V FFS payments are projected for payout in FY 2017-18.

10. The ACA claiming methodology for the FFS supplemental payments are expected to be 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.

EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 147

11. On a cash basis, the estimated QAF payments are:

(Dollars in Thousands)

FY 2016-17	TF	IGT*	SF(HQARF)	FF (TITLE 19)	FF (TITLE 21)	ACA FF
FFS						
FY 2014-15	$25,250	$0	$25,250	$0	$0	$0
FY 2015-16	$1,179,355	$0	$594,209	$585,146	$0	$0
FY 2016-17	$2,619,828	$0	$1,320,289	$1,299,539	$0	$0
Total FFS	$3,824,433	$0	$1,939,748	$1,884,685	$0	$0
Managed Care						
FY 2014-15	$3,102,388	$0	$906,928	$808,485	$91,134	$1,295,841
Total MC	$3,102,388	$0	$906,928	$808,485	$91,134	$1,295,841
NDPH IGT						
FY 2014-15	$95,900	$28,053	$0	$25,008	$2,819	$40,020
Total NDPH IGT	$95,900	$28,053	$0	$25,008	$2,819	$40,020
Total FY 2016-17	**$7,022,721**	**$28,053**	**$2,846,676**	**$2,718,178**	**$93,953**	**$1,335,861**

(Dollars in Thousands)

FY 2017-18	TF	IGT*	SF(HQARF)	FF (TITLE 19)	FF (TITLE 21)	ACA FF	**Return to Fund 3158
FFS							
FY 2013-14	$218,200	$0	$0	($218,200)	$0	$436,400	$218,200
FY 2014-15	$378,440	$0	$0	($378,440)	$0	$756,880	$378,440
FY 2015-16	$30,250	$0	$30,250	$0	$0	$0	$0
FY 2016-17	$1,577,204	$0	$811,727	$765,477	$0	$0	$0
FY 2017-18	$2,547,301	$0	$1,312,988	$1,234,313	$0	$0	$0
Total FFS	$4,751,395	$0	$2,154,965	$1,403,150	$0	$1,193,280	$596,640
Managed Care							
FY 2015-16	$3,348,800	$0	$890,245	$815,356	$116,299	$1,526,900	$0
FY 2016-17	$3,279,858	$0	$948,300	$840,927	$128,332	$1,362,299	$0
FY 2017-18	$3,899,260	$0	$1,162,026	$988,098	$150,791	$1,598,345	$0
Total MC	$10,527,918	$0	$3,000,571	$2,644,381	$395,422	$4,487,544	$0
NDPH IGT							
FY 2015-16	$95,400	$25,360	$0	$23,227	$3,313	$43,500	$0
FY 2016-17	$97,400	$28,576	$0	$25,504	$3,892	$39,428	$0
FY 2017-18	$97,400	$30,368	$0	$26,081	$3,980	$36,971	$0
Total NDPH IGT	$290,200	$84,304	$0	$74,812	$11,185	$119,899	$0
Total FY 2017-18	**$15,569,513**	**$84,304**	**$5,155,536**	**$4,122,343**	**$406,607**	**$5,800,723**	**$596,640**

**The Return to Fund 3158 column is for display purposes only (see Methodology #10).

Funding:
Hospital Quality Assurance Revenue Fund (4260-611-3158)
Title XIX FFP (4260-611-0890)
Title XXI FFP (4260-611-0890)
Reimbursement (4260-610-0995)*

PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER:	148
IMPLEMENTATION DATE:	7/2005
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1071

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$618,284,000	$573,382,000
- STATE FUNDS	$309,142,000	$286,691,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$618,284,000	$573,382,000
STATE FUNDS	$309,142,000	$286,691,000
FEDERAL FUNDS	$309,142,000	$286,691,000

DESCRIPTION

Purpose:
This policy change estimates the funds for the private Disproportionate Share Hospital (DSH) replacement payments.

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.11
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 28 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: 148

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 2016-17, is due to updated payment data through January 2017, and an increase in the federal DSH allotment for FY 2013-14.

The change from the prior estimate, for FY 2017-18, is due to updated payment data through January 2017.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to updated and final payments for FY 2013-14, FY 2014-15, and FY 2015-16 expected in FY 2016-17.

Methodology:
1. The remaining balance of FY 2013-14, FY 2014-15, and FY 2015-16 final payments are assumed to be paid in FY 2016-17.

2. SB 335 reduces Medi-Cal DSH replacement payments to private hospitals by $10.5 million TF ($5.25 million GF) in FY 2013-14.

3. The FY 2016-17 estimated DSH allotment assumes a 2% increase over the tentative FY 2015-16 DSH allotment. The FY 2017-18 estimated DSH allotment assumes a 2% increase over the FY 2016-17 preliminary DSH allotment.

It is assumed that the DSH replacement payments will be made as follows on a cash basis:

FY 2016-17	TF	GF	FF
FY 2013-14	$15,614,000	$7,807,000	$7,807,000
FY 2013-14 SB 335 Adjustment	($12,000)	($6,000)	($6,000)
FY 2014-15	$44,988,000	$22,494,000	$22,494,000
FY 2015-16	$44,114,000	$22,057,000	$22,057,000
FY 2016-17	$513,580,000	$256,790,000	$256,790,000
Total FY 2016-17	**$618,284,000**	**$309,142,000**	**$309,142,000**

FY 2017-18	TF	GF	FF
FY 2016-17	$46,690,000	$23,345,000	$23,345,000
FY 2017-18	$526,692,000	$263,346,000	$263,346,000
Total FY 2017-18	**$573,382,000**	**$286,691,000**	**$286,691,000**

PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER: 148

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

DSH PAYMENT

REGULAR POLICY CHANGE NUMBER:	149
IMPLEMENTATION DATE:	7/2005
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1073

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$531,697,000	$444,414,000
- STATE FUNDS	$173,617,000	$143,968,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$531,697,000	$444,414,000
STATE FUNDS	$173,617,000	$143,968,000
FEDERAL FUNDS	$358,080,000	$300,446,000

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 28 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 2016-17 and 2017-18 DSH allotments are estimated to be $1,215,215,355, and $1,239,519,662 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: 149

Effective July 1, 2015, DPHs, except State Government-operated University of California Hospitals, will be receiving 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 2016-17, is due to updated payment data, including revised payment periods. In addition, the final DPH allotment payments for FY 2011-12 and FY 2012-13 are pending final audit results.

There is no change for FY 2017-18 from the prior estimate.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to updated payment data and fewer prior year payments in FY 2017-18.

DSH PAYMENT

REGULAR POLICY CHANGE NUMBER: 149

Methodology:

1. The FY 2016-17 estimated DSH allotment assumes a 2% increase over the FY 2015-16 DSH allotment. The FY 2017-18 estimated DSH allotment assumes a 2% increase over FY 2016-17.

2. It is assumed that the DSH payments will be made as follows on a cash basis:

FY 2016-17	TF	GF**	FF	IGT*
DSH 2011-12	$14,000	$7,000	$7,000	$0
DSH 2012-13	$5,000	$3,000	$2,000	$0
DSH 2013-14	$11,149,000	$203,000	$1,915,000	$9,031,000
DSH 2014-15	$736,000	$368,000	$368,000	$0
DSH 2015-16	$106,095,000	($1,420,000)	$76,015,000	$31,500,000
DSH 2016-17	$413,698,000	$15,583,000	$279,773,000	$118,342,000
Total FY 2016-17	**$531,697,000**	**$14,744,000**	**$358,080,000**	**$158,873,000**

FY 2017-18	TF	GF**	FF	IGT*
DSH 2016-17	$37,609,000	$1,417,000	$25,434,000	$10,758,000
DSH 2017-18	$406,805,000	$15,583,000	$275,012,000	$116,210,000
Total FY 2017-18	**$444,414,000**	**$17,000,000**	**$300,446,000**	**$126,968,000**

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:	150
IMPLEMENTATION DATE:	7/2005
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1085

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$364,229,000	$300,261,000
- STATE FUNDS	$182,114,500	$127,550,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$364,229,000	$300,261,000
STATE FUNDS	$182,114,500	$127,550,000
FEDERAL FUNDS	$182,114,500	$172,711,000

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: 150

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.

Reason for Change:
The change in FY 2016-17, from the prior estimate, is due to delaying the FY 2013-14 Affordable Care Act (ACA) adjustments to FY 2017-18 as CMS approval is not expected to occur in FY 2016-17.

The change in FY 2017-18, from the prior estimate, is due to the addition of ACA adjustments for FY 2013-14, FY 2014-15, and FY 2015-16. The counties will be reimbursed for the IGT non-federal share of the ACA adjustments. The State Fund (SF) non-federal share of the ACA adjustments will be transferred into the Private Hospital Supplemental Fund.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to the remaining FY 2015-16 payments included in FY 2016-17, and the ACA adjustments expected to occur in FY 2017-18.

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. IGTs are estimated to total $17,600,000 in FY 2016-17 and $18,300,000 in FY 2017-18.

3. SPA 16-022 was approved on December 8, 2016 which reduced the IGT payments from Alameda County to St. Rose Hospital from $16 million TF to $10 million TF in FY 2016-17 and FY 2017-18.

4. The ACA allows for 100% Federal Medical Assistance Percentage (FMAP) for calendar years 2014 through 2016, for newly eligible Medi-Cal beneficiaries. The ACA claiming methodology is pending CMS approval.

5. 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 costs for newly eligible Medi-Cal beneficiaries. For FY 2013-14, FY 2014-15, and FY 2015-16, the ACA supplemental payments will be claimed in FY 2017-18.

    - The 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.

6. 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.

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 150

7. The estimated Private Hospital Supplemental payments and ending balance for FY 2016-17 are shown below:

FY 2016-1 Private Hospital Supplemental Fund Summary	SF
FY 2015-16 Ending Balance	$45,554,000
Appropriation (GF)	$118,400,000
Est. FY 2015-16 Interest Earned	$134,000
2015-16 Remaining IGT	$9,500,000
2016-17 IGT	$8,800,000
Funds Available	$182,388,000
Less: FY 2015-16 Cash Expenditures to Hospitals	($54,914,500)
Less: FY 2016-17 Cash Expenditures to Hospitals	($127,200,000)
Est. FY 2016-17 Remaining Balance	$273,500

FY 2016-17	TF	SF	FF
FY 2015-16 Cash Expenditures to Hospitals**	$109,829,000	$54,914,500	$54,914,500
FY 2016-17 Cash Expenditures to Hospitals**	$254,400,000	$127,200,000	$127,200,000
Total	**$364,229,000**	**$182,114,500**	**$182,114,500**

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	$273,500
Appropriation (GF)	$118,400,000
2017-18 IGT	$9,150,000
Est. FY 2016-17 Interest Earned	$192,500
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	$21,996,000
Funds Available	$169,733,000
Less: FY 2017-18 Cash Expenditures to Hospitals	($127,550,000)
Est. FY 2017-18 Remaining Balance	$42,183,000

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 150

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***	$21,996,000	$0	($21,996,000)	$43,992,000	$21,996,000	$0
FY 2015-16 ACA FF Adjustment to Counties***	$1,825,000	$0	($1,826,000)	$3,651,000	$0	$1,826,000
Total	**$300,261,000**	**$127,550,000**	**$82,388,000**	**$90,323,000**	**$41,717,000**	**$3,445,000**

*The Return to Fund 3097 and Return to Counties columns are for display purposes only (see Methodology #5).

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 (4260-101-0001)

NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	151
IMPLEMENTATION DATE:	10/2013
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1600

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$182,290,000	$184,924,000
- STATE FUNDS	$91,145,000	$54,872,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$182,290,000	$184,924,000
STATE FUNDS	$91,145,000	$54,872,000
FEDERAL FUNDS	$91,145,000	$130,052,000

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 2016-17, from the prior estimate, is a decrease due to:

- Decreased UPL room for FY 2015-16 and FY 2016-17.
- Postponement of the FY 2013-14 through FY 2015-16 Affordable Care Act (ACA) payments to FY 2017-18.
- Postponement of the FY 2016-17 ACA payments to a subsequent fiscal year and no longer is in the estimate.
- Updated ACA totals for FY 2014-15 based upon ACA distribution methodology, currently pending CMS approval.
- Postponement of the FY 2015-16 Children's Services payments to FY 2017-18.

NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 151

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

- Decreased UPL room for FY 2017-18.
- The addition of ACA FY 2013-14 through FY 2015-16 payments, currently pending CMS approval. The non-federal share of the ACA funding adjustment will be reimbursed to NDPHs for IGT overpayments.
- Postponement of the FY 2016-17 Children's Services to a subsequent fiscal year and no longer is in the estimate.
- Postponement of the FY 2017-18 ACA payments to a subsequent fiscal year and no longer is in the estimate.
- The FY 2015-16 Children's Services payments have shifted from FY 2016-17. In addition, the savings from these payments have decreased based on the decrease in the FY 2015-16 UPL room.
- $1.11 million GF payment will be made to reimburse the IGTs to NDPHs.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to:

- The postponement of FY 2013-14 through 2015-16 ACA payments to FY 2017-18, currently pending CMS approval and an additional regular payment to the NDPHs occurring in FY 2016-17.

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, and FY 2017-18, is currently pending UPL methodology review with CMS. 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 is pending CMS approval.

4. The FY 2015-16 tentative UPL amount is 107,522,000. This estimate assumes the same UPL room for FYs 2016-17 and 2017-18.

5. 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 costs for newly eligible Medi-Cal beneficiaries. For FY 2013-14, FY 2014-15, and FY 2015-16, the ACA supplemental payments will be claimed in FY 2017-18. The 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 $256,000 to FY 2013-14 FF is for over collected IGTs during the initial NDPH IGT supplemental payments for non-ACA. One year 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 $7,774,000 to FY 2014-15 FF is for over collected IGTs during the initial NDPH IGT supplemental payments for non-ACA. One year after this FYs supplemental payments are

NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 151

issued, the proportion of the costs for non-ACA and newly eligible Medi-Cal beneficiaries are recalculated.

8. Due to the revised FY 2014-15 ACA payments, fewer IGTs were subject to the 9% retain for FY 2014-15 Children's Services payments. The GF will be required to reimburse the IGTs to the NDPHs in the amount of $1.11 million.

9. The estimated NDPH IGT supplemental payments are:

FY 2016-17	TF	IGT**	FF
FY 2015-16 Payments to NDPHs	$74,768,000	$37,384,000	$37,384,000
FY 2016-17 Payments to NDPHs	$107,522,000	$53,761,000	$53,761,000
Total FY 2016-17	**$182,290,000**	**$91,145,000**	**$91,145,000**

FY 2017-18	TF	GF*	IGT**	FF	ACA	***Return to NDPHs
FY 2013-14 Payments to NDPHs (ACA)	$27,512,000	$0	$0	$0)	$27,512,000	$0
FY 2013-14 ACA Adjustment to NDPHs	$256,000	$0	$0	($256,000)	$512,000	$256,000
FY 2014-15 Payments to NDPHs (ACA)	$7,995,000	$0	$0	$0	$7,995,000	$0
FY 2014-15 ACA Adjustment to NDPHs	$7,774,000	$0	$0	($7,774,000)	$15,548,000	$7,774,000
FY 2014-15 Children's Services ACA Adjustment	$1,111,000	$1,111,000	$0	$0	$0	$1,111,000
FY 2015-16 Payments to NDPHs (ACA)	$32,754,000	$0	$0	$0	$32,754,000	$0
FY 2015-16 Children's Services	$0	($3,552,000)	$3,552,000	$0	$0	$0
FY 2017-18 Payments to NDPHs	$107,522,000	$0	$53,761,000	$53,761,000	$0	$0
Total FY 2017-18	**$184,924,000**	**($2,441,000)**	**$57,313,000**	**$45,731,000**	**$84,321,000**	**$8,030,000**

***The Return to NDPHs column is for display purposes only (see methodology #5-#7).

Funding:
50% Title XIX /50% MIPA (4260-606-0834/4260-101-0890)**
100% GF (4260-101-0001)*
100% Title XIX ACA (4260-101-0890)

MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	152
IMPLEMENTATION DATE:	11/2015
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1899

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$192,175,000	$125,117,000
- STATE FUNDS	$96,087,000	$50,997,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$192,175,000	$125,117,000
STATE FUNDS	$96,087,000	$50,997,000
FEDERAL FUNDS	$96,088,000	$74,120,000

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

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 was approved by CMS on November 22, 2016, which updated the payment cap amount from $100 million to $108 million for payments made to MLK-LA. The $108 million represents $100 million in supplemental payments and $8 million in Diagnosis Related Group (DRG) add-on payments.

Reason for Change:

The change from the prior estimate, for FY 2016-17, is due to the:

- Removal of the FFS and DRG add-on payments as these are now fully captured in the FFS base trends and no longer budgeted in this policy change.
- FY 2015-16 supplemental payment increased based on expected DRG add-on payment data, and
- FY 2015-16 supplemental payment for the Affordable Care Act (ACA) optional population shifting from FY 2016-17 to FY 2017-18.

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

- Removal of the 2017-18 FFS payments as these are now fully captured in the FFS base trends and no longer budgeted in this policy change.
- Addition of the FY 2015-16 DRG add-on reconciliation,
- Inclusion of the FY 2015-16 interim reconciliation which is based on revised DRG add-on payment data resulting in a recoupment of supplemental funds to stay within the $100 million cap, and
- FY 2015-16 supplemental ACA amounts increased based on updated MLK-LA payment data.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to the:

- Inclusion of the FY 2015-16 DRG add-on reconciliation in FY 2017-18,
- FY 2015-16 ACA supplemental payment occurring in FY 2017-18, and
- FY 2017-18 estimate including fewer supplemental payment years than FY 2016-17.

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 77% minimum payment level for FY 2016-17 and 72% minimum payment level for FY 2017-18.

MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 152

5. Expenditures for FY 2016-17 costs up to 77% and FY 2017-18 costs up to 72% of total Medi-Cal FFS inpatient projected costs will be paid through DRG FFS payments which are incorporated in the base.

6. Assume FY 2017-18 includes $9 million TF for the FY 2015-16 DRG add-on reconciliation.

7. Assume the FFS ACA optional population for FY 2015-16 is 44% of the total Medi-Cal FFS inpatient projected costs, based on updated MLK-LA payment data.

8. Assume for FFS and supplemental payments, there are no Title XXI payments, based on updated MLK-LA payment data.

9. SPA 16-017, which was approved by CMS on November 22, 2016, specifies a $108 million cap for IGT payments and the DRG add-on amount.

10. Supplemental payments are used to make payments necessary to meet the minimum funding of 100% of total Medi-Cal FFS inpatient projected costs. Supplemental payments are also used to make payments above the minimum funding requirement. The estimates are as follows:

    - The FY 2015-16 supplemental payments of $92.175 million TF were paid in September 2016. Per SPA 15-008, reimbursement payments were capped at $100 million in FY 2015-16 and included the $92.175 million supplemental payment in addition to the $7.825 million DRG add-on payment.
    - The FY 2015-16 interim reconciliation was completed in FY 2016-17, and resulted in the FY 2015-16 DRG add on payment to be revised to $10.871 million.
    - Due to the $100 million cap for FY 2015-16 for combined IGT and DRG add-on payments, $3.046 million will be recouped from MLK-LA and reimbursed to Los Angeles County and FFP.
    - Based on updated payment data, $38 million of the FY 2015-16 supplemental payment is attributable to the ACA optional population. The FY 2015-16 ACA funding adjustment is budgeted in FY 2017-18.
    - FY 2016-17 and FY 2017-18 supplemental payments are estimated to be $100 million TF annually. The FY 2016-17 and FY 2017-18 ACA amounts will be budgeted after FY 2017-18.
    - Federal approval of the ACA optional population supplemental payments is expected in FY 2017-18.

11. The ACA supplemental payments will be processed one year 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 2015-16, the ACA supplemental payments will be claimed in FY 2017-18. 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. The ACA supplemental claiming methodology is pending federal approval.

MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 152

12. Managed care costs for MLK-LA are reflected in the managed care policy changes. The chart below shows the FY 2016-17 and FY 2017-18 totals with managed care for informational purposes only.
    - A retroactive payment for FY 2015-16 will be made in FY 2016-17 in PC 124 Retro MC Rate Adjustments.
    - The FY 2016-17 and FY 2017-18 managed care payments are in PC 96 Two Plan Model.

(Dollars in Thousands)

FY 2016-17	TF
Supplemental 2015-16	$92,175
Supplemental 2016-17	$100,000
Total (PC 152)	$192,175
Managed Care 2015-16 retro (PC 124)	$9,659
Managed Care 2016-17 (PC 96)	$14,142
Total Managed Care	$23,801
Total FY 2016-17	$215,976

FY 2017-18	TF
DRG Add-On 2015-16 Reconciliation	$9,000
Supplemental 2017-18	$100,000
Supplemental 2015-16 Interim Recon	($3,046)
Total (PC 152)	$105,954
Managed Care 2015-16 retro (PC 124)	$9,177
Managed Care 2016-17 retro (PC 124)	$4,637
Managed Care 2017-18 (PC 96)	$18,227
Total Managed Care	$32,041
Total FY 2017-18	$137,995

MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 152

13. On a cash basis, costs in FY 2016-17 and FY 2017-18 are expected to be:

(Dollars in Thousands)

FY 2016-17	TF	IGT*	FF
Supplemental 2015-16	$92,175	$46,087	$46,088
Supplemental 2016-17	$100,000	$50,000	$50,000
Total	**$192,175**	**$96,087**	**$96,088**

(Dollars in Thousands)

FY 2017-18	TF	GF	IGT*	FF	ACA FF	Return to County**
DRG Add-On 2015-16 Reconciliation	$9,000	$2,520	$0	$2,520	$3,960	$0
Supplemental 2017-18	$100,000	$0	$50,000	$50,000	$0	$0
Supplemental ACA 2015-16	$19,163		$0	($19,162)	$38,325	$19,163
Supplemental 2015-16 Interim Reconciliation	($3,046)	$0	($1,523)	($1,523)	$0	$1,523
Total	**$125,117**	**$2,520**	**$48,477**	**$31,835**	**$42,285**	**$20,686**

**Return to County for display purposes only (see methodology #10)

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
50% Title XIX / 50% Reimbursement GF (4260-610-0995/4260-101-0890)*
100% Title XIX ACA (4260-101-0890)

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	153
IMPLEMENTATION DATE:	4/2004
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	78

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$141,358,000	$415,351,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$141,358,000	$415,351,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$141,358,000	$415,351,000

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 2016-17, from the prior estimate, is a decrease due to:

- Updated actuals based on processed untimely and calendar year claims,
- Delaying the FY 2002-03 reconciliations from FY 2016-17 to FY 2017-18, and
- Delaying the FY 2013-14 Affordable Care Act (ACA) claims to a subsequent fiscal year and no longer including this in the estimate.

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 153

The change in FY 2017-18, from the prior estimate, is a net increase due to:

- Shifting the FY 2002-03 reconciliations from FY 2016-17,
- Delaying the FY 2003-04 reconciliations from FY 2017-18 to a subsequent fiscal year and no longer including this in the estimate,
- Updated estimated ACA claims for FY 2014-15 and FY 2015-16, and
- Updated actuals based on processed untimely and calendar year claims.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to including the FY 2002-03 reconciliation payments, higher FY 2016-17 estimated payments, and the addition of ACA claims in FY 2017-18.

Methodology:

1. Payments of $141,358,000 and $415,351,000 are expected to be made in FY 2016-17 and FY 2017-18, respectively. These payments are based on CPE claims and are adjusted for the changes in the FMAP.

2. Federal approval of the ACA payment methodology is expected in FY 2017-18.

3. The reconciliation mandated by AB 915 against audited cost reports will begin in FY 2017-18. Additional payments for Service Year 2002-03 in the amount of $9,385,000 are expected to be made in FY 2017-18 as a result of the reconciliation.

Estimated costs are as follows:

FY 2016-17	TF	FF
FY 2011-12 (Adjusted Claim)	($382,000)	($382,000)
FY 2012-13 Adjusted Claims	($6,231,000)	($6,231,000)
FY 2012-13 (Calendar Year Claim)	$3,765,000	$3,765,000
FY 2013-14 Adjusted Claims	($2,087,000)	($2,087,000)
FY 2013-14 (Untimely Claim)	$4,316,000	$4,316,000
FY 2014-15 Calendar Year Claim	$52,000	$52,000
FY 2015-16 (Est. Payments)	$141,925,000	$141,925,000
Total FY 2016-17	**$141,358,000**	**$141,358,000**

FY 2017-18	TF	FF	ACA FF
FY 2002-03 (Reconciliation)	$9,385,000	$9,385,000	$0
FY 2014-15 (Est. ACA claims)	$126,754,000	$0	$126,754,000
FY 2015-16 (Calendar Year Claims)	$54,000	$54,000	$0
FY 2015-16 (Est. ACA Claims)	$131,697,000	$0	$131,697,000
FY 2016-17 (Est. Payments)	$147,461,000	$147,461,000	$0
Total FY 2017-18	**$415,351,000**	**$156,900,000**	**$258,451,000**

Funding:

100% Title XIX FF (4260-101-0890)
100% Title XIX ACA FF (4260-101-0890)

CAPITAL PROJECT DEBT REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER:	154
IMPLEMENTATION DATE:	7/1991
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	82

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$100,295,000	$186,120,000
- STATE FUNDS	$39,472,500	$82,810,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$100,295,000	$186,120,000
STATE FUNDS	$39,472,500	$82,810,000
FEDERAL FUNDS	$60,822,500	$103,310,000

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: 154

Reason for Change:
The change from the prior estimate, for FY 2016-17, is a net decrease due to:

- SB 1732 – More accurate projections based on updated payment data and actuals paid to date in FY 2016-17, partially shifting FY 2015-16 interim payments to FY 2017-18, and shifting FY 2013-14 interim reconciliation payments to FY 2017-18.

The change in FY 2017-18, from the prior estimate, is a net increase due to:

- SB 1732 – More accurate projections based on updated payment data, including the remaining FY 2015-16 interim payments in FY 2017-18, shifting the FY 2013-14 interim reconciliation, and no longer including FY 2015-16 interim reconciliations to be paid in FY 2017-18.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to:

- SB 1732 – Increased interim payments estimated to be paid in FY 2017-18.

Methodology:
1. The estimated payments on a cash basis are:

FY 2016-17	TF	GF	FF
Hospitals (SB 1732)			
Interim Payment			
FY 2013-14	$2,686,000	$1,343,000	$1,343,000
FY 2014-15	$6,152,000	$3,076,000	$3,076,000
FY 2015-16	$56,774,000	$28,387,000	$28,387,000
FY 2016-17	$11,836,000	$5,918,000	$5,918,000
Interim Reconciliation			
FY 2012-13	$1,497,000	$748,500	$748,500
DP-NFs (SB 1128)			
Interim Payment			
FY 2014-15	$1,350,000	$0	$1,350,000
FY 2015-16	$20,000,000	$0	$20,000,000
Total FY 2016-17	**$100,295,000**	**$39,472,500**	**$60,822,500**

FY 2017-18	TF	GF	FF
Hospitals (SB 1732)			
Interim Payment			
FY 2015-16	$13,110,000	$6,555,000	$6,555,000
FY 2016-17	$85,050,000	$42,525,000	$42,525,000
FY 2017-18	$66,450,000	33,225,000	$33,225,000
Interim Reconciliation			
FY 2013-14	($727,000)	($363,500)	($363,500)
FY 2014-15	$1,737,000	$868,500	$868,500
DP-NFs (SB 1128)			
Interim Payment			
FY 2016-17	$20,500,000	$0	$20,500,000
Total FY 2017-18	**$186,120,000**	**$82,810,000**	**$103,310,000**

CAPITAL PROJECT DEBT REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 154

Funding:
100% Title XIX (4260-101-0890)
50% Title XIX Capital Debt FFP / 50% GF (4260-102-0001/0890)

FFP FOR LOCAL TRAUMA CENTERS

REGULAR POLICY CHANGE NUMBER:	155
IMPLEMENTATION DATE:	2/2006
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	104

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$140,582,000	$106,601,000
- STATE FUNDS	$70,291,000	$44,845,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$140,582,000	$106,601,000
STATE FUNDS	$70,291,000	$44,845,000
FEDERAL FUNDS	$70,291,000	$61,756,000

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 2016-17, from the prior estimate, is due to increased FY 2016-17 IGTs estimated from Los Angeles County.

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

- The addition of ACA FY 2013-14 through FY 2015-16 payment adjustments, and
- An increase to the estimated Los Angeles County final FY 2016-17 IGT and initial FY 2017-18 IGT amounts.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is a net decrease due to:

- The remaining Alameda County IGT payment for FY 2014-15 occurring in FY 2016-17,
- Higher Los Angeles County FY 2015-16 IGTs in FY 2016-17, and
- ACA payment adjustments occurring in FY 2017-18.

FFP FOR LOCAL TRAUMA CENTERS

REGULAR POLICY CHANGE NUMBER: 155

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, for newly eligible Medi-Cal beneficiaries. The ACA methodology is pending CMS approval.

3. 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 trauma care costs for newly eligible Medi-Cal beneficiaries. For FY 2013-14, FY 2014-15, and FY 2015-16, the ACA supplemental payments will be claimed in FY 2017-18. The 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 2016-17	TF	Special Deposit Fund	FF
FY 2014-15	$20,582	$10,291	$10,291
FY 2015-16	$86,000	$43,000	$43,000
FY 2016-17	$34,000	$17,000	$17,000
Total FY 2016-17	**$140,582**	**$70,291**	**$70,291**

(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	$55,690	$27,845	$27,845	$0	$0
FY 2017-18	$34,000	$17,000	$17,000	$0	$0
Total FY 2017-18	**$106,601**	**$44,845**	**$27,935**	**$33,821**	**$16,911**

*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)

DPH PHYSICIAN & NON-PHYS. COST

REGULAR POLICY CHANGE NUMBER:	156
IMPLEMENTATION DATE:	5/2008
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1078

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$59,450,000	$154,861,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$59,450,000	$154,861,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$59,450,000	$154,861,000

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: 156

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 2016-17 from the prior estimate is due to:

- The addition of the FY 2007-08 final reconciliation,
- Updated FY 2016-17 estimated interim payment based on updated cost reports, and
- Delayed CMS approval of the Affordable Care Act (ACA) claiming methodology resulting in the following ACA payments shifts:
  - The FY 2013-14 ACA interim payments shifted to FY 2017-18, and
  - The FY 2016-17 ACA interim payments shifted to be paid in the future and no longer budgeted in the estimate.

The change in FY 2017-18 from the prior estimate is due to:

- The FY 2007-08 final reconciliation moved to FY 2016-17,
- The addition of FY 2008-09 and FY 2013-14 final reconciliations,
- The FY 2013-14 ACA interim payments shifted from FY 2016-17,
- The addition of the FY 2013-14 ACA final reconciliation payments and FY 2015-16 ACA interim payments,
- Decreased FY 2017-18 estimated interim payments based on updated data, and
- The FY 2017-18 ACA interim payments shifted to be paid in the future and no longer budgeted in the estimate.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to different interim and final reconciliation fiscal years, and the ACA payment shift to FY 2017-18.

Methodology:

1. In FY 2016-17 and FY 2017-18, 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.

DPH PHYSICIAN & NON-PHYS. COST

REGULAR POLICY CHANGE NUMBER: 156

4. Reconciliation/final settlement of program years is anticipated to be completed upon conclusion of final audited settlements.

(Dollars in Thousands)

FY 2016-17	TF	FF
FY 2006-07 Final Reconciliation	($11,531)	($11,531)
FY 2007-08 Final Reconciliation	($3,875)	($3,875)
FY 2012-13 Interim Reconciliation	($9,048)	($9,048)
FY 2013-14 Interim Reconciliation	$15,281	$15,281
FY 2016-17 Interim Payment	$68,623	$68,623
Total	**$59,450**	**$59,450**

FY 2017-18	TF	FF
FY 2008-09 Final Reconciliation	($10,664)	($10,664)
FY 2013-14 Final Reconciliation	($15,100)	($15,100)
FY 2013-14 Interim Payment ACA	$20,681	$20,681
FY 2013-14 Final Reconciliation ACA	($6,983)	($6,983)
FY 2014-15 Interim Reconciliation	($4,020)	($4,020)
FY 2014-15 Interim Payment ACA	$50,447	$50,447
FY 2015-16 Interim Payment ACA	$50,500	$50,500
FY 2017-18 Interim Payment	$70,000	$70,000
Total	**$154,861**	**$154,861**

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

HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	157
IMPLEMENTATION DATE:	7/2017
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1475

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	$100,398,000
- STATE FUNDS	$0	$90,128,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$100,398,000
STATE FUNDS	$0	$90,128,000
FEDERAL FUNDS	$0	$10,270,000

DESCRIPTION

Purpose:
This policy change estimates the payments hospitals will receive from the quality assurance fee (QAF) program.

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)

Interdependent Policy Changes:
PC 84 LIHP MCE Out-of-Network Emergency Care Svs Fund

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 is referred to as QAF I. AB 1653 revised the Medi-Cal hospital provider fee and supplemental payments enacted by AB 1383 by:

- Altering the methodology, timing, and frequency of supplemental payments,
- Increasing capitation payments to Medi-Cal managed health care plans, and
- Increasing payments to mental health plans.

HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 157

AB 188 established the Hospital Quality Assurance Revenue Fund (HQARF) to:

- Provide supplemental payments to hospitals,
- Provide direct grants to DPHs,
- Increase capitation payments to managed health care,
- Increase payments to mental health plans,
- Offset the state cost of providing health care coverage for children, and
- Pay for staff and related administrative expenses required to implement the QAF program.

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 is referred to as QAF II.

SB 335 extended the Hospital QAF program from July 1, 2011 through December 31, 2013. This QAF program is referred to as QAF III. On June 22, 2012, the Department received CMS approval to collect fees from the hospitals and make fee-for-services payments to the hospitals retroactive to July 1, 2011.

AB 1467 increases the amount of QAF allocated for children's health care coverage by:

- Eliminating managed care payments for DPHs in FY 2013-14,
- Reducing managed care payments for private hospitals in FYs 2012-13 and 2013-14, and
- Eliminating grant payments to DPHs in FY 2013-14.

SB 920:

- Modified the QAF calculation and installment payment provisions, supplemental amounts paid to private hospitals for inpatient services,
- Increased the NDPH aggregate grant amounts for each fiscal year, and
- Reduced the Low Income Health Program MCE Out-of-Network Emergency Care Services Fund (LIHP), and deleted NDPHs as recipients of money from the fund.

Reason for Change:

The change from the prior estimate, for FY 2016-17, is a decrease due to shifting all payments to FY 2017-18.

The change from the prior estimate, for FY 2017-18, is an increase due to a shift in payments to FY 2017-18 because of a delay in payment for QAF I Mental Health and QAF II FFS amounts:

- QAF I payments have been delayed following CMS approval, in February 2016, of SPA 09-004. Because other Mental Health supplemental payments must be made before a hospital specific allocation for the QAF I funds can be determined, these payments have been pushed back to FY 2017-18.
- QAF II payments will now be rolled into the current QAF IV program and paid out in FY 2017-18.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to the delay of prior QAF payments to FY 2017-18.

Methodology:

1. Under 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

HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 157

Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 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 first QAF program was effective April 1, 2009 through December 31, 2010 (QAF I); with a two-quarter extension through June 30, 2011 (QAF II). An additional 30-month QAF program is effective for the time period July 1, 2011 through December 31, 2013 (QAF III).

3. On an accrual basis, the QAF III program fee is expected to generate $4.3 billion in FY 2011-12, $4.5 billion in FY 2012-13, and $2.4 billion in FY 2013-14 in fee-for-service (FFS), managed care capitation, grant payments and mental health payments.

4. First FFS payment of the QAF III program to the hospitals occurred in August 2012.

5. QAF I program mental health plan payments of $15.9 million will be paid in FY 2017-18. Payments have been pushed back to accommodate for Mental Health supplemental payments associated with CMS approval of SPA 09-004 in February 2016.

6. QAF II program FFS payments of $827,000 will be paid in FY 2017-18. These funds will be rolled over and dispersed as part of the current QAF IV program.

7. Current HQARF collections and disbursements project that $75.6 million is available for transfer from the HQARF funds. Additional funds of approximately $50 million are available for transfer from the Hospital QAF collection withhold account.

8. QAF III program fees of $83.7 million will be transferred to LIHP in FY 2017-18. See the LIHP MCE Out-of-Network Emergency Care Svs Fund policy change for more information on the LIHP hospital payments.

9. There are no managed care payments in this policy change.

10. On a cash basis, payments to the hospitals are estimated to be:

FY 2017-18	TF	SF (HQARF)	FF	ARRA
QAF I (AB 1383)	$15,898,000	$6,106,000	$7,949,000	$1,843,000
QAF II (SB 90)	$827,000	$349,000	$413,000	$65,000
QAF III (SB 335 LIHP)	$83,673,000	$83,673,000	$0	$0
Total FY 2017-18	**$100,398,000**	**$90,128,000**	**$8,362,000**	**$1,908,000**

Funding:
Hospital Quality Assurance Revenue Fund (4260-611-3158)
Title XIX FFP (4260-611-0890)

CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS

REGULAR POLICY CHANGE NUMBER:	158
IMPLEMENTATION DATE:	6/2002
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	86

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$89,940,000	$73,762,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$89,940,000	$73,762,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$89,940,000	$73,762,000

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: 158

Reason for Change:
There is no change from the prior estimate for FY 2016-17. The change from the prior estimate, for FY 2017-18, is an increase due to the inclusion of Affordable Care Act (ACA) FY 2013-14 through FY 2015-16 payments.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is a decrease due to an additional partial year payment occurring in FY 2016-17.

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. All ACA payments are currently pending Centers for Medicare and Medicaid Services (CMS) approval, which is not expected to occur in FY 2016-17.

FY 2016-17	TF	FFP
FY 2011-12	$87,000	$87,000
FY 2012-13	$63,000	$63,000
FY 2013-14	$4,896,000	$4,896,000
FY 2014-15	$37,118,000	$37,118,000
FY 2015-16	$45,430,000	$45,430,000
FY 2016-17	$2,346,000	$2,346,000
Total FY 2016-17	**$89,940,000**	**$89,940,000**

FY 2017-18	TF	FFP	ACA FFP
FY 2014-15	$1,954,000	$1,954,000	$0
FY 2015-16	$5,048,000	$5,048,000	$0
FY 2016-17	$52,019,000	$52,019,000	$0
FY 2017-18	$2,343,000	$2,343,000	$0
FY 2013-14 ACA	$1,001,000	$0	$1,001,000
FY 2014-15 ACA	$4,779,000	$0	$4,779,000
FY 2015-16 ACA	$6,618,000	$0	$6,618,000
Total FY 2017-18	**$73,762,000**	**$61,364,000**	**$12,398,000**

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

GEMT SUPPLEMENTAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER:	159
IMPLEMENTATION DATE:	4/2014
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1661

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$43,716,000	$76,800,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$43,716,000	$76,800,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$43,716,000	$76,800,000

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: 159

Reason for Change:
The change in FY 2016-17, from the prior estimate, is a decrease due to:

- All supplemental payments for FY 2009-10 through FY 2012-13 will be budgeted in FY 2016-17,
- FY 2010-11 payments have been updated with actuals and all will be budgeted in FY 2016-17,
- FY 2015-16 payments have been updated with actuals, and
- FY 2013-14 through FY 2015-16 ACA payments have shifted to FY 2017-18.

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

- Retroactive periods FY 2009-10 through FY 2010-11 have shifted to FY 2016-17,
- FY 2013-14 through FY 2015-16 ACA payments have been updated with actuals and shifted to FY 2017-18, and
- FY 2016-17 payments have been updated with actuals.

The change from FY 2016-17 and FY 2017-18, in the current estimate, is an increase due to:

- The shift of retroactive periods FY 2009-10 through FY 2012-13 to FY 2016-17, and
- All ACA payments have shifted from FY 2016-17 to FY 2017-18.

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, for newly eligible Medi-Cal beneficiaries. ACA payments estimated in FY 2017-18 are pending CMS approval.

3. Payments estimated for FY 2016-17 and FY 2017-18 are CPE based.

4. In FY 2016-17, payments for FY 2013-14 and FY 2014-15 ACA optional population are made at 50% FMAP. Upon CMS approval, the initial 50% federal financial participation (FFP) will be adjusted in FY 2017-18 to draw down the ACA 100% FMAP payment. This approval is expected to occur in FY 2017-18.

The estimated payments on a cash basis are:

FY 2016-17	Total FFP	Regular FFP	ARRA
FY 2009-10	$14,900,000	$12,100,000	$2,800,000
FY 2010-11	$11,867,000	$9,713,000	$2,154,000
FY 2011-12	$640,000	$640,000	$0
FY 2012-13	$400,000	$400,000	$0
FY 2013-14	$1,681,000	$1,681,000	$0
FY 2014-15	$2,228,000	$2,228,000	$0
FY 2015-16	$12,000,000	$12,000,000	$0
Total FY 2016-17	**$43,716,000**	**$38,762,000**	**$4,954,000**

GEMT SUPPLEMENTAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 159

FY 2017-18	Total FFP	Regular FFP	ACA
FY 2013-14	$3,500,000	($3,500,000)	$7,000,000
FY 2014-15	$18,000,000	($2,400,000)	$20,400,000
FY 2015-16	$16,100,000	$0	$16,100,000
FY 2016-17	$39,200,000	$15,900,000	$23,300,000
Total FY 2017-18	**$76,800,000**	**$10,000,000**	**$66,800,000**

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

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH

REGULAR POLICY CHANGE NUMBER:	160
IMPLEMENTATION DATE:	1/2005
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1038

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$10,037,000	$10,000,000
- STATE FUNDS	$5,018,500	$5,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$10,037,000	$10,000,000
STATE FUNDS	$5,018,500	$5,000,000
FEDERAL FUNDS	$5,018,500	$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 for FY 2016-17 and FY 2017-18 from the prior estimate. The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to Calendar Year (CY) 2016 quarter one funds withheld in FY 2015-16, which were redistributed and paid in FY 2016-17.

Methodology:
1. In FY 2016-17, $37,000 TF of CY 2016 quarter one distributions were withheld in FY 2015-16 and paid in FY 2016-17.

2. Assume annual reimbursements for disproportionate share of outpatient services are $10,000,000 TF ($5,000,000 GF).

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH

REGULAR POLICY CHANGE NUMBER: 160

(Dollars in Thousands)

FY 2016-17	TF	GF	FF
CY 2016	$7,537	$3,768	$3,768
CY 2017	$2,500	$1,250	$1,250
Total	**$10,037**	**$5,018**	**$5,019**

(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**

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

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH

REGULAR POLICY CHANGE NUMBER:	161
IMPLEMENTATION DATE:	1/2005
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1039

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	**$8,009,000**	**$8,000,000**
- STATE FUNDS	**$4,004,500**	**$4,000,000**
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	**$8,009,000**	**$8,000,000**
STATE FUNDS	**$4,004,500**	**$4,000,000**
FEDERAL FUNDS	**$4,004,500**	**$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 2016-17 and FY 2017-18 from the prior estimate. The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to Calendar Year (CY) 2016 quarter one funds which were withheld in FY 2015-16 and paid in FY 2016-17.

Methodology:
1. $9,000 TF of CY 2016 quarter one payments, which were withheld in FY 2015-16, were paid out in FY 2016-17.

2. Assume annual reimbursements to SRHs providing outpatient services are $8,000,000 TF ($4,000,000 GF).

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH

REGULAR POLICY CHANGE NUMBER: 161

(Dollars in Thousands)

FY 2016-17	TF	GF	FF
CY 2016	$6,009	$3,004	$3,005
CY 2017	$2,000	$1,000	$1,000
Total	**$8,009**	**$4,004**	**$4,005**

(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**

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

STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	162
IMPLEMENTATION DATE:	12/2010
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1616

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	**$4,204,000**	**$4,631,000**
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	**$4,204,000**	**$4,631,000**
STATE FUNDS	$0	$0
FEDERAL FUNDS	**$4,204,000**	**$4,631,000**

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 2016-17, from the prior estimate, is a decrease due to:

- Delaying the FY 2013-14 through FY 2015-16 ACA payments to FY 2017-18,
- Receipt of actual FY 2015-16 initial reconciliation claims, and
- Paying three quarters for the FY 2016-17 interim payment instead of one quarter.

The change in FY 2017-18, from the prior estimate, is an increase due to updated FY 2015-16 actuals as well as the above shift in the ACA payments. The FY 2016-17 ACA payment is postponed to a subsequent fiscal year and no longer in the estimate.

STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 162

The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to the ACA payments in FY 2017-18.

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 2016-17	FF
Interim Payments	
FY 2016-17	$3,078,000
Initial Reconciliation Payment	
FY 2015-16	$1,126,000
FY 2016-17 Total	**$4,204,000**

FY 2017-18	FF
ACA Payments	
FY 2013-14	$39,000
FY 2014-15	$135,000
FY 2015-16	$223,000
Interim Payments	
FY 2017-18	$3,208,000
Initial Reconciliation Payment	
FY 2016-17	$1,026,000
FY 2017-18 Total	**$4,631,000**

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

IGT PAYMENTS FOR HOSPITAL SERVICES

REGULAR POLICY CHANGE NUMBER:	163
IMPLEMENTATION DATE:	7/2006
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1158

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$4,000,000	$5,613,000
- STATE FUNDS	$2,000,000	$2,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$4,000,000	$5,613,000
STATE FUNDS	$2,000,000	$2,000,000
FEDERAL FUNDS	$2,000,000	$3,613,000

DESCRIPTION

Purpose:
This policy change estimates the Intergovernmental Transfers (IGTs) used to draw down federal financial participation (FFP) paid to non-SB 1100 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: 163

Reason for Change:
There is no change in total payments from the prior estimate for FY 2016-17, however, the FY 2013-14 through FY 2015-16 ACA payments have shifted to FY 2017-18 due to the pending federal approval of the Affordable Care Act (ACA) payment methodology.

The change from the prior estimate, for FY 2017-18, is an increase due to the updating the ACA payments as follows:

- The FY 2013-14 ACA payments has decreased due to updated claims data,
- The FY 2014-15 and FY 2015-16 ACA payments have increased due to updated claims data,
- The FY 2016-17 has been shifted to a subsequent fiscal year and no longer included in the estimate, and
- The funding now reflects the reimbursement of the nonfederal share of the ACA payments to the counties as a total fund expenditure.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to the shift of ACA payments from FY 2016-17 to FY 2017-18.

Methodology:

1. Annual IGTs on an accrual basis are estimated to be $4,000,000 for FY 2016-17 and FY 2017-18, as outlined in SPA 15-003. Cash basis payments vary from year-to-year based on when the IGTs are actually received.

2. Federal approval of the ACA payment methodology is expected in FY 2017-18. Payments are expected to occur in first 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 applied to the total supplemental payment in order to determine the actual amount of ACA reimbursement for each hospital.

3. The ACA allows for 100% Federal Medical Assistance Percentage (FMAP) for calendar years 2014 through 2016, for newly eligible Medi-Cal beneficiaries.

4. 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 costs for newly eligible Medi-Cal beneficiaries. For FY 2013-14, FY 2014-15, and FY 2015-16, the ACA supplemental payments will be claimed in FY 2017-18. The 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 2016-17	TF	IGT	FF
FY 2016-17	$4,000,000	$2,000,000	$2,000,000
Total FY 2016-17	**$4,000,000**	**$2,000,000**	**$2,000,000**

IGT PAYMENTS FOR HOSPITAL SERVICES

REGULAR POLICY CHANGE NUMBER: 163

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 2017-18	$4,000,000	$2,000,000	$2,000,000	$0	$0
Total FY 2017-18	**$5,613,000**	**$2,000,000**	**$387,000**	**$3,226,000**	**$1,613,000**

*The Return to Counties column is for display purposes only (see Methodology #4).

Funding:
50% Reimbursement GF / 50% Title XIX (4260-610-0995 / 4260-101-0890)
100% Title XIX ACA FF (4260-101-0890)
100% Title XIX FF (4260-101-0890)

NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER:	164
IMPLEMENTATION DATE:	7/2005
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1076

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$3,800,000	$4,950,000
- 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	$3,800,000	$4,950,000
STATE FUNDS	$1,900,000	$1,900,000
FEDERAL FUNDS	$1,900,000	$3,050,000

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.

NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 164

Reason for Change:
The change in FY 2016-17, from the prior estimate, is due to delaying the FY 2013-14 Affordable Care Act (ACA) adjustments to FY 2017-18 as CMS approval is not expected to occur in FY 2016-17.

The change in FY 2017-18, from the prior estimate, is due to the addition of ACA adjustments for FY 2013-14, FY 2014-15, and FY 2015-16. The non-federal share of the ACA adjustments will be transferred into the NDPH Supplemental Fund.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to the ACA adjustments expected to occur in FY 2017-18.

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. The ACA claiming methodology is pending CMS approval.

4. ACA adjustments will be processed one year 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, and FY 2015-16, the ACA adjustments will be claimed in FY 2017-18. 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 2016-17 are shown below:

FY 2016-17 NDPH Supplemental Fund Summary	SF
FY 2015-16 Ending Balance	$454,000
Appropriation (GF)	$1,900,000
Est. FY 2015-16 Interest Earned	$7,000
Funds Available	$2,361,000
Less: FY 2016-17 Cash Expenditures to Hospitals	($1,900,000)
Est. FY 2016-17 Remaining Balance	$461,000

NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 164

FY 2016-17	TF	SF	FF
FY 2016-17 Cash Expenditures to Hospitals*	$3,800,000	$1,900,000	$1,900,000
Total	**$3,800,000**	**$1,900,000**	**$1,900,000**

7. 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	$12,500
FY 2013-14 ACA FF Adjustment to SF	$225,000
FY 2014-15 ACA FF Adjustment to SF	$352,000
FY 2015-16 ACA FF Adjustment to SF	$573,000
Funds Available	$3,523,500
Less: FY 2017-18 Cash Expenditures to Hospitals	($1,900,000)
Est. FY 2017-18 remaining balance	$1,623,500

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***	$225,000	$0	($225,000)	$450,000	$225,000
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
Total	**$4,950,000**	**$1,900,000**	**$750,000**	**$2,300,000**	**$1,150,000**

*The Return to Fund 3096 column is for display purposes only (see Methodology #4).

Funding:
100% GF (4260-104-0001)
NDPH Supplemental Fund (less funded by GF) (4260-698-3096)
50% Title XIX / 50% NDPH Supplemental Fund (4260-601-3096/4260-101-0890)**
100% Title XIX ACA (4260-101-0890)***
100% Title XIX (4260-101-0890)***

FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	165
IMPLEMENTATION DATE:	7/2017
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1140

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	$465,948,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$465,948,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$465,948,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental payments to freestanding, non-hospital based clinics.

Authority:
AB 959 (Chapter 162, Statutes of 2006), Welfare & Institutions Code 14105.965

Interdependent Policy Change:
Not Applicable

Background:
Under this program, freestanding, non-hospital based clinics that are enrolled as Medi-Cal providers and are owned or operated by the State, city, county, city and county, the University of California, health care district, or hospital authorities to govern selected designated public hospitals, created by State law, effective July 1, 2016, would be eligible to receive supplemental payments. The supplemental payment, when combined with the amount received from all other sources of reimbursement, cannot exceed 100% of the costs of providing services to Medi-Cal beneficiaries incurred by the participating facilities. The non-federal match to draw down federal financial participation (FFP) is paid from the public funds of the participating facilities and does not involve State General Funds for non-state facilities.

The State Plan Amendment (SPA) 06-016 for this program was approved on August 8, 2012. Supplemental payments to freestanding, non-hospital based clinics will be retroactive to October 14, 2006.

SPA 16-021, was approved by the Centers for Medicare & Medicaid Services (CMS) on December 6, 2016, which makes technical revisions to update the clinic participation criteria in the relevant State Plan pages, specifically those necessary to reflect hospital authorities to govern selected designated public hospitals, created by state law.

FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 165

Reason for Change:
There is no change from the prior estimate for FY 2016-17.

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

- Updated payment amounts for FY 2008-09 to include funding from the American Recovery and Reinvestment Act of 2009 (ARRA) funding,
- The inclusion of payments for FY 2013-14,
- Updated payments for FY 2015-16 and FY 2016-17, and
- Updated fee-for-service and ACA caseload trends for FY 2014-15 through FY 2016-17.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to program implementation beginning in FY 2017-18.

Methodology:

1. Supplemental payments for freestanding, non-hospital based clinics are expected to begin July 2017.

2. Providers will begin submitting cost reports April 2017.

3. Participation in this program is voluntary. Assuming full participation, annual supplemental payments to freestanding, non-hospital based clinics are expected to total between $47,300,000 and $78,500,000.

4. In FY 2017-18, payments will be made for FY 2006-07 through FY 2008-09, and FY 2013-14 through FY 2016-17.

5. Under the 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.

6. The ACA impact for FY 2013-14 through FY 2016-17 is estimated below using projected caseload trends that considers the ACA implementation and transition of Medi-Cal beneficiaries to Managed Care.

Program payment amounts are estimated to be:

(Dollars in Thousands)

FY 2017-18	TF	FF	ARRA	ACA
FY 2006-07	$47,250	$47,250	$0	$0
FY 2007-08	$61,500	$61,500	$0	$0
FY 2008-09	$70,302	$60,036	$10,266	$0
FY 2013-14	$78,405	$73,595	$0	$4,810
FY 2014-15	$73,052	$65,248	$0	$7,804
FY 2015-16	$69,356	$61,568	$0	$7,788
FY 2016-17	$66,083	$58,783	$0	$7,300
Total FY 2017-18	**$465,948**	**$427,980**	**$10,266**	**$27,702**

FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 165

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

INFANT DEVELOPMENT PROGRAM

REGULAR POLICY CHANGE NUMBER:	166
IMPLEMENTATION DATE:	7/2016
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	2009

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$31,899,000	$26,305,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$31,899,000	$26,305,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$31,899,000	$26,305,000

DESCRIPTION

Purpose:
This policy change estimates the federal match to the California Department of Developmental Services (CDDS) for Infant Development Program (IDP) services for infants and toddlers ages 0 to 3 with and who are at risk of developmental disabilities.

Authority:
Interagency Agreement 11-88601

Interdependent Policy Changes:
Not Applicable

Background:
On October 9, 2015, the 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 and 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 2016-17 and FY 2017-18, is due to updated actual data. The change in the current estimate, from FY 2016-17 to FY 2017-18, is due to FY 2016-17 including higher number of prior year claims than FY 2017-18.

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

(Dollars in Thousands)

	TF	CDDS GF	FF
FY 2016-17	$63,798	$31,899	**$31,899**
FY 2017-18	$52,611	$26,306	**$26,305**

INFANT DEVELOPMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 166

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

CCI IHSS RECONCILIATION

REGULAR POLICY CHANGE NUMBER:	172
IMPLEMENTATION DATE:	10/2016
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1942

	FY 2016-17	FY 2017-18
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.

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),

CCI IHSS RECONCILIATION

REGULAR POLICY CHANGE NUMBER: 172

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 2016-17.

Methodology:

1. Assume the 2014 reconciliation for calendar year (CY) 2014 service months and reimbursement for overpayments and underpayments began in October 2016.

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.

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 June 2017.

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

ARRA HITECH - PROVIDER PAYMENTS

REGULAR POLICY CHANGE NUMBER:	174
IMPLEMENTATION DATE:	12/2011
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1488

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$198,460,000	$175,130,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$198,460,000	$175,130,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$198,460,000	$175,130,000

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: 174

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 2016-17 and FY 2017-18, is an increase due to the extension of the deadline to initiate participation in the program, resulting in an increase in the number of participating professionals and an increase in the hospital incentive payments.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is a decrease due to professionals and hospitals no longer being able to initiate participation in the program after May 2, 2017.

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 will no longer be able to initiate participation in the program after May 2, 2017.

4. Assume the aggregate hospital incentive payment amount is computed on a $2,000,000 base amount adjusted up or down 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 will no longer be able to initiate participation in the program after May 2, 2017. Starting with program year 2016, hospitals must attest in consecutive years.

   For FY 2016-17 and FY 2017-18, eligible incentive payments are adjusted based on current hospitals' pending payments. The first year eligible incentive payment will average $400,000, the second year will average $1,005,000, the third year will average $600,000, and the fourth year will average $450,000.

ARRA HITECH - PROVIDER PAYMENTS

REGULAR POLICY CHANGE NUMBER: 174

5. The estimated payments for FY 2016-17 and FY 2017-18 are on a cash-basis. The estimate for FY 2016-17 includes actual payments through January 2017.

FY 2016-17 Incentive Payments:

Eligibility Year	Professionals	Incentive Payments	FF
1	2,923	$21,250	$62,114,000
2	3,422	$8,500	$29,087,000
3	1,419	$8,500	$12,062,000
4	1,178	$8,500	$10,013,000
5	727	$8,500	$6,180,000
6	64	$8,500	$544,000
		Total FY 2016-17 Professional Payments	$120,000,000

Eligibility Year	Hospitals	Incentive Payments	FF
1	49	$400,000	$19,600,000
2	32	$1,005,000	$32,160,000
3	37	$600,000	$22,200,000
4	10	$450,000	$4,500,000
		Total FY 2016-17 Hospital Payments	$78,460,000

FY 2017-18 Incentive Payments:

Eligibility Year	Professionals	Incentive Payments	FF
2	5,145	$8,500	$43,733,000
3	2,186	$8,500	$18,581,000
4	953	$8,500	$8,101,000
5	522	$8,500	$4,437,000
6	265	$8,500	$2,253,000
		Total FY 2017-18 Professional Payments	$77,105,000

Eligibility Year	Hospitals	Incentive Payments	FF
2	45	$1,005,000	$45,225,000
3	34	$600,000	$20,400,000
4	72	$450,000	$32,400,000
		Total FY 2017-18 Hospital Payments	$98,025,000

Fiscal Year	Professional Payments	Hospital Payments	FF
FY 2016-17	$120,000,000	$78,460,000	**$198,460,000**
FY 2017-18	$77,105,000	$98,025,000	**$175,130,000**

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

ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS

REGULAR POLICY CHANGE NUMBER:	176
IMPLEMENTATION DATE:	6/2011
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1232

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$77,067,000	$110,533,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$77,067,000	$110,533,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$77,067,000	$110,533,000

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 2016-17. Funding for services provided between October 1, 2008, through June 30, 2011, will be reimbursed at the appropriate FMAP rate.

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

ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS

REGULAR POLICY CHANGE NUMBER: 176

Reason for Change:
The change in FY 2016-17, from the prior estimate, is a decrease due to updated expenditures and the shifting of ARRA payments to FY 2017-18. The change in FY 2017-18, from the prior estimate, and the change from FY 2016-17 to FY 2017-18 in the current estimate, is an increase due to updated expenditures and ARRA payments that will be completed in FY 2017-18.

Methodology:
1. FY 2016-17 includes a portion of payments for FY 2009-10, FY 2014-15 and FY 2015-16 expenditures. FY 2017-18 includes a portion of payments for FY 2015-16 and FY 2016-17 expenditures.

2. Updated estimates, on a cash basis, provided by CDDS:

(Dollars in Thousands)

CASH BASIS	TF	CDDS GF	FFP Regular	FFP ARRA	Total FFP
FY 2016-17	$154,134	$77,067	$77,067	$0	**$77,067**
FY 2017-18	$201,066	$90,533	$100,533	$10,000	**$110,533**

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

ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS

REGULAR POLICY CHANGE NUMBER:	180
IMPLEMENTATION DATE:	7/2010
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1526

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$12,711,000	$19,921,000
- STATE FUNDS	$5,817,000	$8,339,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$12,711,000	$19,921,000
STATE FUNDS	$5,817,000	$8,339,000
FEDERAL FUNDS	$6,894,000	$11,582,000

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 2016-17. 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: 180

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 2016-17 and FY 2017-18, as well as the change from FY 2016-17 to FY 2017-18 in the current estimate is due to updated expenditures and the addition of ARRA in FY 2017-18.

Methodology:
Updated estimates, on a cash basis, provided by CDDS:

(In Thousands)

Fiscal Year	ICF-DD Admin Fee	QA Fee Reimbursements	Total Funds	CDDS GF	DHCS GF	FFP	ARRA
FY 2016-17	$1,078	$5,817	$13,788	$1,077	**$5,817**	**$6,894**	**$0**
FY 2017-18	$1,587	$8,339	$20,681	$1,588	**$8,339**	**$10,754**	**$828**

Funding:
100% GF (4260-101-0001)
100% FFP (4260-101-0890)

*Actuals may differ due to rounding

OVERTIME FOR WPCS PROVIDERS

REGULAR POLICY CHANGE NUMBER:	181
IMPLEMENTATION DATE:	2/2016
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1852

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$11,466,000	$12,284,000
- STATE FUNDS	$5,733,000	$6,142,000
PAYMENT LAG	0.9760	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$11,190,800	$12,284,000
STATE FUNDS	$5,595,410	$6,142,000
FEDERAL FUNDS	$5,595,410	$6,142,000

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

Interdependent Policy Changes:
Not Applicable

Background:
New federal regulations require In-Home Supportive Services (IHSS) and WPCS employees to be paid overtime adding costs to the Department related to the WPCS policy change. The W&I Code, Section 12300.4 identifies two additional costs to the IHSS and WPCS Program. These new areas include 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; with certain exemptions. Beginning February 1, 2016, the Department began paying for overtime. A three month hold harmless period from February 2016 through April 2016 was included to allow a transition period for providers to help understand the requirements.

The California Department of Social Services and the Department are allowing exemptions to promote continuity and quality of care standards. Primarily, the Department will allow overtime between IHSS and WPCS up to 90 hours per week for recipients up to the waiver limit, a 12-hour work day or 360 hours per month, on a case by case basis.

OVERTIME FOR WPCS PROVIDERS

REGULAR POLICY CHANGE NUMBER: 181

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. Beginning January 1, 2018, the minimum wage will increase from $10.50 to $11.00 per hour.

Reason for Change:
The decrease from the prior estimate, for FY 2016-17, is due to the 3-month hold harmless being paid in FY 2015-16, which reduced the cost in FY 2016-17 by $3,480,000 TF. Overall, costs did increase for FY 2016-17 and FY 2017-18 due to an increase in the weighted average rate and the number of providers who received an approved exemption. The change from FY 2016-17 to FY 2017-18, 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 overtime and travel time costs began in February 2016.

2) Assume 1,695 WPCS beneficiaries will have providers receiving overtime in FY 2016-17 and 1,785 in FY 2017-18.

3) Assume the annual cost for overtime without exemptions or travel time in FY 2016-17 is $5,612,000 and $5,921,000 in FY 2017-18.

4) Assume 650 WPCS beneficiaries will have providers receiving overtime exemptions in FY 2016-17 and 700 in FY 2017-18.

5) Assume the annual cost for overtime for providers who received exemption in FY 2016-17 is $5,200,000 and $5,691,000 in FY 2017-18.

6) Assume the annual travel time cost for WPCS providers in FY 2016-17 is $653,000 and $671,000 in FY 2017-18.

7) The estimated cost for overtime, including exemptions, and travel time for WPCS providers is **$11,466,000 TF ($5,733,000 GF)** in FY 2016-17 and **$12,284,000 TF ($6,142,000 GF)** in FY 2017-18.

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

MEDI-CAL ESTATE RECOVERIES

REGULAR POLICY CHANGE NUMBER:	182
IMPLEMENTATION DATE:	4/2017
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	1991

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$12,587,000	$64,707,000
- STATE FUNDS	$6,293,500	$32,353,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$12,587,000	$64,707,000
STATE FUNDS	$6,293,500	$32,353,500
FEDERAL FUNDS	$6,293,500	$32,353,500

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 or 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 from the prior estimate, for FY 2016-17 and FY 2017-18, is an increase due to an adjusted estimate on uncollectible ERs that are deemed optional for recovery. The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to a full year of estimated costs instead of the partial year costs estimated in FY 2016-17.

MEDI-CAL ESTATE RECOVERIES

REGULAR POLICY CHANGE NUMBER: 182

Methodology:

1. The ER program changes, pursuant to SB 833, were effective January 1, 2017, but costs are not estimated to begin until April 1, 2017.

2. The SB 833 changes are assumed to decrease Estate Recoveries to $4.85 million TF annually.

3. The FY 2017-18 ER base estimate is projected to be $69.557 million TF. As a result, the annual costs of the SB 833 ER changes are estimated to be $64.707 million TF.

   $69.557 million TF - $4.85 million TF = $64.707 million TF

4. In FY 2016-17, the estimated costs beginning April 2017 are estimated to be $12.587 million TF. The annual estimated costs of $64.707 million TF is assumed in FY 2017-18.

Uncollectible Estate Recoveries	TF	GF	FF
FY 2016-17 Total	**$12,587,000**	**$6,293,500**	**$6,293,500**
FY 2017-18 Total	**$64,707,000**	**$32,353,500**	**$32,353,500**

Funding:

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

MINIMUM WAGE INCREASE FOR HCBS WAIVERS

REGULAR POLICY CHANGE NUMBER:	183
IMPLEMENTATION DATE:	1/2017
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1975

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	**$8,216,000**	$15,546,000
- STATE FUNDS	**$4,108,000**	**$7,773,000**
PAYMENT LAG	0.6580	0.9840
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	**$5,406,100**	$15,297,300
STATE FUNDS	**$2,703,060**	**$7,648,630**
FEDERAL FUNDS	**$2,703,060**	**$7,648,630**

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 181 – 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 the Department to create 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 would 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 would 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: 183

Reason for Change:
The change from the prior estimate, for FY 2016-17 and FY 2017-18, is an increase in full year costs due to the addition of a 44 waiver slots in the ALW to account for the expansion into San Francisco County and the integration of the existing San Francisco Community Living Support Benefit (SF CLSB) waiver population into the ALW. Although, FY 2016-17 decreased from the prior estimate when applying a payment lag. The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to 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.

2. Assume a 20% additional cost for employers due to required payroll taxes and other costs.

ALW
3. In CY 2016, assume the total amount of users is 3,700 and 4,092 in CY 2017.

4. For FY 2016-17, assume the total care coordination and assisted living cost minimum wage increase is $8,084,000 TF. For FY 2017-18, assume the total care coordination and assisted living cost minimum wage increase is $15,245,000 TF.

AIDS MCWP
5. For calendar year (CY) 2016, assume there are 1,000 attendant care users. For CY 2017, assume there are 1,020 attendant care users.

6. A unit is counted as 15 minutes of time.

7. For calendar year (CY) 2016, assume a participant uses 541 units of attendant care services annually. For CY 2017, assume a participant uses 552 units of attendant care services annually. For CY 2018, assume a participant uses 563 units of attendant care services annually.

8. For CY 2016 assume the estimated attendant care service rate is $4.73 per unit. 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.

9. Assume the FY 2016-17 cost for the AIDS MCWP Waiver minimum wage increase is $132,000 TF. Assume the FY 2017-18 cost for AIDS MCWP Waiver minimum wage is $301,000 TF.

FY 2016-17	TF	GF	FF
ALW	$8,084,000	$4,042,000	$4,042,000
HIV/AIDS	$132,000	$66,000	$66,000
Total	**$8,216,000**	**$4,108,000**	**$4,108,000**

FY 2017-18	TF	GF	FF
ALW	$15,245,000	$7,622,000	$7,623,000
HIV/AIDS	$301,000	$151,000	$150,000
Total	**$15,546,000**	**$7,773,000**	**$7,773,000**

MINIMUM WAGE INCREASE FOR HCBS WAIVERS

REGULAR POLICY CHANGE NUMBER: 183

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

WPCS WORKERS' COMPENSATION

REGULAR POLICY CHANGE NUMBER:	184
IMPLEMENTATION DATE:	11/2016
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1866

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$7,511,000	$3,019,000
- STATE FUNDS	$3,755,500	$1,509,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$7,511,000	$3,019,000
STATE FUNDS	$3,755,500	$1,509,500
FEDERAL FUNDS	$3,755,500	$1,509,500

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:
The change from the prior estimate, for FY 2016-17 and FY 2017-18, is an increase due to a newly added contract agreement between CDSS and the State Controller's Office (SCO). The SCO performs the check write functions for worker's compensation payments. The Department reimburses CDSS for 1% of these fees. The change from FY 2016-17 to FY 2017-18, in the current estimate, is an overall decrease due to retroactive payments in FY 2016-17 but slightly offset due to the rise in healthcare costs.

WPCS WORKERS' COMPENSATION

REGULAR POLICY CHANGE NUMBER: 184

Methodology:

1. Assume the Department pays worker's compensation for providers beginning November 1, 2016, retroactive to October 2014.

2. Based on data provided by the CDSS, beginning October 2014, FY 2014-15 costs are estimated to be $2,264,000, $2,500,000 in FY 2015-16, and $2,747,000 in FY 2016-17. The total cost to be paid for workers' compensation in FY 2016-17 is $7,511,000 TF. The total cost to be paid for workers' compensation in FY 2017-18 is $3,019,000 TF.

FY 2016-17	TF	GF	FF
FY 2014-15 costs	$2,264,000	$1,132,000	$1,132,000
FY 2015-16 costs	$2,500,000	$1,250,000	$1,250,000
FY 2016-17 costs	$2,747,000	$1,374,000	$1,373,000
FY 2016-17 Total	**$7,511,000**	**$3,756,000**	**$3,755,000**
FY 2017-18 Total	**$3,019,000**	**$1,510,000**	**$1,509,000**

Funding:

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

INDIAN HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER:	185
IMPLEMENTATION DATE:	4/1998
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	111

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	**$3,208,000**	**$6,239,000**
- STATE FUNDS	-$20,795,000	-$20,795,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	100.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	**$6,239,000**
STATE FUNDS	$0	-$20,795,000
FEDERAL FUNDS	$0	$27,034,000

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 IHS/MOA between the federal IHS and the Centers for Medicare and Medicaid Services (CMS) on April 21, 1998. The agreement permits the Department to be reimbursed at 100% FFP for payments made by the State for services rendered to AIs through IHS tribal facilities.

Federal policy permits retroactive claiming of 100% FFP to the date of the MOA, July 11, 1996, or at whatever later date a clinic qualifies and elects to participate as an IHS facility under the MOA.

The per visit rate payable to the Indian health clinics is adjusted annually through changes posted in the Federal Register. These rates are set by IHS with the concurrence of the Federal Office of Management and Budget and are based on cost reports compiled by IHS.

Reason for Change:
There is no change from the prior estimate for FY 2016-17. The increase from the prior estimate, for FY 2017-18, is due to an increase in the anticipated CY 2017 per visit rate from $13 to $23. The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to the rate increase in budget year (BY) of $23.

Methodology:
1. Currently, there are 59 Indian health clinics participating in Medi-Cal.

INDIAN HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER: 185

2. In FY 2015-16, the Department spent $41,590,000 TF ($20,795,000 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. The FY 2016-17 estimate includes an additional $1,069,000 due to the increased rate for the period of January 2016 through June 2016. The annual rate increase for the additional $18 is $2,139,000 TF.

5. The FY 2017-18 estimate includes an additional $1,367,000 TF due to the anticipated rate increase from $368 to $391 for the period of January 2017 through June 2017. The annual rate increase for the additional $23 is $2,733,000 TF.

	FY 2016-17	FY 2017-18
CY 2016 rate increase	$2,139,000	$2,139,000
CY 2017 rate increase	$0	$2,733,000
Retro Jan –June 2016 rate increase	$1,069,000	$0
Retro Jan –June 2017 rate increase	$0	$1,367,000
Total Rate increase	**$3,208,000**	**$6,239,000**
FY 2015-16 Base expenditures	$41,590,000	$47,829,000
Total expenditures	$44,798,000	$47,829,000

(Dollars in Thousands)

FY 2016-17	TF	GF	FF
IHS FY 2015-16 Base exp. (50% GF / 50% FF)	($41,590)	($20,795)	($20,795)
IHS total expenditures (100% FF)	$44,798	$0	$44,798
FY 2016-17 Total	**$3,208**	**($20,795)**	**$24,003**

FY 2017-18			
IHS FY 2015-16 Base exp. (50% GF / 50% FF)	($41,590)	($20,795)	($20,795)
IHS total expenditures (100% FF)	$47,829	$0	$47,829
FY 2017-18 Total	**$6,239**	**($20,795)**	**$27,034**

*Totals may differ due to rounding.

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

CDDS DENTAL SERVICES

REGULAR POLICY CHANGE NUMBER:	189
IMPLEMENTATION DATE:	2/2012
ANALYST:	Nikaela Ratliff
FISCAL REFERENCE NUMBER:	1629

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$984,000	$984,000
- STATE FUNDS	$984,000	$984,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$984,000	$984,000
STATE FUNDS	$984,000	$984,000
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. Select adult optional dental services were reinstated May 1, 2014.

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.

Reason for Change:
There is no change from the prior estimate. There is also no change from FY 2016-17 to FY 2017-18 in the current estimate.

CDDS DENTAL SERVICES

REGULAR POLICY CHANGE NUMBER: 189

Methodology:
1. Assume the benefit costs will be $984,000 annually, based on actual invoices.
2. All costs are reimbursed by CDDS.

Funding:
100% Reimbursement GF (4260-610-0995)

NURSING FACILITY/ACUTE HOSPITAL WAIVER RENEWAL

REGULAR POLICY CHANGE NUMBER:	190
IMPLEMENTATION DATE:	10/2017
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	2010

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	**$8,940,000**
- STATE FUNDS	$0	**$4,470,000**
PAYMENT LAG	1.0000	0.7550
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	**$6,749,700**
STATE FUNDS	$0	**$3,374,850**
FEDERAL FUNDS	$0	**$3,374,850**

DESCRIPTION

Purpose:
This policy change estimates the cost of renewing the Nursing Facility / Acute Hospital (NF/AH) Waiver.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
The NF/AH 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.

Under the NF/AH Waiver renewal, the Department plans to:

- Increase the number of waiver slots with long-term savings by expanding capacity of the NF/AH 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;

- 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

NURSING FACILITY/ACUTE HOSPITAL WAIVER RENEWAL

REGULAR POLICY CHANGE NUMBER: 190

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;

- 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; and

- Rename the wavier to the Home and Community Based (HCB) Alternatives Waiver.

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 2018 at an average of 92 per month. This decreased the cost since it is assumed that not all new participants will begin January 1, 2018.

Methodology:

1. The Department received approval in November 2016 for a waiver amendment, retroactive to February 1, 2016, that removes the individual cost limit requirement for waiver participants.

2. Beginning February 1, 2016, for CY 2017 and CY 2018, assume 1,192 and 1,255, respectively, current participants are over their waiver cap and their monthly cost for unmet need is $367.

3. The existing waiver was granted an extension through March 31, 2017.

4. There are currently 3,974 waiver participants. Assume 200 new participants will be enrolled in CY 2017. Assume 1,100 new participants will be enrolled in CY 2018 and 1,000 participants annually thereafter until 2021.

5. Of the 200 participants newly enrolled in CY 2017, assume 120 of those participants will be from long-term skilled nursing facilities and the Early Periodic Screening and Diagnostic Treatment (EPSDT) Program and 80 participants will be from the community. Of the 1,100 participants newly enrolled in CY 2018, assume 660 participants will be from long-term skilled nursing facilities and the EPSDT Program and 440 will be from the community.

6. Assume the monthly cost for care management is $275 and that care management costs will not begin until October 2017 to allow time to implement the Care Management model.

7. Assume the monthly cost for waiver services from the community is $3,040.

8. Assume the monthly cost for wavier services transitioning from institutions and EPSDT is $4,698.

9. Assume the average monthly cost in a skilled nursing facility is $10,736.

NURSING FACILITY/ACUTE HOSPITAL WAIVER RENEWAL

REGULAR POLICY CHANGE NUMBER: 190

FY 2017-18	TF	GF	FF
Care Management	$10,828,000	$5,414,000	$5,414,000
Waiver Svcs. - Community	$7,588,000	$3,794,000	$3,794,000
Waiver Svcs. - EPSDT	$2,684,000	$1,342,000	$1,342,000
Waiver Svcs. – Institutional Tran.	$9,606,000	$4,803,000	$4,803,000
Unmet Need	$4,505,000	$2,252,000	$2,252,000
Institutional Transitions Savings	($21,953,000)	($10,976,000)	($10,976,000)
Total	**$8,940,000**	**$4,470,000**	**$4,470,000**

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

MANAGED CARE ADMIN FINES AND PENALTIES REVENUE

REGULAR POLICY CHANGE NUMBER:	191
IMPLEMENTATION DATE:	7/2016
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1986

	FY 2016-17	FY 2017-18
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 for purposes of funding health care services for children, seniors, persons with disabilities, and dual eligibles in the Medi-Cal program.

Authority:
Chapter 23, Statutes of 2016 (2016 Budget Act)

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). The Major Risk Medical Insurance Program (MRMIP) is a high risk pool that was originally designed to provide health insurance to Californians unable to obtain coverage in the individual health insurance market because of a pre-existing condition. With the implementation of the Affordable Care Act, individuals may not be denied coverage because of a pre-existing condition, which resulted in a significant decrease in MRMIP caseload. The 2016 Budget Act authorized the Department to use revenues transferred in the Major Risk Medical Insurance Fund for purposes of funding health care services in the Medi-Cal program.

Reason for Change:
There is no change from the prior estimate.

MANAGED CARE ADMIN FINES AND PENALTIES REVENUE

REGULAR POLICY CHANGE NUMBER: 191

Methodology:

1. The FY 2016-17 estimate is based on actual fines and penalties assessed by DMHC.

2. The total fines and penalties revenue for FY 2016-17 is:

FY 2016-17	
Major Risk Medical Insurance Fund	$3,404,000
GF	($3,404,000)
Net Impact	**$0**

Funding:

Major Risk Medical Insurance Fund (4260-101-0313)
Title XIX GF (4260-101-0001)

COUNTY SHARE OF OTLICP-CCS COSTS

REGULAR POLICY CHANGE NUMBER:	192
IMPLEMENTATION DATE:	7/2014
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	1906

	FY 2016-17	FY 2017-18
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 2016-17, is an increase due to updated monthly expenditures from July 1, 2016 through December 30, 2016 and the addition of three new treatments and services (DEFLAZACORT, Exondys 51 and SPINRAZA) for CCS beneficiaries. The change from the prior estimate, for FY 2017-18, is an increase due to updated monthly expenditures from July 1, 2016 through December 30, 2016 and the addition of three new treatments and services (DEFLAZACORT, Exondys 51 and SPINRAZA) for CCS beneficiaries. The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to an increase in projected CCS-OTLICP eligibles to receive DEFLAZACORT, Exondys 51 and SPINRAZA.

COUNTY SHARE OF OTLICP-CCS COSTS

REGULAR POLICY CHANGE NUMBER: 192

Methodology:

1. The county share reimbursement (6%) for CCS-OTLICP is estimated to be $7,793,000 in FY 2016-17 and $8,217,000 in FY 2017-18.

Fiscal Year	TF	GF	GF Reimbursement
FY 2016-17	**$0**	($7,793,000)	$7,793,000
FY 2017-18	**$0**	($8,217,000)	$8,217,000

Funding:
100% Title XXI State GF (4260-113-0001)
Reimbursement (4260-610-0995)

FUNDING ADJUST.—ACA OPT. EXPANSION

REGULAR POLICY CHANGE NUMBER:	193
IMPLEMENTATION DATE:	7/2015
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1915

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$1,736,550,000	-$1,764,846,210
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$1,736,550,000	-$1,764,846,210
FEDERAL FUNDS	$1,736,550,000	$1,764,846,210

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:
PC 042 Dental Transformation Initiative Utilization
PC 128 AB 1629 Annual Rate Adjustment
PC 131 DPH Interim Rate Growth
PC 132 LTC Rate Adjustment
PC 135 Hospice Rate Increases
PC 136 Discontinue Pharmacy Rate Reductions
PC 138 GDSP Prenatal Screening Program Fee Increase
PC 140 Alternative Birthing Center Reimbursement
PC 144 Laboratory Rate Methodology Change
PC 145 Reduction to Radiology Rates
Fee-for-Service Base Expenditures

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. 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: 193

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 2016-17 is 100% through CY 2016 and drops to 95% for CY 2017. The federal match for FY 2017-18 is matched at 95% through CY 2017 and then decreases to 94% in CY 2018.

3) The total amount of unadjusted ACA optional expansion funding for all policy changes in FY 2016-17 is estimated as $3,649,123,739 and $3,963,227,170 in FY 2017-18. These amounts are credited to the Title XIX fund.

4) The amounts adjusted by this policy change are as follows:
(Dollars in Thousands)

FY 2016-17	GF	FF
Fee-For-Service Base Dollars	$ (1,731,939)	$ 1,731,939
PC 042 Dental Transformation Initiative Utilization	$ (494)	$ 494
PC 128 AB 1629 Annual Rate Adjustments	$ (3,598)	$ 3,598
PC 132 LTC Rate Adjustment	$ (330)	$ 330
PC 135 Hospice Rate Increases	$ (8)	$ 8
PC 136 Discontinue Pharmacy Rate Reductions	$ (618)	$ 618
PC 144 Laboratory Rate Methodology Change	$ 273	$ (273)
PC 145 Reduction To Radiology Rates	$ 165	$ (165)
Total	**$ (1,736,550)**	**$ 1,736,550**

FUNDING ADJUST.—ACA OPT. EXPANSION

REGULAR POLICY CHANGE NUMBER: 193

FY 2017-18	GF	FF
Fee-For-Service Base Dollars	$ (1,756,852)	$ 1,756,852
PC 042 Dental Transformation Initiative Utilization	$ (201)	$ 201
PC 128 AB 1629 Annual Rate Adjustments	$ (5,654)	$ 5,654
PC 131 DPH Interim Rate Growth	$ (6,607)	$ 6,607
PC 132 LTC Rate Adjustment	$ (498)	$ 498
PC 135 Hospice Rate Increases	$ (281)	$ 281
PC 136 Discontinue Pharmacy Rate Reductions	$ (3,168)	$ 3,168
PC 138 GDSP Prenatal Screening Fee Increase	$ (354)	$ 354
PC 140 Alternative Birthing Center Reimbursement	$ (6)	$ 6
PC 144 Laboratory Rate Methodology Change	$ 4,376	$ (4,376)
PC 145 Reduction To Radiology Rates	$ 4,399	$ (4,399)
Total	**$ (1,764,846)**	**$ 1,764,846**

Funding:
(Dollars in Thousands)

FY 2016-17	TF	GF	FF
Title XIX 50/50	$ (3,649,124)	$ (1,824,562)	$(1,824,562)
ACA Title XIX 100% FF	$ 1,888,893	$ -	$ 1,888,893
ACA Title XIX 95% FF	$ 1,760,231	$ 88,012	$ 1,672,219
Total	**$ -**	**$ (1,736,550)**	**$ 1,736,550**

FY 2017-18	TF	GF	FF
Title XIX 50/50	$ (3,963,228)	$ (1,981,614)	$(1,981,614)
ACA Title XIX 95% FF	$ 2,102,633	$ 105,132	$ 1,997,501
ACA Title XIX 94% FF	$ 1,860,595	$ 111,636	$ 1,748,959
Total	**$ -**	**$ (1,764,846)**	**$ 1,764,846**

FUNDING ADJUST.—OTLICP

REGULAR POLICY CHANGE NUMBER:	194
IMPLEMENTATION DATE:	7/2015
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1926

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$74,000	$154,000
- STATE FUNDS	-$171,665,760	-$176,826,160
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$74,000	$154,000
STATE FUNDS	-$171,665,760	-$176,826,160
FEDERAL FUNDS	$171,739,760	$176,980,160

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 Dollars
PC 042 Dental Transformation Initiative Utilization
PC 074 Pathways to Well-Being
PC 132 LTC Rate Adjustment
PC 133 Annual MEI Increase For FQHCs/RHCs
PC 135 Hospice Rate Increases
PC 136 Discontinue Pharmacy Rate Reductions
PC 144 Laboratory Rate Methodology Change
PC 145 Reduction to Radiology Rates
PC 146 10% Provider Payment Reduction
PC 128 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% through September 30, 2015. Beginning October 1, 2015, the enhanced federal match increased to 88%. The enhanced federal matching rate will continue until September 30, 2017,

FUNDING ADJUST.—OTLICP

REGULAR POLICY CHANGE NUMBER: 194

reverting to 65% on October 1, 2017.

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 2016-17 is estimated as $451,849,889 and $465,534,652 in FY 2017-18. 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 2016-17, the Department estimates the additional CHIP funding will offset general fund spending by $171.7M.
   b. In FY 2017-18, the Department estimates the additional CHIP funding will offset general fund spending by $176.8M.

4) The Department estimates the Total Fund after the adjustment of CHIP funding to be $74,000 in FY 2016-17 and $154,000 in FY 2017-18.

5) The amounts adjusted by policy change are as follows:

(Dollars in Thousands)

FY 2016-17	TF	GF	FF
Base Adjustments Combined	$ -	$ 5,942	$ (5,942)
Fee-For-Service Base Dollars	$ -	$ (177,773)	$ 177,773
PC 042 Dental Transformation Initiative Utilization	$ -	$ (106)	$ 106
PC 074 Pathways To Well-Being	$ 74	$ -	$ 74
PC 132 LTC Rate Adjustment	$ -	$ (4)	$ 4
PC 135 Hospice Rate Increases	$ -	$ (11)	$ 11
PC 136 Discontinue Pharmacy Rate Reductions	$ -	$ (57)	$ 57
PC 144 Laboratory Rate Methodology Change	$ -	$ 43	$ (43)
PC 145 Reduction To Radiology Rates	$ -	$ 23	$ (23)
PC 146 10% Provider Payment Reduction	$ -	$ 322	$ (322)
PC 128 AB 1629 Annual Rate Adjustments	$ -	$ (44)	$ 44
Total	**$ 74**	**$ (171,666)**	**$ 171,740**

FUNDING ADJUST.—OTLICP

REGULAR POLICY CHANGE NUMBER: 194

FY 2017-18	TF	GF	FF
Base Adjustments Combined	$ -	$ 6,184	$ (6,184)
Fee-For-Service Base Dollars	$ -	$ (183,381)	$ 183,381
PC 042 Dental Transformation Initiative Utilization	$ -	$ (46)	$ 46
PC 074 Pathways To Well-Being	$ 154	$ -	$ 154
PC 132 LTC Rate Adjustment	$ -	$ (7)	$ 7
PC 133 Annual MEI Increase For FQHCs/RHCs	$ -	$ (541)	$ 541
PC 135 Hospice Rate Increases	$ -	$ (344)	$ 344
PC 136 Discontinue Pharmacy Rate Reductions	$ -	$ (283)	$ 283
PC 144 Laboratory Rate Methodology Change	$ -	$ 651	$ (651)
PC 145 Reduction To Radiology Rates	$ -	$ 592	$ (592)
PC 146 10% Provider Payment Reduction	$ -	$ 426	$ (426)
PC 128 AB 1629 Annual Rate Adjustments	$ -	$ (77)	$ 77
Total	**$ 154**	**$ (176,826)**	**$ 176,980**

Funding:
50% Title XIX FF / 50% GF (4260-101-0001/0890)
88% Title XXI FF / 12% GF (4260-113-0890/0001)

FFP REPAYMENT FOR CDDS COSTS

REGULAR POLICY CHANGE NUMBER:	195
IMPLEMENTATION DATE:	5/2016
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1956

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$36,262,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$36,262,000	$0
FEDERAL FUNDS	-$36,262,000	$0

DESCRIPTION

Purpose:
This policy change estimates the reimbursement from the California Department of Developmental Services (CDDS) and payment to the Centers for Medicare and Medicaid Services (CMS) for an overpayment of CDDS Medi-Cal eligible costs.

Authority:
Federal Regulations

Interdependent Policy Changes:
Not Applicable

Background:
Through the audit and cost settlement process, audit findings may result in the Department identifying overpayments related to Medi-Cal services provided in Intermediate Care Facilities for the Developmentally Disabled (ICF/DD). For any fiscal year in which audit findings have determined that an ICF/DD was overpaid, the Department will recoup any overpayment. Conversely, if the audit findings determine that an ICF-DD was underpaid, the Department will pay CDDS. Any additional FFP due to CDDS will be budgeted in the Developmental Centers/State Op Small Fac policy change.

The Department originally expected to receive reimbursement from CDDS in FY 2015-16 and FY 2016-17, however a delay in receiving reimbursements from CDDS pushed back expected receipt of reimbursement from CDDS to FY 2016-17.

Reason for Change:
The change from the prior estimate, for FY 2016-17, is a decrease due to an audit appeal for FY 2010-11 which reduced the amount of the overpayment. It is currently assumed that the full reimbursement for the affected FYs will be received in FY 2016-17.

FFP REPAYMENT FOR CDDS COSTS

REGULAR POLICY CHANGE NUMBER: 195

Methodology:

1. FY 2008-09 audits were appealed by CDDS for Fairview, Lanterman, Porterville, and Sonoma. The results of the appeal determined that CDDS was overpaid $16,608,437 Total Computable ($9,720,447 FFP).

2. FY 2009-10 audits were appealed by CDDS for Fairview, Lanterman, Porterville, and Sonoma. The results of the appeal determined that CDDS was overpaid $17,223,249 Total Computable ($10,569,832 FFP).

3. The Department completed the FY 2010-11 audits and determined that CDDS was overpaid $37,301,887 Total Computable ($22,203,580 FFP). CDDS filed an appeal for Canyon Springs, Fairview, Lanterman, Porterville, and Sonoma, which resulted in a reduction of the overpayment by $7,379,722 Total Computable ($4,327,310 FFP).

   As result of the appeal, it was determined that CDDS was overpaid $29,922,165 Total Computable ($17,876,270 FFP) for FY 2010-11.

4. The Department completed the FY 2011-12 audits and determined that CDDS was overpaid $10,798,966 Total Computable ($5,399,483 FFP).

5. FY 2016-17 includes the net balance of reimbursements from CDDS and costs to CMS for FY 2008-09 through FY 2011-12.

6. Reimbursement and costs are as follows:

(Dollars in Thousands)

FY 2016-17	TF	GF	FF	Reimbursement
CDDS Reimbursement	$0	($36,262)	$0	$36,262
CMS Payment	$0	$36,262	($36,262)	$0
Total	**$0**	$0	**($36,262)**	**$36,262**

Funding:

100% Reimbursement (4260-610-0995)
100% Title XIX FFP (4260-101-0890)

CLPP FUND

REGULAR POLICY CHANGE NUMBER:	196
IMPLEMENTATION DATE:	7/2005
ANALYST:	Sasha Jetton
FISCAL REFERENCE NUMBER:	1633

	FY 2016-17	FY 2017-18
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 2016-17 or FY 2017-18. There is no change between fiscal years 2016-17 and 2017-18

CLPP FUND

REGULAR POLICY CHANGE NUMBER: 196

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 2016-17 and FY 2017-18 is $725,000.

Funding:

	FY 2016-17
100% CLPP Fund (4260-111-0080)	$ 725,000
100% GF (4260-101-0001)	**$ (725,000)**
Net Impact	**$ -**

	FY 2017-18
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:	197
IMPLEMENTATION DATE:	4/2014
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1654

	FY 2016-17	FY 2017-18
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 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

CCI-TRANSFER OF IHSS COSTS TO DHCS

REGULAR POLICY CHANGE NUMBER: 197

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 from Prior Estimate:
FY 2016-17 costs increased from the previous estimate due to an increase in IHSS rates for non-CMC populations. While there was an increase in rates for FY 2017-18 from the previous estimate, total costs decreased due to the exclusion of IHSS as of January 1, 2018. Costs decreased from FY 2016-17 to FY 2017-18 due to the exclusion of IHSS as of January 1, 2018.

Methodology:
1. Estimated below is the overall impact of the CCI demonstration in FY 2016-17 and FY 2017-18.

(Dollars in Thousands)

FY 2016-17	TF	GF	FFP	Reimb.
CCI-Managed Care Payments (PC 98):				
Base managed care payments	$6,163,115	$3,081,557	$3,081,557	$0
Base managed care payments for add'l enrollment	$135,799	$67,899	$67,899	
Transfer of IHSS Costs to CDSS	$3,622,356	$1,811,178	$1,811,178	$0
Transfer of IHSS Costs to CDSS for add'l enrollment	$121,466	$60,733	$60,733	
Total Managed Care Payments	$10,042,736	$5,021,368	$5,021,368	$0
CCI-Savings and Deferral :				
Total Savings (In the Base)	($6,190,790)	($3,095,395)	($3,095,395)	$0
FFS Savings for Additional Enrollment (PC 210):	($94,594)	($47,297)	($47,297)	$0
Defer Managed Care Payment (In the Base)	$32,477	$16,239	$16,239	$0
Total	($6,252,907)	($3,126,453)	($3,126,453)	$0
IHSS Savings (In the Base)	($1,871,911)	$0	($1,871,911)	$0
Delay 1 Checkwrite (In the Base)	$56,580	$28,290	$28,290	$0
CCI-Transfer of IHSS Costs to DHCS (PC 197)	**$0**	**($1,871,911)**	**$0**	**$1,871,911**
CCI-Admin Costs, HCO Costs (OA 13, 17, 72)	$25,737	$12,869	$12,869	$0
Retro MC Rate Adjustments (PC 124)	$312,427	($193,737)	$156,214	$349,950
CCI-Quality Withhold Repayments (PC 220)	$1,353	$676	$677	$0
Total of CCI PCs including pass through	$2,314,014	($128,899)	$221,053	$2,221,861

CCI-TRANSFER OF IHSS COSTS TO DHCS

REGULAR POLICY CHANGE NUMBER: 197

(Dollars in Thousands)

FY 2017-18	TF	GF	FFP	Reimb.
CCI-Managed Care Payments (PC 98):				
Base managed care payments	$7,094,234	$3,547,117	$3,547,117	$0
Base managed care payments for add'l enrollment	$346,790	$173,395	$173,395	
Transfer of IHSS Costs to CDSS	$2,333,595	$1,166,798	$1,166,798	$0
Transfer of IHSS Costs to CDSS for add'l enrollment	$161,921	$80,960	$80,960	
Total Managed Care Payments	$9,936,539	$4,968,270	$4,968,270	$0
CCI-Savings and Deferral :				
Total Savings (In the Base)	($7,131,022)	($3,565,511)	($3,565,511)	$0
FFS Savings for Additional Enrollment (PC 210):	($332,853)	($166,427)	($166,427)	$0
Defer Managed Care Payment (In the Base)	($11,375)	($5,687)	($5,687)	$0
Total	($7,475,250)	($3,737,625)	($3,737,625)	$0
IHSS Savings (In the Base)	($1,247,758)	$0	($1,247,758)	$0
Delay 1 Checkwrite (In the Base)	$17,212	$8,606	$8,606	$0
CCI-Transfer of IHSS Costs to DHCS (PC 197)	**$0**	**($1,247,758)**	**$0**	**$1,247,758**
CCI-Admin Costs, HCO Costs (OA 13, 17, 72)	$26,423	$13,212	$13,212	$0
Retro MC Rate Adjustments (PC 124)	$1,234,221	$191,375	$617,110	$425,736
CCI-Quality Withhold Repayments (PC 220)	$9,000	$4,500	$4,500	$0
Health Insurer Fee (PC 19)	$5,724	$2,862	$2,862	$0
Total of CCI PCs including pass through	$2,506,111	$203,441	$629,176	$1,673,494

Funding:
100% Reimbursement (4260-610-0995)
General Fund (4260-101-0001)

EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER:	198
IMPLEMENTATION DATE:	4/2015
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1760

	FY 2016-17	FY 2017-18
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 extension of a quality assurance fee (QAF) for hospitals from January 1, 2014 and after.

Authority:
SB 239 (Chapter 657, Statutes of 2013)
AB 1607 (Chapter 27, Statutes of 2016)
Proposition 52 (2016)

Interdependent Policy Changes:
Not Applicable

Background:
SB 335 (Chapter 286, Statutes of 2011) establishes the Hospital QAF program from July 1, 2011 through December 31, 2013, which provides additional funding to hospitals and for children's health care. The fee revenue is primarily used to match federal funds to provide supplemental payments to private hospitals, increased payments to managed care plans, and direct grants to public hospitals.

SB 239 extended the Hospital QAF program from January 1, 2014 through December 31, 2016. The Department submitted State Plan Amendments (SPA) for this program on March 31, 2014. The Department received approval for these SPAs in December 2014.

SB 239 also requires the Department to increase capitation payments for the actuarial equivalent of AB 113 (Chapter 20, Statutes of 2011) payments to non-designated public hospitals (NDPH).

AB 1607 extended the inoperative date of the Hospital QAF program to January 1, 2018, creating a one-year extension of the program.

Proposition 52, approved by California voters on November 8, 2016, permanently extends the Hospital QAF program.

EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 198

Reason for Change:
There is no change from the prior estimate for FY 2016-17. The change in FY 2017-18, from the prior estimate, is a decrease due to:

- Updating projected payments for the HQAF program period from January 1, 2017 to June 30, 2019 (HQAF V) using a draft fee/payment model with projected FFS and grant payments.

The change from FY 2016-17 to FY 2017-18, in the current estimate is an increase due to an additional FY 2017-18 payment.

Methodology:

1. Payments for children's health care are estimated through the period ending March 30, 2018 in this policy change.

2. On an accrual basis, annual funds for children's health care coverage are:
   - FY 2013-14: $310,000,000
   - FY 2014-15: $726,400,000
   - FY 2015-16: $844,700,000
   - FY 2016-17: $853,400,000
   - FY 2017-18: $841,500,000

   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. The FY 2014-15 through FY 2017-18 amounts are the initial children's health care coverage funds calculation and will be adjusted based on the final reconciliation.

3. Payments associated with 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.

4. On a cash basis, the payments to health care coverage for children are:

(Dollars in Thousands)

FY 2016-17	TF	GF	Hosp. QA Rev Fund
FY 2015-16	$0	($211,175)	$211,175
FY 2016-17	$0	($464,000)	$464,000
Total FY 2016-17	**$0**	**($675,175)**	**$675,175**

(Dollars in Thousands)

FY 2017-18	TF	GF	Hosp. QA Rev Fund
FY 2016-17	$0	($389,400)	$389,400
FY 2017-18	$0	($631,125)	$631,125
Total FY 2017-18	**$0**	**($1,020,525)**	**$1,020,525**

Funding:
100% GF (4260-101-0001)
100% Hospital Quality Assurance Revenue Fund (4260-611-3158)

CIGARETTE AND TOBACCO SURTAX FUNDS

REGULAR POLICY CHANGE NUMBER:	199
IMPLEMENTATION DATE:	1/2006
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1087

	FY 2016-17	FY 2017-18
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 for FY 2014-15 and FY 2015-16. 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: 199

Methodology:

FY 2016-17	
Hospital Services Account	$112,172,000
Physicians' Services Account	$28,463,000
Unallocated Account	$57,925,000
Total CTPS/Prop. 99	**$198,560,000**
GF	**($198,560,000)**
Net Impact	**$0**

FY 2017-18	
Hospital Services Account	$111,400,000
Physicians' Services Account	$40,220,000
Unallocated Account	$56,904,000
Total CTPS/Prop. 99	**$208,524,000**
GF	**($208,524,000)**
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)

MEDI-CAL RECOVERIES FIFTY PERCENT RULE

REGULAR POLICY CHANGE NUMBER:	200
IMPLEMENTATION DATE:	7/2017
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	2008

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	-$12,160,000
- STATE FUNDS	$0	-$12,160,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$12,160,000
STATE FUNDS	$0	-$12,160,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the recoveries and costs associated with Medi-Cal Recoveries Fifty Percent Rule.

Authority:
Welfare & Institutions (W&I) Code 14124.78 (Pending Amendment)

Interdependent Policy Changes:
Not Applicable

Background:
The Department recovers Medi-Cal treatment costs from liable third parties, thereby ensuring that Medi-Cal is the payer of last resort. When a Medi-Cal beneficiary seeks treatment for an injury, the federal government pays a percentage of the cost of treating the injury known as Federal Financial Participation (FFP). When the Department makes a recovery, federal law requires the Department to reimburse a portion of the recovery equal to the FFP provided for the services to treat the injury.

The Fifty Percent Rule requires the Department to take no more than half of a settlement after all attorney's fees and legal costs are paid. An audit from Centers for Medicare and Medicaid Services (CMS), found that W&I Code Section 14124.78 ("Fifty Percent Rule") did not comply with the Social Security Act ("the Act"). Specifically, the Act requires the federal government's share of financing for injury-related services in a third party liability action to be fully reimbursed prior to the Medi-Cal beneficiary receiving funds. The Department had no valid justification under the Fifty Percent Rule for allowing Medi-Cal beneficiaries to obtain settlement funds prior to the Federal Fund (FF) being fully reimbursed and required the Department to reimburse the difference in cases settled under the Fifty Percent Rule. The Department has been reimbursing the FFP share for cases settled under the Fifty Percent Rule from the General Fund (GF).

Amending W&I Code Section 14124.78 to revise the Fifty Percent Rule will increase the GF savings, as the Department will no longer take funds from the GF to subsidize the federal repayment obligation.

MEDI-CAL RECOVERIES FIFTY PERCENT RULE

REGULAR POLICY CHANGE NUMBER: 200

Reason for Change:
There is no change from the prior estimate for FY 2016-17 and FY 2017-18.

Methodology:
1. The following amounts are the total estimated recovery of settlements under the Fifty Percent Rule and based on the settlement amounts from actuals in FY 2015-16.

2. Effective July 2017, the Department will no longer share the settlement amounts with Medi-Cal beneficiaries.

3. For beneficiaries with a FFP of 50%, the Department will now collect the entire amount, reimburse 50% of this amount to the FF, and reimburse the remaining 50% to the GF.

4. For beneficiaries with a FFP of 100%, the Department will collect the entire portion and reimburse 100% of that amount to FF.

Prior to Amending The Fifty Percent Rule	**TF**	**GF**	**FF**	**Beneficiary***
Cases with 50% FFP	($8,210,000)	$0	($8,210,000)	($8,210,000)
Cases with 100% FFP	($3,950,000)	$3,950,000	($7,900,000)	($3,950,000)
Total	($12,160,000)	$3,950,000	($16,110,000)	($12,160,000)

After Amending The Fifty Percent Rule	**TF**	**GF**	**FF**	**Beneficiary***
Cases with 50% FFP	($16,420,000)	($8,210,000)	($8,210,000)	$0
Cases with 100% FFP	($7,900,000)	($0)	($7,900,000)	$0
Total	($24,320,000)	($8,210,000)	($16,110,000)	$0
Difference in FY 2017-18	**($12,160,000)**	**($12,160,000)**	**($0)**	$12,160,000

*Not included in the total funds.

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

MEDICARE BUY-IN QUALITY REVIEW PROJECT RECOVERIES

REGULAR POLICY CHANGE NUMBER:	201
IMPLEMENTATION DATE:	7/2017
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	1985

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	-$2,000,000
- STATE FUNDS	$0	-$1,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	100.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates recovery of overpayments from the Centers for Medicare and Medicaid Services (CMS) and Medicare providers.

Authority:
Welfare & Institutions Code 14124.92

Interdependent Policy Changes:
OA 34 Medicare Buy-In Quality Review Project

Background:
The Department entered into a three-year contract with the University of Massachusetts (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 beneficiaries. UMASS will assist the Department in auditing the invoices received from CMS to pay the Medicare premiums. The contract costs are budgeted in the Medicare Buy-In Quality Review Project policy change.

Reason for Change:
The change from the prior estimate, for FY 2016-17, is a decrease due to a delay of data transmittal to the contractor. The contractor was unable to attain recovery overpayments in FY 2016-17.

The change from the prior estimate, for FY 2017-18, is a decrease due to revising the estimate based on historical data of the contractor's past performance. Due to the Medicare recoveries continuing at the historical levels, the overpayment recoveries in FY 2017-18 are fully captured in the Medicare Buy-In payment base trends.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to no activity from the contractor in FY 2016-17 and projected overpayment recoveries resuming in FY 2017-18.

MEDICARE BUY-IN QUALITY REVIEW PROJECT RECOVERIES

REGULAR POLICY CHANGE NUMBER: 201

Methodology:

1. The estimated overpayment recoveries in FY 2017-18 are $2 million TF. The recoveries are estimated to continue at historical levels and are fully incorporated in the Medicare Buy-In payment base trends.

Fiscal Year	TF	GF	FF
FY 2017-18	($2,000,000)	($1,000,000)	($1,000,000)

Funding:

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

NONCONTRACT HOSP INPATIENT COST SETTLEMENTS

REGULAR POLICY CHANGE NUMBER:	202
IMPLEMENTATION DATE:	7/2008
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1340

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	-$6,096,000	$0
- STATE FUNDS	-$3,048,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$6,096,000	$0
STATE FUNDS	-$3,048,000	$0
FEDERAL FUNDS	-$3,048,000	$0

DESCRIPTION

Purpose:
This policy change estimates the noncontract hospital inpatient cost settlements.

Authority:
Welfare & Institutions (W&I) Code 14170

Interdependent Policy Changes:
Not Applicable

Background:
All noncontract hospitals were paid their costs for services to Medi-Cal beneficiaries. Initially, the Department paid the noncontract hospitals an interim payment. The hospitals were then required to submit an annual cost report no later than five months after the close of their fiscal year. The Department reviewed each hospital's cost report and completed a tentative cost settlement. The tentative cost settlement resulted in a payment to the hospital or a recoupment from the hospital. A final settlement is then completed no later than 36 months after the hospital's cost report is submitted. The Department audits the hospitals' costs in accordance with Medicare's standards and the determination of cost-based reimbursement. The final cost settlement will result in final hospital allowable costs and either a payment to the hospital above the tentative cost settlement amount or a recoupment from the hospital.

Beginning July 1, 2013, with the implementation of the Diagnosis Related Group (DRG) hospital inpatient payment methodology, the Selective Provider Contracting Program (SPCP) contract and noncontract hospital per diem rate methodology was discontinued for private hospitals. Non-Designated Public Hospitals (NDPHs) transitioned to the DRG reimbursement methodology on January 1, 2014. Although the contract and noncontract hospital designations are eliminated under the DRG, noncontract hospital inpatient cost settlements for dates prior to the DRG implementation will continue as required by W&I Code 14170.

NONCONTRACT HOSP INPATIENT COST SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 202

Reason for Change:
The change from the prior estimate, for FY 2016-17, is an increase due to updated actual data through February 2017. The change from FY 2016-17 to FY 2017-18, in the current estimate, is a decrease due to the assumed completion of cost settlements in FY 2016-17.

Methodology:
1. Payments and recoupments for noncontract hospital inpatient cost settlements, made in FY 2015-16, net totaled ($13,811,000) TF.

2. Based on more recent data trends and the actuals through February 2017, noncontract hospital cost settlements are estimated to result in a net recoupment of ($6,096,000) in FY 2016-17.

3. It is expected that the cost settlements will cease with FY 2013-14 cost audits that are assumed to be completed in FY 2016-17.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2016-17	($6,096)	($3,048)	($3,048)

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

DRUG REBATES - RETROACTIVE ACA ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER:	204
IMPLEMENTATION DATE:	12/2016
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	2013

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$487,276,200	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$487,276,200	$0
FEDERAL FUNDS	-$487,276,200	$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. The Department anticipates ACA drug rebates to be 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:
There is no change from the prior estimate for both FY 2016-17 and FY 2017-18.

Methodology:
1. The ACA adjustments are for the retroactive periods from April 2015 to June 2016.

DRUG REBATES - RETROACTIVE ACA ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 204

2. The estimated total ACA adjustment is:

FY 2016-17	TF	GF	FF
Total	$0	$487,276,000	($487,276,000)

Funding:
100% GF (4260-101-0001)
100% Title XIX FF (4260-101-0890)
100% ACA Title XIX FF (4260-101-0890)

AUDIT SETTLEMENTS

REGULAR POLICY CHANGE NUMBER:	205
IMPLEMENTATION DATE:	7/2016
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	110

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$548,000	$13,928,000
- STATE FUNDS	$548,000	$13,928,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$548,000	$13,928,000
STATE FUNDS	$548,000	$13,928,000
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:
The Department reached audit settlements with the Office of Inspector General (OIG):
Federal Audit A-09-15-02014: Family planning drugs and supplies claimed under the Family PACT program in Los Angeles and Orange counties. This audit is a result of duplicate payments identified in the review of Family PACT drugs and supplies in Orange County. The audit covers payments made during the period October 1, 2011, through September 30, 2012.

Federal Audit A-09-15-02017: Family planning drugs and supplies claimed under the Family PACT program in Los Angeles County. The audit will determine whether the Department complied with Federal and State requirements when claiming Federal reimbursement at the 90% rate for family planning drugs and supplies provided under the Family PACT program. The audit period covers payments made during the period October 1, 2011, through September 30, 2012.

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 OIG found that the Department reclaimed the overpayments incorrectly at a higher 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

AUDIT SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 205

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.

Reason for Change:
There is no change from the prior estimate for FY 2016-17. The change from the prior estimate, for FY 2017-18, is the addition of audits and a sanction.

Methodology:

FY 2016-17	Audit	Finding	TF
Family PACT A-09-15-02014	Overpayments for Drugs and Supplies	Identified and estimated amount of duplicate payments for FPACT	$31,000
Family PACT A-09-15-02017	CA Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Services	Identified and estimated amount of improper payments for FPACT	$517,000
		Total	**$548,000**

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)

INTEGRATION OF THE SF CLSB INTO THE ALW

REGULAR POLICY CHANGE NUMBER:	206
IMPLEMENTATION DATE:	7/2017
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	2014

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	-$918,000
- STATE FUNDS	$0	-$459,000
PAYMENT LAG	1.0000	0.8130
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$746,300
STATE FUNDS	$0	-$373,170
FEDERAL FUNDS	$0	-$373,170

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 14 counties, expanding into San Francisco County will increase the total population by 44 participants per year, allowing for the 22 SF CLSB waiver participants to transition and 22 institutional transitions in the state's highest institutional cost county. 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 ends June 30, 2017.

Reason for Change:
There is no change from the prior estimate for FY 2017-18.

INTEGRATION OF THE SF CLSB INTO THE ALW

REGULAR POLICY CHANGE NUMBER: 206

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 22 new beneficiaries will transition from a skilled nursing facility through CCT then into the ALW in CY 2017. Assume 22 beneficiaries currently enrolled in SF CLSB will transition into the ALW in CY 2017.

3. Assume the monthly cost for care management is $200.

4. Assume the average monthly cost for wavier services transitioning from institutions is $1,184.

5. Assume the average monthly cost for the SF Waiver is $1,165.

6. Assume the average monthly cost in a skilled nursing facility and transitioning through CCT is $7,914.

FY 2017-18	TF	GF	FF
Total Cost from Waiver Services	$649,000	$324,000	$325,000
Total Savings from SNF Transitions	($1,567,000)	($783,000)	($784,000)
Net Impact Savings	**($918,000)**	**($459,000)**	**($459,000)**

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

ANNUAL CONTRACEPTIVE COVERAGE

REGULAR POLICY CHANGE NUMBER:	208
IMPLEMENTATION DATE:	5/2017
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	2016

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	**$6,092,000**	$36,554,000
- STATE FUNDS	**$1,374,200**	**$8,244,500**
PAYMENT LAG	0.6155	0.9950
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	**$3,749,600**	$36,371,200
STATE FUNDS	$845,820	**$8,203,280**
FEDERAL FUNDS	**$2,903,810**	$28,167,950

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 will expand 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 in FY 2016-17 from the prior estimate is due to the implementation date change from July 1, 2017 to May 1, 2017. There is no change from the prior estimate for FY 2017-18. The increase from FY 2016-17 to FY 2017-18 in the current estimate is due to having two months of implementation in FY 2016-17 versus twelve months of implementation in FY 2017-18.

ANNUAL CONTRACEPTIVE COVERAGE

REGULAR POLICY CHANGE NUMBER: 208

Methodology:

1. Assume annual contraceptive coverage will be implemented May 1, 2017, retroactive to January 1, 2017.
2. Assume a 10% increase in utilization due to the change in policy. This includes beneficiaries switching from one contraceptive to another.
3. Managed care costs are not included in this policy change.

340B Clinics

4. 340B clinics currently dispense 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 $13,588,000 TF ($3,065,000 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 $63,777,000 TF ($14,385,000 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 $5,096,000 TF ($1,149,000 GF).
10. Pharmacy rebate savings due to utilization increase for oral contraceptives, and hormonal patch and ring are $35,715,000 TF ($8,056,000 GF).

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

(Dollars in Thousands)

Annual Cost	**TF**	**GF**	**FF**
340B - Onsite Dispensing	$ 13,588	$ 3,065	$ 10,523
Pharmacy Costs	$ 63,777	$ 14,385	$ 49,392
Dispensing Fee Savings	$ (5,096)	$ (1,149)	$ (3,947)
Rebate Savings	$ (35,715)	$ (8,056)	$ (27,659)
Net Cost	**$ 36,554**	**$ 8,245**	**$ 28,309**

Funding:

(Dollars in Thousands)

FY 2016-17	**TF**	**GF**	**FF**
90% Title XIX / 10% GF (4260-101-0890/0001)	$ 5,242	$ 1,000	$ 5,000
100% GF (4260-101-0001)	$ 850	$ 850	$ -
Total	**$ 6,092**	**$ 1,850**	**$ 5,000**

FY 2017-18	**TF**	**GF**	**FF**
90% Title XIX / 10% GF (4260-101-0890/0001)	$ 31,455	$ 3,146	$ 28,309
100% GF (4260-101-0001)	$ 5,099	$ 5,099	$ -
Total	**$ 36,554**	**$ 8,245**	**$ 28,309**

TITLE XXI FEDERAL MATCH REDUCTION

REGULAR POLICY CHANGE NUMBER:	209
IMPLEMENTATION DATE:	10/2017
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	2017

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	-$112,361,000
- STATE FUNDS	$0	$396,960,330
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$112,361,000
STATE FUNDS	$0	$396,960,330
FEDERAL FUNDS	$0	-$509,321,330

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:
OBRA Non-Emergency Funding Adjustment
PC 004 Medi-Cal Access Program Mothers 213-322% FPL
PC 007 County Health Initiative Matching (CHIM)
PC 008 Medi-Cal Access Program Infants 266-322% FPL
PC 010 Non-OTLICP CHIP
PC 011 Non-Emergency Funding Adjustment
PC 012 SCHIP Funding For Prenatal Care
PC 013 CHIPRA - M/C for Children & Pregnant Women
PC 016 OTLICP Premiums
PC 019 Health Insurer Fee
PC 029 Behavioral Health Treatment
PC 031 Behavioral Health Treatment - DDS Transition
PC 034 CCS Demonstration Project
PC 036 Implement AAP Bright Futures Periodicity for EPSDT
PC 039 Pediatric Palliative Care Waiver
PC 045 Medical Management And Treatment for ALD
PC 051 Pediatric Palliative Care Expansion and Savings
PC 055 New High Cost Treatments for Specific Conditions
PC 061 State Supplemental Drug Rebates
PC 062 Federal Drug Rebate Program
PC 063 Narcotic Treatment Program
PC 064 Drug Medi-Cal Organized Delivery System Waiver
PC 065 Outpatient Drug Free Treatment Services

TITLE XXI FEDERAL MATCH REDUCTION

REGULAR POLICY CHANGE NUMBER: 209

PC 066 Intensive Outpatient Treatment Services
PC 068 Residential Treatment Services
PC 071 SMHS for Children
PC 079 Interim and Final Cost Settlements - SMHS
PC 096 Two Plan Model
PC 097 County Organized Health Systems
PC 099 Geographic Managed Care
PC 101 MCO Enrollment Tax Mgd. Care Plans-Incr. Cap.Rates
PC 102 Regional Model
PC 103 Managed Care Rate Range IGTs
PC 106 Dental Managed Care (Other M/C)
PC 123 Managed Care Drug Rebates
PC 124 Retro Mc Rate Adjustments
PC 126 Dental Retroactive Rate Changes
PC 147 Extended Hospital QAF - Hospital Payments
PC 171 Dental Services
PC 179 EPSDT Screens
PC 194 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 October 1, 2017, the ACA enhanced federal matching rate for the CHIP program will be reduced by 23 percent to 65%, unless Congress takes action to both reauthorize the program and extend the funding at the enhanced amount. 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 (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 in FY 2017-18 is estimated as $112,361,000.

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)

CCI-FFS SAVINGS FOR ADDITIONAL ENROLLMENT

REGULAR POLICY CHANGE NUMBER:	210
IMPLEMENTATION DATE:	12/2016
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	2018

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	-$94,594,000	-$332,853,000
- STATE FUNDS	-$47,297,000	-$166,426,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	80.17 %	52.83 %
APPLIED TO BASE		
TOTAL FUNDS	-$18,758,000	-$157,006,800
STATE FUNDS	-$9,379,000	-$78,503,380
FEDERAL FUNDS	-$9,379,000	-$78,503,380

DESCRIPTION

Purpose:
This policy change estimates the savings from transitioning dual eligible beneficiaries from fee-for-service (FFS) into Medi-Cal managed care health plans, including for their Medi-Cal Long-Term Care (LTC) institutional and community-based services and supports benefits, as part of the Coordinated Care Initiative (CCI).

Authority:
SB 1008 (Chapter 33, Statutes of 2012)
SB 1036 (Chapter 45, Statutes of 2012)

Interdependent Policy Changes:
Not Applicable

Background:
In coordination with Federal and State government, the 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 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

CCI-FFS SAVINGS FOR ADDITIONAL ENROLLMENT

REGULAR POLICY CHANGE NUMBER: 210

discontinued in 2017-18. Based on the lessons learned from the CCI demonstration project, the Budget proposes the extension of the Cal MediConnect program and the mandatory enrollment of dual eligible and integrating of long-term services and support, except In-Home Supportive Services (IHSS), into managed care. IHSS would be removed from capitation rate payments effective January 1, 2018.

Reason for Change:
The savings for FY 2016-17 have decreased from the prior estimate due to fewer eligibles enrolling in CMC in December 2016 and January 2017. The savings for FY 2017-18 have decreased from the prior estimate due to the assumption of fewer eligibles enrolling in CMC in February 2017. The savings increased from FY 2016-17 to FY 2017-18 in the current estimate due to an increase in eligibles in FY 2017-18 as a result of completion of enrollment in February 2017.

Methodology:

1. 32,638 dual eligible beneficiaries enrolled into CCI in December 2016 and January 2017. Of these, 1,261 enrolled in a Cal MediConnect (CMC) Plan.

2. Assume an additional 30,462 dual eligible beneficiaries enrolled into CCI in February 2017. Of these, assume 1,177 enrolled in a CMC Plan.

3. Estimated below is the overall impact of the CCI demonstration in FY 2016-17 and FY 2017-18.

(Dollars in Thousands)

FY 2016-17	TF	GF	FFP	Reimb.
CCI-Managed Care Payments (PC 98):				
Base managed care payments	$6,163,115	$3,081,557	$3,081,557	$0
Base managed care payments for add'l enrollment	$135,799	$67,899	$67,899	
Transfer of IHSS Costs to CDSS	$3,622,356	$1,811,178	$1,811,178	$0
Transfer of IHSS Costs to CDSS for add'l enrollment	$121,466	$60,733	$60,733	
Total Managed Care Payments	$10,042,736	$5,021,368	$5,021,368	$0
CCI-Savings and Deferral :				
Total Savings (In the Base)	($6,190,790)	($3,095,395)	($3,095,395)	$0
FFS Savings for Additional Enrollment (PC 210):	**($94,594)**	**($47,297)**	**($47,297)**	**$0**
Defer Managed Care Payment (In the Base)	$32,477	$16,239	$16,239	$0
Total	($6,252,907)	($3,126,453)	($3,126,453)	$0
IHSS Savings (In the Base)	($1,871,911)	$0	($1,871,911)	$0
Delay 1 Checkwrite (In the Base)	$56,580	$28,290	$28,290	$0
CCI-Transfer of IHSS Costs to DHCS (PC 197)	$0	($1,871,911)	$0	$1,871,911
CCI-Admin Costs, HCO Costs (OA 13, 17, 72)	$25,737	$12,869	$12,869	$0
Retro MC Rate Adjustments (PC 124)	$312,427	($193,737)	$156,214	$349,950
CCI-Quality Withhold Repayments (PC 220)	$1,353	$676	$677	$0
Total of CCI PCs including pass through	$2,314,014	($128,899)	$221,053	$2,221,861

CCI-FFS SAVINGS FOR ADDITIONAL ENROLLMENT

REGULAR POLICY CHANGE NUMBER: 210

(Dollars in Thousands)

FY 2017-18	TF	GF	FFP	Reimb.
CCI-Managed Care Payments (PC 98):				
Base managed care payments	$7,094,234	$3,547,117	$3,547,117	$0
Base managed care payments for add'l enrollment	$346,790	$173,395	$173,395	
Transfer of IHSS Costs to CDSS	$2,333,595	$1,166,798	$1,166,798	$0
Transfer of IHSS Costs to CDSS for add'l enrollment	$161,921	$80,960	$80,960	
Total Managed Care Payments	$9,936,539	$4,968,270	$4,968,270	$0
CCI-Savings and Deferral :				
Total Savings (In the Base)	($7,131,022)	($3,565,511)	($3,565,511)	$0
FFS Savings for Additional Enrollment (PC 210):	**($332,853)**	**($166,427)**	**($166,427)**	**$0**
Defer Managed Care Payment (In the Base)	($11,375)	($5,687)	($5,687)	$0
Total	($7,475,250)	($3,737,625)	($3,737,625)	$0
IHSS Savings (In the Base)	($1,247,758)	$0	($1,247,758)	$0
Delay 1 Checkwrite (In the Base)	$17,212	$8,606	$8,606	$0
CCI-Transfer of IHSS Costs to DHCS (PC 197)	$0	($1,247,758)	$0	$1,247,758
CCI-Admin Costs, HCO Costs (OA 13, 17, 72)	$26,423	$13,212	$13,212	$0
Retro MC Rate Adjustments (PC 124)	$1,234,221	$191,375	$617,110	$425,736
CCI-Quality Withhold Repayments (PC 220)	$9,000	$4,500	$4,500	$0
Health Insurer Fee (PC 19)	$5,724	$2,862	$2,862	$0
Total of CCI PCs including pass through	$2,506,111	$203,441	$629,176	$1,673,494

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

HEALTH CARE SVCS. PLANS FINES AND PENALTIES FUND

REGULAR POLICY CHANGE NUMBER:	212
IMPLEMENTATION DATE:	7/2017
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	2021

	FY 2016-17	FY 2017-18
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 a decrease due to updated MRMIP program expenditures.

HEALTH CARE SVCS. PLANS FINES AND PENALTIES FUND

REGULAR POLICY CHANGE NUMBER: 212

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	$46,633,000
GF	($46,633,000)
Net Impact	**$0**

Funding:

Health Care Services Plans Fines and Penalties Fund (4260-101-3311)
Title XIX GF (4260-101-0001)

DP-NF CAPITAL PROJECT DEBT REPAYMENT

REGULAR POLICY CHANGE NUMBER:	214
IMPLEMENTATION DATE:	7/2017
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1936

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$57,224,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$57,224,000
FEDERAL FUNDS	$0	-$57,224,000

DESCRIPTION

Purpose:
This policy change estimates the federal financial participation repayment to the Centers for Medicare and Medicaid Services (CMS) for ineligible claims made through the distinct part skilled nursing facility (DP-NF) Capital Project Debt Reimbursement supplemental payment program.

Authority:
SB 1128 (Chapter 757, Statutes of 1999)

Interdependent Policy Changes:
Not Applicable

Background:
SB 1128 authorized a DP-NF of a public acute care hospital providing specified services and other specific conditions as specified in Section 14105.26 of the Welfare and Institutions Code, to receive Medi-Cal reimbursement for debt service incurred for the financing of eligible capital construction projects. The Department claims federal funds using certified public expenditures. To be eligible for payments, the capital projects must be completed and have been issued a certificate of occupancy.

On June 16, 2015, CMS notified the Department that it denied the “good cause” waiver request, thus 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:
This is a new policy change.

DP-NF CAPITAL PROJECT DEBT REPAYMENT

REGULAR POLICY CHANGE NUMBER: 214

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)

GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS

REGULAR POLICY CHANGE NUMBER:	215
IMPLEMENTATION DATE:	8/2017
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	2024

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	$1,187,500,000
- STATE FUNDS	$0	$593,750,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$1,187,500,000
STATE FUNDS	$0	$593,750,000
FEDERAL FUNDS	$0	$593,750,000

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

Interdependent Policy Changes:
Not Applicable

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: 215

- 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 will submit SPA 17-009 to CMS in March 2017 with a January 1, 2017 effective date.

Reason for Change:
This is a new policy change.

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 approximately $950 million total computable payments annually.

4. Payments would be made on a lump-sum quarterly basis throughout the fiscal year and would not be paid as individual increases to current reimbursement rates for specific services.

5. Assume an effective date of January 1, 2017, pending CMS approval of SPA 17-009.

6. Assume two quarters of FY 2016-17 will be paid in FY 2017-18.

7. Assume three quarters of FY 2017-18 will be paid in FY 2017-18, and one quarter will be paid in a subsequent fiscal year.

(Dollars in Thousands)

FY 2017-18	TF	IGT	FF
FY 2016-17	$475,000	$237,500	$237,500
FY 2017-18	$712,500	$356,250	$356,250
Total	**$1,187,500**	**$593,750**	**$593,750**

Funding:
100% Title XIX FFP (4260-101-0890)
100% Reimbursement GF (4260-101-0995)

BORDER OUT-OF-STATE DIAGNOSIS RELATED GROUP

REGULAR POLICY CHANGE NUMBER:	216
IMPLEMENTATION DATE:	3/2017
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	2025

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	**$2,734,000**	$0
- STATE FUNDS	**$1,005,000**	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	**$2,734,000**	$0
STATE FUNDS	**$1,005,000**	$0
FEDERAL FUNDS	**$1,729,000**	$0

DESCRIPTION

Purpose:
This policy change estimates corrected Diagnosis Related Group (DRG) payments to border out-of state (OOS) hospitals.

Authority:
SPA 15-020

Interdependent Policy Changes:
Not Applicable

Background:
In 2014, 19 border hospitals filed a lawsuit, *Asante et al. v. California Department of Health Care Services*, which challenged the validity of California's DRG OOS hospital reimbursement policies.

While pending judgment, the Centers for Medicaid and Medicare Services (CMS) approved State Plan Amendment (SPA) 15-020 on September 29, 2015 for hospital admissions on or after July 1, 2015. SPA 15-020 updated the fee-for-service (FFS) DRG rates for border OOS hospitals as well as defined the term "border hospitals" as hospitals located outside the State of California that are within 55 miles' driving distance from the nearest physical location at which a road crosses the California border as defined by the U.S. Geological Survey.

SPA 15-020 updates the FFS DRG payments for border hospitals based on:

- Medicare's hospital-specific wage index used to adjust the labor share portion of the DRG base price,
- Select, qualified border hospitals will receive the higher "remote rural' base price
- A state-specific cost-to-charge ratio, and
- The neonatal intensive care unit (NICU) surgery policy adjustor upon California Children's Services (CCS) approval.

BORDER OUT-OF-STATE DIAGNOSIS RELATED GROUP

REGULAR POLICY CHANGE NUMBER: 216

The implementation of SPA 15-020 for admissions was delayed while pending final judgment for the Asante case.

A final judgment was issued on October 12, 2016 regarding the Asante case which required the Department to modify the FFS DRG rates for the 19 border OOS hospitals for decisions related to the first two provisions in SPA 15-020 mentioned above, for admissions on or after December 21, 2015. The court decision will be implemented while the Department is appealing the judgment.

On December 11, 2016, the claims processing system was updated to reflect changes made by both SPA 15-020 and the Asante judgment of October 12, 2016.

Reason for Change:
This is a new policy change.

Methodology:
1. The Department will implement an Erroneous Payment Correction (EPC) for border OOS hospitals in March 2017.

2. The EPC will reprocess FFS DRG payments for border OOS hospitals for the time period from July 1, 2015 through December 10, 2016.

3. The net EPC is estimated to be $2,395,000 TF for FY 2015-16 services and $339,000 TF for FY 2016-17 services.

4. The Affordable Care Act (ACA) optional population is funded at 100% Federal Medical Assistance Percentage (FMAP) beginning Calendar Year (CY) 2014 to CY 2016.

5. The ACA optional population attributable to the EPC is estimated to be approximately 26% for FY 2015-16 and 29% for FY 2016-17, based on actual claims data.

FY 2016-17	TF	GF	FF	ACA FF
FY 2015-16	$2,395,000	$885,000	$885,000	$625,000
FY 2016-17	$339,000	$120,000	$120,000	$99,000
Total	**$2,734,000**	**$1,005,000**	**$1,005,000**	**$724,000**

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

TRANSITIONAL SMHS CLAIMS

REGULAR POLICY CHANGE NUMBER:	217
IMPLEMENTATION DATE:	9/2017
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	2026

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	**$1,472,000**
- STATE FUNDS	$0	**$1,472,000**
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	**$1,472,000**
STATE FUNDS	$0	**$1,472,000**
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 and 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:
This is a new policy change.

TRANSITIONAL SMHS CLAIMS

REGULAR POLICY CHANGE NUMBER: 217

Methodology:

1. Payments to 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	FF
FY 2017-18	$1,472	**$1,472**	$0

Funding:

100% GF (4260-101-0001)

MEDI-CAL COUNTY INMATE REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER:	219
IMPLEMENTATION DATE:	8/2017
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	2029

	FY 2016-17	FY 2017-18
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 6 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:
This is a new policy change.

Methodology:
1. Claims with dates of services beginning April 1, 2017 will be processed by the FI.

MEDI-CAL COUNTY INMATE REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 219

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 $27,385,000 TF ($18,040,000 FF) and $109,537,000 TF ($72,060,000 FF) will be paid in FY 2016-17 and FY 2017-18, respectively.

4. Assume reimbursement will occur in the second month of each quarter, beginning in August 2017 for medical costs for dates of service April 1, 2017 through June 30, 2017.

5. The total estimated GF reimbursement will be $37,456,000 TF in FY 2017-18:

(Dollars in Thousands)

FY 2016-17	GF	Reimbursement
Non ACA	$537	$0
ACA	$483	$0
Juvenile	$7,415	$0
Compassionate Release	$911	$0
Total	$9,346	$0

FY 2017-18	GF	Reimbursement
Non ACA	$2,147	$2,148
ACA	$2,028	$2,004
Juvenile	$29,660	$29,660
Compassionate Release	$3,643	$3,644
Total	$37,478	**$37,456**

Funding:
100% GF (4260-101-0001)
Reimbursement GF (4260-610-0995)

CCI-QUALITY WITHHOLD REPAYMENTS

REGULAR POLICY CHANGE NUMBER:	220
IMPLEMENTATION DATE:	5/2017
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	2031

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	**$1,353,000**	**$9,000,000**
- STATE FUNDS	**$676,500**	**$4,500,000**
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	**$1,353,000**	**$9,000,000**
STATE FUNDS	**$676,500**	**$4,500,000**
FEDERAL FUNDS	**$676,500**	**$4,500,000**

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 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: 220

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:
This is a new Policy Change. The difference between FY 2016-17 and FY 2017-18 is because FY 2016-17 is budgeting for CY 2014 repayments at 83% due to plans not meeting the benchmarks and FY 2017-18 is budgeting for CY 2015 repayments at 100%.

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 first year of CCI (CY 2014) will be repaid in April 2017. Of the amount withheld, only 83% will be repaid because plans did not meet the benchmarks.

4. Assume quality withholds for CY 2015 repaid in FY 2017-18 will be repaid at 100%.

FY 2016-17	TF	GF	FF
Quality Withhold Repayment (CY 2014)	$1,353,000	$676,000	$677,000

FY 2017-18	TF	GF	FF
Quality Withhold Repayment (CY 2015)	$9,000,000	$4,500,000	$4,500,000

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

MEC OPTIONAL EXPANSION ADJUSTMENT

REGULAR POLICY CHANGE NUMBER:	221
IMPLEMENTATION DATE:	7/2017
ANALYST:	Karen Fairgrieves
FISCAL REFERENCE NUMBER:	2033

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	-$515,297,000
- STATE FUNDS	$0	$227,139,970
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$515,297,000
STATE FUNDS	$0	$227,139,970
FEDERAL FUNDS	$0	-$742,436,970

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, which qualifies as Minimum Essential Coverage. Enrollment systems were corrected August 2016 to eliminate further enrollment of Medicare Part A eligibles into the Optional Expansion eligibility group.

Reason for Change:
This is a new policy change.

Methodology:
1. Medicare Part A eligibles currently enrolled in the Optional Expansion eligibility 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

2. An adjustment will continue until all eligibles have been redetermined and no Medicare Part A eligibles remain in the Optional Expansion aid codes. For January 2014 – June 2016, the actual

MEC OPTIONAL EXPANSION ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 221

expenditures will be adjusted for in FY 2017-18.

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 $364.78 million.

4. Those Medi-Cal eligibles with Part A are estimated in the Optional Expansion aid category, this policy also adjusts the funding for expenditures estimated for FY 2017-18.

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 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. The IGT component is budgeted as a Reimbursement.
   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 not budgeted, but displayed for informational purposes.

8. A detailed account of the adjustment:

(Dollars in Thousands)	TF	FF	GF	IGT Reimb.	HQAF	Repay DPH IGT (GF)	CF
FY 2013-14							
FFS	$0	-$808	$808				
SMHS/Drug Medi-Cal	-$98	-$98					$98
Managed Care	$0	-$7,035	$7,035				
Recoup from Plans	-$19,329	-$19,905	-$1,225	$296	$280	$1,225	
Subtotal FY 2013-14	-$19,427	-$27,847	$6,619	$296	$280	$1,225	$98
FY 2014-15							
FFS	$0	-$9,060	$9,060	$0	$0	$0	$0
SMHS/Drug Medi-Cal	-$4,343	-$4,343	$0	$0	$0	$0	$4,343
Managed Care	$0	-$30,862	$30,862	$0	$0	$0	$0
Recoup from Plans	-$118,236	-$120,796	-$6,729	$973	$1,587	$6,729	$0
Subtotal FY 2014-15	-$122,578	-$165,061	$33,193	$973	$1,587	$6,729	$4,343

MEC OPTIONAL EXPANSION ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 221

	TF	FF	GF	IGT Reimb.	HQAF	Repay DPH IGT (GF)	CF
FY 2015-16							
FFS	$0	-$15,144	$15,144	$0	$0	$0	$0
SMHS/Drug Medi-Cal	-$6,576	-$6,576	$0	$0	$0	$0	$6,576
Managed Care	$0	-$45,835	$45,835	$0	$0	$0	$0
Recoup from Plans	-$112,152	-$112,152	$0	$0	$0	$0	$0
Subtotal FY 2015-16	-$118,728	-$179,707	$60,979	$0	$0	$0	$6,576
FY 2016-17							
FFS	$0	-$19,184	$19,184	$0	$0	$0	$0
SMHS/Drug Medi-Cal	-$10,258	-$9,745	-$513	$0	$0	$0	$10,258
Managed Care	$0	-$45,779	$45,779	$0	$0	$0	$0
Recoup from Plans	-$115,065	-$112,188	-$2,877	$0	$0	$0	$0
Subtotal FY 2016-17	-$125,323	-$186,896	$61,573	$0	$0	$0	$10,258
FY 2017-18							
FFS	$0	-$19,049	$19,049	$0	$0	$0	$0
SMHS/Drug Medi-Cal	-$10,656	-$9,484	-$1,172	$0	$0	$0	$10,656
Managed Care	$0	-$44,199	$44,199	$0	$0	$0	$0
Reduce Managed Care Expend	-$118,584	-$112,062	-$6,522	$0	$0	$0	$0
Subtotal FY 2014-15	-$129,240	-$184,793	$55,553	$0	$0	$0	$10,656
Total							
FFS	$0	-$63,245	$63,245	$0	$0	$0	$0
SMHS/Drug Medi-Cal	-$31,931	-$30,246	-$1,685	$0	$0	$0	$31,931
Managed Care	$0	-$173,709	$173,709	$0	$0	$0	$0
Recoup from Plans	-$364,781	-$365,041	-$10,831	$1,269	$1,868	$7,954	$0
Reduce Managed Care Expend	-$118,584	-$112,062	-$6,522	$0	$0	$0	$0
Total	**-$515,296**	**-$744,304**	**$217,917**	**$1,269**	**$1,868**	**$7,954**	$31,931

Funding:

	Total Funds	Federal Funds	State Funds
100% ACA Title XIX FF (4260-101-0890)	$ (629,818)	$ (629,818)	
95% ACA Title XIX FF /5% GF (4260-101-0890/0001)	$ (277,185)	$ (263,326)	$ (13,859)
94% ACA Title XIX FF /6% GF (4260-101-0890/0001)	$ (141,013)	$ (132,552)	$ (8,461)
50 % Title XIX FF / 50% GF (4260-101-0890/0001)	$ 496,382	$ 248,191	$ 248,191
100% Title XIX FF (4260-101-0890)	$ 33,200	$ 33,200	
100% Reimbursement GF (4260-610-0995)	$ 1,269		$ 1,269

MEC OPTIONAL EXPANSION ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 221

HQAF Title XIX FF (4260-611-0890)	$ 1,868	$ 1,868	
Total	$ (515,297)	$ (742,437)	$ 227,140

CMS DEFERRED CLAIMS

REGULAR POLICY CHANGE NUMBER:	222
IMPLEMENTATION DATE:	3/2017
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	2034

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$14,926,000	$12,378,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$14,926,000	$12,378,000
FEDERAL FUNDS	-$14,926,000	-$12,378,000

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:
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, Medi-Cal has 120 days to resolve with CMS.

When CMS issues a deferral of claims for federal financial participation (FFP) to the state in accordance with the timelines set forth in 42 CFR 430.40, the state must immediately return the deferred FFP to the applicable Payment Management System (PMS) subaccount while the deferral is being resolved. After CMS reviews the deferred claims, CMS will determine the allowability of the claims. If CMS determines that the deferred claims are allowable under federal requirements, CMS will release the deferred funds to the appropriate PMS subaccount and will notify the Department that the funds are available for draw.

The California Medi-Cal 2020 Demonstration Waiver requires Medi-Cal to bring all deferrals current by June 30, 2017. The Department is working with CMS to resolve the specific items. All deferred claims and negative balances that must be repaid by the end of the demonstration waiver, June 30, 2020.

CMS DEFERRED CLAIMS

REGULAR POLICY CHANGE NUMBER: 222

Reason for Change:
This is a new policy change.

Methodology:
1. CMS has deferred inpatient per diem payments that were paid to Designated Public Hospitals for services provided in State Fiscal Year (SFY) 2014-15 Quarters 2 and 3. The deferrals are for claims that were over the two-year claiming limit. The Department will repay the federal funds according to the required timelines but will continue to work on resolving the deferrals.

2. The Department assumes deferrals will be issued for SFY 2014-15 Quarter 4 and SFY 2015-16 Quarters 1 through 3 in FY 2017-18.

3. The Department will make the following estimated payments for the hospital per diem deferrals:

FY 2016-17	Total Estimated Repayment
SFY 2014-15, Quarter 2 (Oct-Dec 2014)	$9,257,000
SFY 2014-15, Quarter 3 (Jan-Mar 2015)	$5,669,000
Total FY 2016-17	**$14,926,000**
FY 2017-18	
Est. SFY 2014-15, Quarter 4 (Apr-Jun 2015)	$5,513,000
Est. SFY 2015-16, Quarter 1 (Jul-Sep 2015)	$3,086,000
Est. SFY 2015-16, Quarter 2 (Oct-Dec 2015)	$2,135,000
Est. SFY 2015-16, Quarter 3 (Jan-Mar 2016)	$1,644,000
Total FY 2017-18	**$12,378,000**

Funding:
100% Title XIX FFP (4260-101-0890)
100% GF (4260-101-0001)

CMS DEFERRALS & NEGATIVE BALANCE REPAYMENT

REGULAR POLICY CHANGE NUMBER:	223
IMPLEMENTATION DATE:	7/2016
ANALYST:	Karen Fairgrieves
FISCAL REFERENCE NUMBER:	2035

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$226,344,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$226,344,000	$0
FEDERAL FUNDS	-$226,344,000	$0

DESCRIPTION

Purpose:
This policy change estimates the expenditure to settle the Centers for Medicare and Medicaid Services' (CMS) deferred payments and negative balances.

Authority:
California Medi-Cal 2020 Demonstration Waiver

Interdependent Policy Changes:
Not Applicable

Background:
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, Medi-Cal has 120 days to resolve. If the issue is not resolved, CMS issues a disallowance and reduces the federal funds available for that fiscal quarter. CMS has previously granted Medi-Cal permission to continue the deferral process beyond the 120 days without repayment of federal funds. For fiscal quarters with a CMS finalization grant, a negative balance with CMS remains due to disallowed claims in which repayment has not occurred.

The California Medi-Cal 2020 Demonstration Waiver requires Medi-Cal to identify all deferrals and negative balances by June 30, 2017. The Department is working to resolve the specific items. Once identified and agreed upon by the Department and CMS, a repayment plan will be developed. All deferred claims and negative balances must be repaid by the end of the demonstration waiver, June 30, 2020.

Reason for Change:
This is a new policy change.

CMS DEFERRALS & NEGATIVE BALANCE REPAYMENT

REGULAR POLICY CHANGE NUMBER: 223

Methodology:

1. The Department expects to reimburse CMS $226,344,000 in FY 2016-17 for the items the Department has agreed are owed.

2. The Department will continue to reconcile the remaining CMS deferred and disallowed claims. The remaining repayments are anticipated to begin in FY 2018-19.

	Repayments
FY 2016-17 Repayment	**$226,344,000**

Funding:

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

MEDI-CAL RECOVERIES SETTLEMENTS AND LEGAL COSTS

REGULAR POLICY CHANGE NUMBER:	224
IMPLEMENTATION DATE:	7/2017
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	2036

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	-$1,730,000
- STATE FUNDS	$0	-$865,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$1,730,000
STATE FUNDS	$0	-$865,000
FEDERAL FUNDS	$0	-$865,000

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, 14124.74 and 14124.78 (Pending Amendment)

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 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 to Medi-Cal beneficiaries in specified circumstances.

Multiple Settlements
The 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. Currently, W&I Code Section 14124.785 limits 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, whichever is less.

MEDI-CAL RECOVERIES SETTLEMENTS AND LEGAL COSTS

REGULAR POLICY CHANGE NUMBER: 224

Attorneys have found a way to use the provisions in existing law to deny the Department some or all recovery when there are multiple settlements. Often, attorneys only provide information on the first settlement and the Department's recovery is limited by the statutory reductions. Later, when multiple settlements are disclosed, the Department is not be 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 the ratio of the Department's lien to the total settlement amount.

In cases where the settlement is smaller than the Department's lien, the formula for the state's proportionate share of the litigation costs creates situations where the Department must reduce its lien by amounts greater than the actual litigation costs. In some cases the litigation cost reductions significantly erode the Department's lien to result in zero recovery.

The Department has proposed Trailer Bill Language to address lost Medi-Cal personal injury recoveries pertaining to multiple settlements and the state's portion of litigation costs.

Reason for Change:

This is a new policy change.

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 on actual cases where liens were reduced. The total reductions for these cases were estimated to be $5.3 million TF.
3. Assume 10% of the total amount lost due 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 on 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)**

Funding:

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

MEDI-CAL NONMEDICAL TRANSPORTATION

REGULAR POLICY CHANGE NUMBER:	225
IMPLEMENTATION DATE:	7/2017
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	2037

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	**$6,000,000**
- STATE FUNDS	$0	**$1,725,530**
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	**$6,000,000**
STATE FUNDS	$0	**$1,725,530**
FEDERAL FUNDS	$0	**$4,274,470**

DESCRIPTION

Purpose:
This policy change estimates the managed care costs of covering Medi-Cal nonmedical transportation services as required by AB 2394.

Authority:
AB 2394 (Chapter 615, Statutes of 2016)

Interdependent Policy Changes:
Not Applicable

Background:
Title 42 Code of Federal Regulations (CFR) 431.53 requires Medicaid agencies to ensure necessary transportation for beneficiaries to and from providers. Consistent with federal requirements, AB 2394 effective July 1, 2017, requires Medi-Cal to cover nonmedical transportation (NMT) for all Medi-Cal full-scope beneficiaries, subject to utilization controls and federally permissible time and distance standards for a beneficiary to obtain covered services.

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.

Medi-Cal currently provides NMT services as an indirect benefit that may be covered administratively through local transportation resources reimbursed through the County-Based Medi-Cal Administrative Activities (CMAA) program. Also, Medi-Cal Managed Care Plans (MCPs) currently have the option to provide NMT services.

Reason for Change:

MEDI-CAL NONMEDICAL TRANSPORTATION

REGULAR POLICY CHANGE NUMBER: 225

This is a new policy change.

Methodology:

1. The annual managed care costs of covering Medi-Cal NMT are estimated to be $6 million TF beginning July 1, 2017.

FY 2017-18	TF	GF	FF
50% Title XIX / 50% GF	$3,078,000	$1,539,000	$1,539,000
100% State GF	$11,000	$11,000	$0
ACA 95% FFP / 5% GF	$1,531,000	$77,000	$1,454,000
ACA 94% FFP / 6% GF	$1,096,000	$66,000	$1,030,000
Family Planning 90% FFP / 10% GF	$43,000	$4,000	$39,000
88% Title XXI / 12% GF	$241,000	$29,000	$212,000
Total FY 2017-18	**$6,000,000**	**$1,726,000**	**$4,274,000**

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)
100% State GF (4260-101-0001)
ACA 95% FFP / 5% GF (4260-101-0001/0890)
ACA 94% FFP / 6% GF (4260-101-0001/0890)
Family Planning 90% FFP / 10% GF (4260-101-0001/0890)
88% Title XXI / 12% GF (4260-101-0001/0890)

NOD - SETTLEMENT PAYMENT TO DMC PLANS

REGULAR POLICY CHANGE NUMBER:	227
IMPLEMENTATION DATE:	7/2016
ANALYST:	Nikaela Ratliff
FISCAL REFERENCE NUMBER:	2039

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$19,999,000	$0
- STATE FUNDS	$9,999,500	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$19,999,000	$0
STATE FUNDS	$9,999,500	$0
FEDERAL FUNDS	$9,999,500	$0

DESCRIPTION

Purpose:
The policy change estimates the cost of the ten (10) percent monthly withhold payments for FY 2014-15 and FY 2015-16 to the Dental Managed Care (DMC) plans, paid in FY 2016-17.

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 Department of Health Care Services (DHCS) has established performance measures designed to evaluate the performance of the DMC dental health plans. The Department withheld 10% of the monthly capitation payment, which was payable in whole or in part, based upon the completion of the annual performance evaluation. In an effort to align Department objectives with the plans' ability to best serve the beneficiary population, the Department made the decision to return the withhold in full for the periods of July 2014 through June 2016.

Reason for Change:
This is a new Policy Change.

Methodology:

FY 2016-17	TF	GF	FF
GMC	$8,450,945	$4,225,473	$4,225,473
PHP	$11,548,255	$5,774,127	$5,774,127

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

FY 2015-16 ACCRUAL ADJUSTMENT

REGULAR POLICY CHANGE NUMBER:	228
IMPLEMENTATION DATE:	7/2016
ANALYST:	Karen Fairgrieves
FISCAL REFERENCE NUMBER:	2040

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$65,357,000	$0
- STATE FUNDS	$65,357,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$65,357,000	$0
STATE FUNDS	$65,357,000	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change offsets FY 2015-16 Accrual Adjustments.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
The Department submits an annual accrual-basis estimate to the California State Controller's Office Year End Financial Reports known as the budgetary-legal basis annual report. The accrual-basis estimate consists of prior year liabilities to be paid in subsequent years. The Department's accrual estimate is audited by the California State Auditor.

Reason for Change:
This is a new policy change.

Methodology:
1. At the end of the FY 2015-16 accrual-basis audit, the California State Auditor requested the Department to make accrual related adjustments for some Medi-Cal accrual items involving other state departments/funds to offset accruals made by those state departments/funds.

2. Medi-Cal is on a cash-basis and such accruals should not be made. Items should be budgeted and accounted for in the year payment occurred.

3. This policy change reverses these accrual items for a total of $65,357,000 GF.

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

BEHAVIORAL HEALTH TREATMENT - BIS DDS TRANSITION

REGULAR POLICY CHANGE NUMBER:	229
IMPLEMENTATION DATE:	1/2018
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	2041

	FY 2016-17	FY 2017-18
FULL YEAR COST - TOTAL FUNDS	$0	$11,163,000
- STATE FUNDS	$0	**$4,912,000**
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$11,163,000
STATE FUNDS	$0	**$4,912,000**
FEDERAL FUNDS	$0	**$6,251,000**

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: 229

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 – DDS Transition policy change.

Additional RC clients, without an ASD diagnosis, have been receiving BHT/BIS services through the RCs. Effective January 1, 2018, the Department will start transitioning these additional RC clients to Medi-Cal for BHT/BIS.

Reason for Change:
This is a new policy change.

Methodology:
1. An estimated 2,000 beneficiaries will transition into the Medi-Cal BHT program beginning January 1, 2018.

2. Assume 280 fee-for-service (FFS) beneficiaries will transition on January 1, 2018.

3. Assume 1,720 managed care beneficiaries will transition over six months during the period January 1, 2018 through June 30, 2018.

4. Total estimated payments are:

FY 2017-18	TF	GF	FF
Fee-for-Service	$924,000	$407,000	$517,000
Managed Care	$10,239,000	$4,505,000	$5,734,000
Total	**$11,163,000**	**$4,912,000**	**$6,251,000**

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

SUMMARY OF COUNTY ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2016-17

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER				
1	COUNTY ADMINISTRATION BASE	$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	$162,387,000	$157,225,500	$5,161,500	$0
4	CalWORKS APPLICATIONS	$65,008,000	$32,504,000	$32,504,000	$0
5	CASE MANAGEMENT FOR OTLICP	$45,142,000	$22,571,000	$22,571,000	$0
6	LOS ANGELES COUNTY HOSPITAL INTAKES	$33,495,000	$31,112,500	$2,382,500	$0
7	ENHANCED FEDERAL FUNDING	$0	$352,315,000	($352,315,000)	$0
8	PRIOR YEAR RECONCILIATIONS	$0	$0	$0	$0
9	SAVE	$0	$3,500,000	($3,500,000)	$0
	OTHER SUBTOTAL	**$2,264,025,000**	**$1,578,224,500**	**$685,800,500**	**$0**
	GRAND TOTAL	**$2,264,025,000**	**$1,578,224,500**	**$685,800,500**	**$0**

MEDI-CAL COUNTY ADMINISTRATION
POLICY CHANGE COST BREAKDOWN
FISCAL YEAR 2016-17

NO.	POLICY CHANGE TITLE	ONE-TIME CHANGES		ON-GOING CHANGES		TOTAL POLICY CHANGES	GENERAL FUNDS
		PROCEDURAL	CASELOAD	PROCEDURAL	CASELOAD		
	OTHER						
1	COUNTY ADMINISTRATION BASE	$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	$162,387,000	$0	$0	$0	$162,387,000	$5,161,500
4	CalWORKS APPLICATIONS	$0	$0	$65,008,000	$0	$65,008,000	$32,504,000
5	CASE MANAGEMENT FOR OTLICP	$0	$0	$0	$45,142,000	$45,142,000	$22,571,000
6	LOS ANGELES COUNTY HOSPITAL INTAKES	$0	$0	$0	$33,495,000	$33,495,000	$2,382,500
7	ENHANCED FEDERAL FUNDING	$0	$0	$0	$0	$0	($352,315,000)
8	PRIOR YEAR RECONCILIATIONS	$0	$0	$0	$0	$0	$0
9	SAVE	$0	$0	$0	$0	$0	($3,500,000)
	OTHER SUBTOTAL	**$162,387,000**	**$655,310,000**	**$1,367,691,000**	**$78,637,000**	**$2,264,025,000**	**$685,800,500**
	GRAND TOTAL	**$162,387,000**	**$655,310,000**	**$1,367,691,000**	**$78,637,000**	**$2,264,025,000**	**$685,800,500**

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 BASE	$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	$175,828,000	$175,828,000	$0	$0
4	CalWORKS APPLICATIONS	$59,448,000	$29,724,000	$29,724,000	$0
5	CASE MANAGEMENT FOR OTLICP	$44,683,000	$22,341,500	$22,341,500	$0
6	LOS ANGELES COUNTY HOSPITAL INTAKES	$33,495,000	$31,112,500	$2,382,500	$0
7	ENHANCED FEDERAL FUNDING	$0	$266,354,000	($266,354,000)	$0
8	PRIOR YEAR RECONCILIATIONS	$0	$0	$0	$0
9	SAVE	$0	$3,500,000	($3,500,000)	$0
	OTHER SUBTOTAL	**$2,271,447,000**	**$1,507,856,500**	**$763,590,500**	**$0**
	GRAND TOTAL	**$2,271,447,000**	**$1,507,856,500**	**$763,590,500**	**$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 BASE	$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	$175,828,000	$0	$0	$0	$175,828,000	$0
4	CalWORKS APPLICATIONS	$0	$0	$59,448,000	$0	$59,448,000	$29,724,000
5	CASE MANAGEMENT FOR OTLICP	$0	$0	$0	$44,683,000	$44,683,000	$22,341,500
6	LOS ANGELES COUNTY HOSPITAL INTAKES	$0	$0	$0	$33,495,000	$33,495,000	$2,382,500
7	ENHANCED FEDERAL FUNDING	$0	$0	$0	$0	$0	($266,354,000)
8	PRIOR YEAR RECONCILIATIONS	$0	$0	$0	$0	$0	$0
9	SAVE	$0	$0	$0	$0	$0	($3,500,000)
	OTHER SUBTOTAL	**$175,828,000**	**$655,310,000**	**$1,362,131,000**	**$78,178,000**	**$2,271,447,000**	**$763,590,500**
	GRAND TOTAL	**$175,828,000**	**$655,310,000**	**$1,362,131,000**	**$78,178,000**	**$2,271,447,000**	**$763,590,500**

COMPARISON OF FISCAL IMPACTS OF COUNTY ADMINISTRATION POLICY CHANGES
MAY 2017 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2016 ESTIMATE
FISCAL YEAR 2016-17

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	2016-17 APPROPRIATION		NOV. 2016 EST. FOR 2016-17		MAY 2017 EST. FOR 2016-17		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER										
1	1	COUNTY ADMINISTRATION BASE	$1,302,683,000	$651,341,500	$1,302,683,000	$651,341,500	$1,302,683,000	$651,341,500	$0	$0	$0	$0
2	2	IMPLEMENTATION OF ACA	$655,310,000	$327,655,000	$655,310,000	$327,655,000	$655,310,000	$327,655,000	$0	$0	$0	$0
3	3	SAWS	$172,422,000	$8,535,000	$162,387,000	$5,161,500	$162,387,000	$5,161,500	($10,035,000)	($3,373,500)	$0	$0
4	4	CalWORKS APPLICATIONS	$65,008,000	$32,504,000	$65,008,000	$32,504,000	$65,008,000	$32,504,000	$0	$0	$0	$0
5	5	CASE MANAGEMENT FOR OTLICP	$46,916,000	$23,458,000	$45,924,000	$22,962,000	$45,142,000	$22,571,000	($1,774,000)	($887,000)	($782,000)	($391,000)
6	6	LOS ANGELES COUNTY HOSPITAL INTAKES	$30,102,000	$1,588,500	$33,495,000	$2,382,500	$33,495,000	$2,382,500	$3,393,000	$794,000	$0	$0
7	7	ENHANCED FEDERAL FUNDING	$0	($359,003,000)	$0	($357,815,000)	$0	($352,315,000)	$0	$6,688,000	$0	$5,500,000
8	8	PRIOR YEAR RECONCILIATIONS	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
9	9	SAVE	$0	($3,500,000)	$0	($3,500,000)	$0	($3,500,000)	$0	$0	$0	$0
		OTHER SUBTOTAL	**$2,272,441,000**	**$682,579,000**	**$2,264,807,000**	**$680,691,500**	**$2,264,025,000**	**$685,800,500**	**($8,416,000)**	**$3,221,500**	**($782,000)**	**$5,109,000**
		COUNTY ADMINISTRATION GRAND TOTAL	**$2,272,441,000**	**$682,579,000**	**$2,264,807,000**	**$680,691,500**	**$2,264,025,000**	**$685,800,500**	**($8,416,000)**	**$3,221,500**	**($782,000)**	**$5,109,000**

COMPARISON OF FISCAL IMPACTS OF COUNTY ADMINISTRATION POLICY CHANGES
MAY 2017 ESTIMATE COMPARED TO NOVEMBER 2016 ESTIMATE
FISCAL YEAR 2017-18

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2016 EST. FOR 2017-18		MAY 2017 EST. FOR 2017-18		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER						
1	1	COUNTY ADMINISTRATION BASE	$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	$175,828,000	$0	$0	$0
4	4	CalWORKS APPLICATIONS	$70,020,000	$35,010,000	$59,448,000	$29,724,000	($10,572,000)	($5,286,000)
5	5	CASE MANAGEMENT FOR OTLICP	$46,085,000	$23,042,500	$44,683,000	$22,341,500	($1,402,000)	($701,000)
6	6	LOS ANGELES COUNTY HOSPITAL INTAKES	$33,495,000	$2,382,500	$33,495,000	$2,382,500	$0	$0
7	7	ENHANCED FEDERAL FUNDING	$0	($356,550,000)	$0	($266,354,000)	$0	$90,196,000
8	8	PRIOR YEAR RECONCILIATIONS	$0	$0	$0	$0	$0	$0
9	9	SAVE	$0	($3,500,000)	$0	($3,500,000)	$0	$0
		OTHER SUBTOTAL	**$2,283,421,000**	**$679,381,500**	**$2,271,447,000**	**$763,590,500**	**($11,974,000)**	**$84,209,000**
		COUNTY ADMINISTRATION GRAND TOTAL	**$2,283,421,000**	**$679,381,500**	**$2,271,447,000**	**$763,590,500**	**($11,974,000)**	**$84,209,000**

COMPARISON OF FISCAL IMPACTS OF COUNTY ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2016-17 AND 2017-18

NO.	POLICY CHANGE TITLE	MAY 2017 EST. FOR 2016-17 TOTAL FUNDS	MAY 2017 EST. FOR 2016-17 GENERAL FUNDS	MAY 2017 EST. FOR 2017-18 TOTAL FUNDS	MAY 2017 EST. FOR 2017-18 GENERAL FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE GENERAL FUNDS
	OTHER						
1	COUNTY ADMINISTRATION BASE	$1,302,683,000	$651,341,500	$1,302,683,000	$651,341,500	$0	$0
2	IMPLEMENTATION OF ACA	$655,310,000	$327,655,000	$655,310,000	$327,655,000	$0	$0
3	SAWS	$162,387,000	$5,161,500	$175,828,000	$0	$13,441,000	($5,161,500)
4	CalWORKS APPLICATIONS	$65,008,000	$32,504,000	$59,448,000	$29,724,000	($5,560,000)	($2,780,000)
5	CASE MANAGEMENT FOR OTLICP	$45,142,000	$22,571,000	$44,683,000	$22,341,500	($459,000)	($229,500)
6	LOS ANGELES COUNTY HOSPITAL INTAKES	$33,495,000	$2,382,500	$33,495,000	$2,382,500	$0	$0
7	ENHANCED FEDERAL FUNDING	$0	($352,315,000)	$0	($266,354,000)	$0	$85,961,000
8	PRIOR YEAR RECONCILIATIONS	$0	$0	$0	$0	$0	$0
9	SAVE	$0	($3,500,000)	$0	($3,500,000)	$0	$0
	OTHER SUBTOTAL	**$2,264,025,000**	**$685,800,500**	**$2,271,447,000**	**$763,590,500**	**$7,422,000**	**$77,790,000**
	COUNTY ADMINISTRATION GRAND TOTAL	**$2,264,025,000**	**$685,800,500**	**$2,271,447,000**	**$763,590,500**	**$7,422,000**	**$77,790,000**

MEDI-CAL COUNTY ADMINISTRATION
POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	OTHER
1	COUNTY ADMINISTRATION BASE
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	PRIOR YEAR RECONCILIATIONS
9	SAVE

COUNTY ADMINISTRATION BASE

COUNTY ADMIN. POLICY CHANGE NUMBER:	1
IMPLEMENTATION DATE:	7/2012
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1704

	FY 2016-17		FY 2017-18	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$1,302,683,000	$0	$1,302,683,000
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$1,302,683,000	$0	$1,302,683,000
STATE FUNDS	$0	$651,341,500	$0	$651,341,500
% 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	$1,302,683,000
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$1,302,683,000	$0	$1,302,683,000
STATE FUNDS	$0	$651,341,500	$0	$651,341,500

DESCRIPTION

Purpose:
This policy change reflects the base 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. The base estimate reflects the allocation to the counties utilizing recent workload data, county expenditure data, and other county-submitted information.

The base 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 BASE

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.

Reason for Change:
There is no change.

Methodology:
1) The total rounded estimated FY 2016-17 and FY 2017-18 county administration costs are:

(Dollars in Thousands)

FY 2016-17	TF	GF	FF
Staff Salary Costs	$909,622	$454,811	$454,811
Support Staff Costs	$373,643	$186,821	$186,821
Staff Development Costs	$19,416	$9,708	$9,708
Total Base Allocation	**$1,302,683**	**$651,341**	**$651,342**

FY 2017-18	TF	GF	FF
Staff Salary Costs	$909,622	$454,811	$454,811
Support Staff Costs	$373,643	$186,821	$186,821
Staff Development Costs	$19,416	$9,708	$9,708
Total Base Allocation	**$1,302,683**	**$651,341**	**$651,342**

COUNTY ADMINISTRATION BASE

COUNTY ADMIN. POLICY CHANGE NUMBER: 1

Medi-Cal County Administration				
FY 2016-17 and FY 2017-18				
County	Total Staff Salary Costs	Support Staff	Staff Development Costs	Base Allocation
Alameda	$32,542,588	$11,615,145	$1,385,854	$45,543,587
Alpine	$41,700	$0	$0	$41,700
Amador	$681,637	$366,187	$10,341	$1,058,165
Butte	$5,379,540	$2,399,702	$25,500	$7,804,742
Calaveras	$694,063	$441,347	$6,910	$1,142,320
Colusa	$635,448	$291,552	$21,716	$948,716
Contra Costa	$23,315,114	$12,617,981	$304,333	$36,237,428
Del Norte	$558,190	$259,284	$11,200	$828,674
El Dorado	$2,652,217	$1,101,127	$90,000	$3,843,344
Fresno	$28,892,408	$16,305,175	$657,347	$45,854,930
Glenn	$1,059,460	$342,764	$18,000	$1,420,224
Humboldt	$3,875,219	$1,057,846	$119,300	$5,052,365
Imperial	$5,074,973	$1,872,353	$115,220	$7,062,546
Inyo	$554,240	$212,327	$11,000	$777,567
Kern	$17,115,100	$7,278,489	$196,890	$24,590,479
Kings	$2,702,453	$955,428	$144,250	$3,802,131
Lake	$1,631,990	$568,477	$51,706	$2,252,173
Lassen	$492,642	$218,634	$23,468	$734,744
Los Angeles	$273,758,990	$119,782,655	$2,103,000	$395,644,645
Madera	$3,292,642	$1,697,142	$4,465	$4,994,249
Marin	$3,206,326	$1,600,478	$103,412	$4,910,216
Mariposa	$417,966	$539,071	$0	$957,037
Mendocino	$3,488,586	$1,469,968	$15,718	$4,974,272
Merced	$9,075,836	$1,956,051	$144,064	$11,175,951
Modoc	$387,012	$332,812	$15,000	$734,824
Mono	$207,098	$110,669	$20,000	$337,767
Monterey	$11,136,422	$5,713,668	$475,000	$17,325,090
Napa	$2,072,297	$1,160,104	$43,563	$3,275,964
Nevada	$1,527,574	$732,652	$25,631	$2,285,857
Orange	$77,886,813	$20,747,854	$2,000,674	$100,635,341
Placer	$4,215,254	$1,860,122	$91,206	$6,166,582
Plumas	$373,319	$197,689	$5,171	$576,179

COUNTY ADMINISTRATION BASE

COUNTY ADMIN. POLICY CHANGE NUMBER: 1

Medi-Cal County Administration				
FY 2016-17 and FY 2017-18				
County	**Total Staff Salary Costs**	**Support Staff**	**Staff Development Costs**	**Base Allocation**
Riverside	$42,122,663	$23,700,136	$750,977	$66,573,776
Sacramento	$30,420,717	$12,121,920	$885,878	$43,428,515
San Benito	$1,150,098	$389,751	$64,103	$1,603,952
San Bernardino	$42,437,752	$17,141,455	$861,000	$60,440,207
San Diego	$54,194,098	$24,937,737	$2,311,253	$81,443,088
San Francisco	$21,609,931	$4,737,695	$206,824	$26,554,450
San Joaquin	$16,284,780	$4,472,548	$434,329	$21,191,657
San Luis Obispo	$5,329,928	$3,862,538	$149,947	$9,342,413
San Mateo	$15,595,364	$5,437,955	$551,844	$21,585,163
Santa Barbara	$14,576,928	$6,200,380	$881,375	$21,658,683
Santa Clara	$53,322,942	$15,373,238	$1,500,000	$70,196,180
Santa Cruz	$7,550,308	$3,000,456	$422,880	$10,973,644
Shasta	$4,145,591	$2,114,811	$200,000	$6,460,402
Sierra	$113,167	$173,930	$1,500	$288,597
Siskiyou	$1,013,009	$258,380	$128,037	$1,399,426
Solano	$9,405,955	$4,679,039	$500,000	$14,584,994
Sonoma	$11,267,525	$2,945,891	$237,048	$14,450,464
Stanislaus	$15,194,676	$3,970,500	$160,184	$19,325,360
Sutter	$2,950,607	$1,943,224	$50,000	$4,943,831
Tehama	$1,468,661	$679,223	$5,500	$2,153,384
Trinity	$353,544	$128,062	$11,500	$493,106
Tulare	$16,162,830	$4,855,829	$459,400	$21,478,059
Tuolumne	$1,153,800	$800,054	$8,928	$1,962,782
Ventura	$17,008,190	$8,607,859	$265,114	$25,881,163
Yolo	$3,821,963	$3,233,330	$71,160	$7,126,453
Yuba	$2,022,731	$2,072,590	$58,121	$4,153,442
Total	**$909,622,876**	**$373,643,283**	**$19,416,841**	**$1,302,683,000**

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 2016-17		FY 2017-18	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$655,310,000	$0	$655,310,000	$0
TOTAL FUNDS	$655,310,000	$0	$655,310,000	$0
STATE FUNDS	$327,655,000	$0	$327,655,000	$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.	$655,310,000	$0	$655,310,000	$0
TOTAL FUNDS	$655,310,000	$0	$655,310,000	$0
STATE FUNDS	$327,655,000	$0	$327,655,000	$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.

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 2016-17	$ 655,310	$ 327,655	$ 327,655
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 2016-17		FY 2017-18	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$162,387,000	$0	$175,828,000	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$162,387,000	$0	$175,828,000	$0
STATE FUNDS	$5,161,500	$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.	$162,387,000	$0	$175,828,000	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$162,387,000	$0	$175,828,000	$0
STATE FUNDS	$5,161,500	$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 Reposting System (LEADER) and LEADER Replacement System (LRS) 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 four county consortium systems: LEADER, the LEADER Replacement System (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.

LEADER is one of the automated system for Los Angeles County and is currently in the maintenance

SAWS

COUNTY ADMIN. POLICY CHANGE NUMBER: 3

and operation (M&O) phase. On November 12, 2014, the Los Angeles County Board of Supervisors approved an additional two-year sole source extension of the current LEADER M&O services contract. The contract has been extended through April 2017 and will allow ongoing M&O of the LEADER system. LEADER ceased being the system of record for Los Angeles County's public assistance programs, such as Medi-Cal, on October 8, 2016. Final decommissioning activities are underway. LRS replaced LEADER and seventeen other county systems. The implementation of LRS is currently in the final phase. To comply with requests from the federal regulators, the foster care and adoption portions of LRS, used by the county Department of Children and Family Services, will require additional major system releases lasting into mid-2017.

The CalWIN consortium is fully implemented in all 18 counties and is currently in the maintenance and operation phase. The C-IV system is 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 LEADER and C-IV consortia.

Counties in all three of the SAWS have upgraded and expanded the current county call center infrastructure to interface with Covered California's service center. This expansion is required to meet the increase in call volume and the increase in services provided to beneficiaries.

Reason for Change:
There is no change from the prior estimate.

Methodology:
1) The following estimate was provided by CDSS on a cash basis.

(Dollars in Thousands)

Line Item	FY 2016-17	FY 2017-18
Statewide Project Management	$2,178	$2,177
CalHEERS Interface Development	$0	$0
SB 1341 Medi-Cal/SAWS	$7,919	$5,020
SAWS Customer Service Centers	$0	$0
LEADER - Replacement	$58,210	$42,129
LA County LEADER M&O*	$10,323	$0
WCDS-CalWIN	$42,648	$45,941
Consortium IV	$39,835	$35,897
Consortium IV – Migration	$0	$43,718
State Client Index	$68	$68
Appeals Case Management System (ACMS)	$1,206	$878
Total	**$162,387**	**$175,828**

Funding:
50% Title XIX FF / 50% GF (4260-101-0001/0890)*
Medicaid Management Information Systems Enhanced Funding identified in CA 7 Enhanced Federal Funding
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 2016-17		FY 2017-18	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$65,008,000	$0	$59,448,000
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$65,008,000	$0	$59,448,000
STATE FUNDS	$0	$32,504,000	$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	$65,008,000	$0	$59,448,000
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$65,008,000	$0	$59,448,000
STATE FUNDS	$0	$32,504,000	$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 from the previous estimate for FY 2016-17. The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to a projected decrease in actual expenditures in the most recent claim data.

Methodology:
1) The estimated costs for FY 2016-17 and FY 2017-18 were provided on a cash basis by CDSS.

CalWORKS APPLICATIONS

COUNTY ADMIN. POLICY CHANGE NUMBER: 4

(Dollars in thousands)

Fiscal Year	TF	GF	FF
FY 2016-17	$65,008	$32,504	$32,504
FY 2017-18	$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 2016-17		FY 2017-18	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$45,142,000	$0	$44,683,000
TOTAL FUNDS	$0	$45,142,000	$0	$44,683,000
STATE FUNDS	$0	$22,571,000	$0	$22,341,500
% 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	$45,142,000	$0	$44,683,000
TOTAL FUNDS	$0	$45,142,000	$0	$44,683,000
STATE FUNDS	$0	$22,571,000	$0	$22,341,500

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 is due to updated average monthly caseload data showing decreases of 1.73% in FY 2016-17 and 3.14% in FY 2017-18. The change in the current estimate from FY 2016-17 to FY 2017-18 is due to a 1.02% decrease in 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 930,898 for FY 2016-17 and 940,454 for FY 2017-18.

3. The estimated costs are:

(Dollars In Thousands)

Fiscal Year	TF	GF	FF
FY 2016-17	$ 45,142	$ 22,571	$ 22,571
FY 2017-18	$ 44,683	$ 22,341	$ 22,342

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 2016-17		FY 2017-18	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$33,495,000	$0	$33,495,000
TOTAL FUNDS	$0	$33,495,000	$0	$33,495,000
STATE FUNDS	$0	$2,382,500	$0	$2,382,500
% 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	$33,495,000	$0	$33,495,000
TOTAL FUNDS	$0	$33,495,000	$0	$33,495,000
STATE FUNDS	$0	$2,382,500	$0	$2,382,500

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:
There is no change from the prior estimate.

Methodology:
1. The reimbursement rate is $268 for both current year and budget year. Assume in FY 2016-17 and FY 2017-18, PFSWs will continue processing a base caseload of 2,215 per month.

LOS ANGELES COUNTY HOSPITAL INTAKES

COUNTY ADMIN. POLICY CHANGE NUMBER: 6

FY 2016-17: 2,215 x $268 x 12 = $7,123,000 TF ($3,561,500 GF)
FY 2017-18: 2,215 x $268 x 12 = $7,123,000 TF ($3,561,500 GF)

2. The Department completed the FY 2014-15 Los Angeles County Hospital Intakes reconciliation in FY 2016-17.

3. 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)

Line Item	FY 2016-17			FY 2017-18		
	TF	GF	FF	TF	GF	FF
PFSW Base	$7,123	$3,561	$3,562	$7,123	$3,561	$3,562
FY 2014-15 Recon.	$12,007	($1,179)	$13,186	$0	$0	$0
FY 2014-15 Pass.	$14,365	$0	$14,365	$0	$0	$0
FY 2015-16 Recon.	$0	$0	$0	$12,007	($1,179)	$13,186
FY 2015-16 Pass.	$0	$0	$0	$14,365	0	$14,365
Total	**$33,495**	**$2,382**	**$31,113**	**$33,495**	**$2,382**	**$31,113**

Funding:

FY 2016-17	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	$27,551	$0	$27,551
100% GF	4260-101-0001	($1,179)	($1,179)	$0
Total		**$33,495**	**$2,382**	**$31,113**

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	$27,551	$0	$27,551
100% GF	4260-101-0001	($1,179)	($1,179)	$0
Total		**$33,495**	**$2,382**	**$31,113**

ENHANCED FEDERAL FUNDING

COUNTY ADMIN. POLICY CHANGE NUMBER:	7
IMPLEMENTATION DATE:	1/2015
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1835

	FY 2016-17		FY 2017-18	
	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	-$352,315,000	$0	-$266,354,000	$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	-$352,315,000	$0	-$266,354,000	$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 3 SAWS
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

ENHANCED FEDERAL FUNDING

COUNTY ADMIN. POLICY CHANGE NUMBER: 7

Department submitted an Advanced Planning Document (APD) to secure CMS approval. CMS approved the APD on September 29, 2014. In July 2015, 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 2016, 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, 2016.

Reason for Change:
The reason for change from the November 2016 estimate to the current estimate, for FY 2016-17, is that the Department updated FY 2016-17 actual claims for County Administrative costs, which decreased the overall amount eligible for enhanced 75/25 funding. The reason for change from FY 2016-17 to FY 2017-18, in the current estimate, is due to higher estimated claims in FY 2017-18.

Methodology:
1. The effective date for the approval for the Department's APD is September 29, 2014, with retroactivity for April-September 2014. In addition, both FY 2016-17 and FY 2017-18 contain additional funding related to the implementation of the Affordable Care Act.

2. Assume that 67.5% 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 2016-17	TF	GF	FF
FY 2016-17 at 50% FFP	$ 1,409,258	$ 704,629	$ 704,629
FY 2016-17 at 75% FFP	$ 1,409,258	$ 352,315	$ 1,056,944
Total FY 2015-16 Difference	**$ -**	**$ (352,315)**	**$ 352,315**

FY 2017-18	TF	GF	FF
FY 2017-18 at 50% FFP	$ 1,065,415	$ 532,707	$ 532,707
FY 2017-18 at 75% FFP	$ 1,065,415	$ 266,354	$ 799,061
Total FY 2016-17 Difference	**$ -**	**$ (266,354)**	**$ 266,354**

Funding:
50% Title XIX FF/ 50% GF (4260-101-0001/0890)
75% Title XIX GF/ 25% GF (4260-101-0001/0890)

PRIOR YEAR RECONCILIATIONS

COUNTY ADMIN. POLICY CHANGE NUMBER:	8
IMPLEMENTATION DATE:	12/2011
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1191

	FY 2016-17		FY 2017-18	
	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	$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.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$0	$0	$0
STATE FUNDS	$0	$0	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the reconciliation of county administration expenditures to the county administration allocation.

Authority:
Welfare & Institutions Code 14154

Interdependent Policy Changes:
Not Applicable

Background:
Two years following the end of a fiscal year, county administration expenditures are reconciled to the county administration allocation for the applicable fiscal year. Counties have one year from the end of a quarter to amend their quarterly administrative claim which is used by the Department for the county administration reconciliation process. Any amount overspent in the allocation will be owed to the counties, and any amount underspent will be owed to the State.

Reason for Change:
There is no change.

Methodology:
1) In FY 2016-17, the Department completed the final reconciliation for FY 2014-15. The table reflects the reconciliation dollars for FY 2016-17 and estimated dollars for FY 2017-18 based on the previous year's final reconciliation.

PRIOR YEAR RECONCILIATIONS

COUNTY ADMIN. POLICY CHANGE NUMBER: 8

FY 2016-17	TF	GF	FF
FY 2014-15 Final Reconciliation	$0	$0	$0

FY 2017-18	TF	GF	FF
FY 2015-16 Final Reconciliation	$0	$0	$0

Funding:
50% Title XIX FF/ 50% GF (4260-101-0001/0890)
75% Title XIX FF/ 25% GF (4260-101-0001/0890)

SAVE

COUNTY ADMIN. POLICY CHANGE NUMBER:	9
IMPLEMENTATION DATE:	10/1988
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	215

	FY 2016-17		FY 2017-18	
	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	-$3,500,000	$0	-$3,500,000	$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	-$3,500,000	$0	-$3,500,000	$0

DESCRIPTION

Purpose:
The policy change estimates the technical adjustment in funding from Title XIX 50% Federal Financial Participation (FFP) to Title XIX 100% FFP for the Systematic Alien Verification for Entitlements (SAVE) system.

Authority:
Welfare & Institutions Code 14154

Interdependent Policy Changes:
Not Applicable

Background:
The Immigration Reform and Control Act (IRCA) of 1986 required states to use the SAVE system to verify immigrant status for Medi-Cal applicants beginning in October 1988. The counties complete time studies for eligibility workers and supervisors based on time spent for SAVE verifications. Beginning May of 2018, counties will be federally required to use the web-based SAVE system for the third step of the SAVE process.

Reason for Change:
There is no change from the prior estimate.

Methodology:
1. Reconciliation is completed 18 months after the end of each FY to adjust funding received by counties from 50% FFP to 100% FFP.

SAVE

COUNTY ADMIN. POLICY CHANGE NUMBER: 9

2. The Medi-Cal accrual costs for SAVE reported over the last three years by the counties were:

Fiscal Year	Reported	Fiscal Year	Estimated
FY 2013-14*	$6,261,572	FY 2016-17**	$7,000,000
FY 2014-15*	$6,618,661	FY 2017-18**	$7,000,000
FY 2015-16*	$7,553,372	FY 2018-19**	$7,000,000

* Actual
** Preliminary

3. Based on claims through June 2016, federal funds will be:
(Dollars in Thousands)

FY 2016-17		TF	GF	FF
50% Title XIX /50% GF	4260-101-0001/0890	($7,000)	($3,500)	($3,500)
100 % Title XIX FFP	4260-101-0890	$7,000	$0	$7,000
Net Impact		**$0**	**($3,500)**	**$3,500**

FY 2017-18		TF	GF	FF
50% Title XIX /50% GF	4260-101-0001/0890	($7,000)	($3,500)	($3,500)
100% Title XIX FFP	4260-101-0890	$7,000	$0	$7,000
Net Impact		**$0**	**($3,500)**	**$3,500**

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

May 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 2016-2017 ESTIMATE:	**Total Funds**	**Federal Funds**	**State Funds**
OTHER ADMINISTRATION			
County Administration	$1,809,675,000	$1,629,732,150	$179,942,850
Fiscal Intermediary	$403,326,000	$287,850,000	$115,476,000
Total Other Administration Tab	**$2,213,001,000**	**$1,917,582,150**	**$295,418,850**
Management Summary:			
COUNTY ADMINISTRATION	**$4,073,700,000**	**$3,207,957,000**	**$865,743,000**
Shown in Other Administration Tab	$1,809,675,000	$1,629,732,150	$179,942,850
Shown in County Administration Tab	$2,264,025,000	$1,578,224,850	$685,800,150
FISCAL INTERMEDIARY	**$403,326,000**	**$287,849,000**	**$115,477,000**
Shown in Other Administration Tab	$403,326,000	$287,850,000	$115,476,000

FY 2017-2018 ESTIMATE:	**Total Funds**	**Federal Funds**	**State Funds**
OTHER ADMINISTRATION			
County Administration	$2,302,898,000	$2,093,738,240	$209,159,760
Fiscal Intermediary	$423,230,000	$268,691,000	$154,539,000
Total Other Administration Tab	**$2,726,128,000**	**$2,362,429,240**	**$363,698,760**
Management Summary:			
COUNTY ADMINISTRATION	**$4,574,347,000**	**$3,601,595,000**	**$972,752,000**
Shown in Other Administration Tab	$2,302,898,000	$2,093,738,240	$209,159,760
Shown in County Administration Tab	$2,271,449,000	$1,507,856,760	$763,592,240
FISCAL INTERMEDIARY	**$423,230,000**	**$268,691,000**	**$154,539,000**
Shown in Other Administration Tab	$423,230,000	$268,691,000	$154,539,000

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2016-17

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	DHCS-OTHER				
1	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	$147,217,000	$147,217,000	$0	$0
2	CCS CASE MANAGEMENT	$191,546,000	$126,396,420	$65,149,580	$0
4	COUNTY SPECIALTY MENTAL HEALTH ADMIN	$110,963,000	$110,939,000	$24,000	$0
5	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	$96,773,000	$96,773,000	$0	$0
6	EPSDT CASE MANAGEMENT	$33,962,000	$21,846,750	$12,115,250	$0
7	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	$30,329,000	$23,131,200	$7,197,800	$0
8	PAVE SYSTEM	$18,616,000	$16,162,800	$2,453,200	$0
9	SMH MAA	$31,681,000	$31,681,000	$0	$0
10	POSTAGE & PRINTING	$19,625,000	$9,720,000	$9,905,000	$0
11	SMHS COUNTY UR & QA ADMIN	$18,906,000	$18,906,000	$0	$0
12	ARRA HITECH INCENTIVE PROGRAM	$18,178,000	$16,579,000	$0	$1,599,000
13	ACTUARIAL COSTS FOR RATE DEVELOPMENT	$16,222,000	$8,111,000	$8,111,000	$0
14	MIS/DSS CONTRACT	$14,481,000	$10,695,250	$3,785,750	$0
15	SURS AND MARS SYSTEM REPLACEMENT	$14,262,000	$11,326,500	$2,935,500	$0
16	INTERIM AND FINAL COST SETTLEMENTS-SMHS	$13,177,000	$13,177,000	$0	$0
17	CCI-ADMINISTRATIVE COSTS	$11,213,000	$5,606,500	$5,606,500	$0
18	PASRR	$10,248,000	$7,686,000	$2,562,000	$0
20	LITIGATION RELATED SERVICES	$9,980,000	$4,990,000	$4,990,000	$0
21	MEDI-CAL RECOVERY CONTRACTS	$7,915,000	$5,936,250	$1,978,750	$0
22	NEWBORN HEARING SCREENING PROGRAM	$7,105,000	$3,552,500	$3,552,500	$0
23	CA-MMIS GO-FORWARD OVERSIGHT	$5,318,000	$4,545,100	$772,900	$0
24	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$5,291,000	$3,534,250	$1,389,750	$367,000
26	HIPAA CAPITATION PAYMENT REPORTING SYSTEM	$4,763,000	$3,572,250	$1,190,750	$0
27	DRUG MEDI-CAL COUNTY ADMINISTRATION	$4,710,000	$4,710,000	$0	$0
28	MEDS MODERNIZATION	$2,942,000	$2,562,300	$379,700	$0
29	SDMC SYSTEM M&O SUPPORT	$2,325,000	$1,162,500	$1,162,500	$0
30	ENROLLMENT ASSIST FOR BHT INSTITUTIONALLY DEEMED	$2,200,000	$1,100,000	$1,100,000	$0
31	CA-MMIS GO-FORWARD STATE TRANSITION	$2,090,000	$1,786,200	$303,800	$0
32	MITA	$1,996,000	$1,796,400	$199,600	$0

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2016-17

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	DHCS-OTHER				
33	SSA COSTS FOR HEALTH COVERAGE INFO.	$949,000	$474,500	$474,500	$0
34	MEDICARE BUY-IN QUALITY REVIEW PROJECT	$174,000	$87,000	$87,000	$0
35	FAMILY PACT PROGRAM ADMIN.	$1,207,000	$603,500	$603,500	$0
36	CALIFORNIA HEALTH INTERVIEW SURVEY	$1,373,000	$1,373,000	$0	$0
37	SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES	$950,000	$0	$950,000	$0
38	MMA - DSH ANNUAL INDEPENDENT AUDIT	$1,091,000	$545,500	$545,500	$0
39	DMC COUNTY UR & QA ADMIN	$111,000	$111,000	$0	$0
40	IRS REPORTING FOR MIN. ESSENTIAL COVERAGE	$376,000	$188,000	$188,000	$0
41	ENCRYPTION OF PHI DATA	$750,000	$375,000	$375,000	$0
42	MEDICARE BENEFICIARY IDENTIFIER	$335,000	$301,500	$33,500	$0
43	CA-MMIS PROCUREMENT CONSULTANTS	$478,000	$408,400	$69,600	$0
44	POSTAGE AND PRINTING - THIRD PARTY LIAB.	$710,000	$355,000	$355,000	$0
45	VENDOR FOR AAC RATE STUDY	$645,000	$322,500	$322,500	$0
46	CLINICAL DATA COLLECTION	$468,000	$421,200	$46,800	$0
47	ETL DATA SOLUTION	$363,000	$275,550	$87,450	$0
48	CCT OUTREACH - ADMINISTRATIVE COSTS	$291,000	$291,000	$0	$0
50	DENTAL PAPD PROJECT MANAGER	$226,000	$169,500	$56,500	$0
51	STATE CONTROLLER'S OFFICE INTERAGENCY AGREEMENT	$32,000	$24,000	$8,000	$0
52	CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT	$100,000	$100,000	$0	$0
53	PREVENTION OF CHRONIC DISEASE GRANT PROJECT	$80,000	$80,000	$0	$0
54	TAR POSTAGE	$54,000	$27,000	$27,000	$0
55	ACA EXPANSION ADMIN COSTS	$86,000	$43,000	$43,000	$0
56	EPOCRATES	$9,000	$4,500	$4,500	$0
	DHCS-OTHER SUBTOTAL	**$864,892,000**	**$721,782,820**	**$141,143,180**	**$1,966,000**
	DHCS-MEDICAL FI				
59	MEDICAL FI OPERATIONS	$94,123,000	$63,565,250	$30,557,750	$0
60	MEDICAL FI COST REIMBURSEMENT	$38,228,000	$28,257,300	$9,970,700	$0
61	MEDICAL FI HOURLY REIMBURSEMENT	$27,551,000	$21,563,250	$5,987,750	$0

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2016-17

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	DHCS-MEDICAL FI				
62	MEDICAL FI OTHER ESTIMATED COSTS	$11,280,000	$8,010,000	$3,270,000	$0
63	MEDICAL FI GO-FORWARD AND CLOSE OUT ACTIVITIES	$5,000,000	$4,272,700	$727,300	$0
64	MEDICAL FI MISCELLANEOUS EXPENSES	$2,100,000	$1,419,000	$681,000	$0
65	MEDICAL FI CHANGE ORDERS	$486,000	$349,000	$137,000	$0
67	CA-MMIS XEROX SETTLEMENT AGREEMENT	($41,320,000)	$0	($41,320,000)	$0
	DHCS-MEDICAL FI SUBTOTAL	**$137,448,000**	**$127,436,500**	**$10,011,500**	**$0**
	DHCS-HEALTH CARE OPT				
68	HCO COST REIMBURSEMENT	$41,644,000	$21,614,300	$20,029,700	$0
69	HCO OPERATIONS	$39,189,000	$20,337,400	$18,851,600	$0
70	HCO - ENROLLMENT CONTRACTOR COSTS	$15,560,000	$8,075,260	$7,484,740	$0
71	HCO ESR HOURLY REIMBURSEMENT	$14,013,000	$7,272,880	$6,740,120	$0
72	HCO CCI - CAL MEDICONNECT AND MLTSS	$13,514,000	$6,757,000	$6,757,000	$0
	DHCS-HEALTH CARE OPT SUBTOTAL	**$123,920,000**	**$64,056,840**	**$59,863,160**	**$0**
	DHCS-DENTAL FI				
75	DENTAL FI OPERATIONS	$98,000,000	$65,500,000	$32,500,000	$0
76	DENTAL NEW FI TAKEOVER	$7,808,000	$5,856,000	$1,952,000	$0
77	DENTAL FI HOURLY REIMBURSEMENT	$12,765,000	$9,573,750	$3,191,250	$0
78	DENTAL FI COST REIMBURSEMENT	$10,951,000	$5,833,000	$5,118,000	$0
79	DENTAL BENEFICIARY OUTREACH & ED PROGRAM - ADMIN	$681,000	$340,500	$340,500	$0
80	DENTAL ASO TAKEOVER	$1,473,000	$1,104,750	$368,250	$0
81	DENTAL TREATMENT AUTHORIZATION REQUEST PROCESSING	$744,000	$419,750	$324,250	$0
82	DENTAL FI FEDERAL RULE - REVALIDATION	$400,000	$200,000	$200,000	$0
83	DENTAL FI CD-MMIS COSTS	$137,000	$102,750	$34,250	$0
84	DENTAL FI FEDERAL RULE - DATABASE CHECKS	$340,000	$170,000	$170,000	$0
85	DENTAL FI HIPAA ADDENDUM SECURITY RISK ASSESSMENT	$260,000	$195,000	$65,000	$0
86	DENTAL FI CONLAN, SCHWARZMER, STEVENS V. BONTA	$255,000	$127,500	$127,500	$0
	DHCS-DENTAL FI SUBTOTAL	**$133,814,000**	**$89,423,000**	**$44,391,000**	**$0**

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2016-17

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER DEPARTMENTS				
89	PERSONAL CARE SERVICES	$364,530,000	$364,530,000	$0	$0
90	HEALTH-RELATED ACTIVITIES - CDSS	$270,590,000	$270,590,000	$0	$0
91	CALHEERS DEVELOPMENT	$131,661,000	$104,952,490	$26,708,510	$0
92	CDDS ADMINISTRATIVE COSTS	$54,966,000	$54,966,000	$0	$0
93	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$27,676,000	$27,676,000	$0	$0
94	MATERNAL AND CHILD HEALTH	$29,049,000	$29,049,000	$0	$0
95	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	$29,829,000	$29,829,000	$0	$0
96	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	$14,641,000	$10,711,000	$0	$3,930,000
97	ACA OUTREACH AND ENROLLMENT COUNSELORS	$14,032,000	$7,016,000	$0	$7,016,000
98	CLPP CASE MANAGEMENT SERVICES	$4,818,000	$4,818,000	$0	$0
99	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$3,910,000	$3,910,000	$0	$0
100	CALIFORNIA SMOKERS' HELPLINE	$1,287,000	$1,287,000	$0	$0
101	VITAL RECORDS DATA	$856,000	$856,000	$0	$0
102	KIT FOR NEW PARENTS	$1,119,000	$1,119,000	$0	$0
103	VETERANS BENEFITS	$956,000	$956,000	$0	$0
104	CDPH I&E PROGRAM AND EVALUATION	$686,000	$686,000	$0	$0
105	CHHS AGENCY HIPAA FUNDING	$849,000	$849,000	$0	$0
106	MEDI-CAL INPATIENT SERVICES FOR INMATES	$813,000	$813,000	$0	$0
107	MERIT SYSTEM SERVICES FOR COUNTIES	$198,000	$99,000	$99,000	$0
108	CDDS DENTAL SERVICES - ADMIN	$120,000	$0	$0	$120,000
109	PIA EYEWEAR COURIER SERVICE	$341,000	$170,500	$170,500	$0
	OTHER DEPARTMENTS SUBTOTAL	**$952,927,000**	**$914,882,990**	**$26,978,010**	**$11,066,000**
	GRAND TOTAL	**$2,213,001,000**	**$1,917,582,150**	**$282,386,850**	**$13,032,000**

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	$495,234,000	$495,234,000	$0	$0
2	CCS CASE MANAGEMENT	$196,000,000	$129,310,000	$66,690,000	$0
3	MH/UCD & BTR – LIHP – ADMINISTRATIVE COSTS	$119,816,000	$119,816,000	$0	$0
4	COUNTY SPECIALTY MENTAL HEALTH ADMIN	$115,824,000	$115,703,000	$121,000	$0
5	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	$76,169,000	$76,169,000	$0	$0
6	EPSDT CASE MANAGEMENT	$33,962,000	$21,846,750	$12,115,250	$0
7	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	$33,704,000	$25,537,280	$8,166,720	$0
8	PAVE SYSTEM	$18,562,000	$15,875,850	$2,686,150	$0
9	SMH MAA	$32,512,000	$32,512,000	$0	$0
10	POSTAGE & PRINTING	$19,820,000	$9,817,500	$10,002,500	$0
11	SMHS COUNTY UR & QA ADMIN	$20,876,000	$20,461,000	$415,000	$0
12	ARRA HITECH INCENTIVE PROGRAM	$18,729,000	$17,105,000	$0	$1,624,000
13	ACTUARIAL COSTS FOR RATE DEVELOPMENT	$16,872,000	$8,436,000	$8,119,000	$317,000
14	MIS/DSS CONTRACT	$11,379,000	$8,365,250	$3,013,750	$0
15	SURS AND MARS SYSTEM REPLACEMENT	$10,790,000	$8,812,950	$1,977,050	$0
16	INTERIM AND FINAL COST SETTLEMENTS-SMHS	($25,692,000)	($25,692,000)	$0	$0
17	CCI-ADMINISTRATIVE COSTS	$11,213,000	$5,606,500	$5,606,500	$0
18	PASRR	$11,699,000	$8,774,250	$2,924,750	$0
19	PERFORMANCE OUTCOMES SYSTEM	$14,952,000	$8,762,000	$6,190,000	$0
20	LITIGATION RELATED SERVICES	$9,980,000	$4,990,000	$4,990,000	$0
21	MEDI-CAL RECOVERY CONTRACTS	$10,218,000	$7,663,500	$2,554,500	$0
22	NEWBORN HEARING SCREENING PROGRAM	$7,800,000	$3,900,000	$3,900,000	$0
24	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$5,291,000	$3,534,250	$1,389,750	$367,000
25	CA-MMIS MEDCOMPASS SOLUTION	$1,803,000	$1,540,500	$262,500	$0
26	HIPAA CAPITATION PAYMENT REPORTING SYSTEM	$4,931,000	$3,698,250	$1,232,750	$0
27	DRUG MEDI-CAL COUNTY ADMINISTRATION	$3,310,000	$3,310,000	$0	$0
29	SDMC SYSTEM M&O SUPPORT	$2,325,000	$1,162,500	$1,162,500	$0
32	MITA	$2,750,000	$2,475,000	$275,000	$0
33	SSA COSTS FOR HEALTH COVERAGE INFO.	$1,500,000	$750,000	$750,000	$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				
34	MEDICARE BUY-IN QUALITY REVIEW PROJECT	$200,000	$100,000	$100,000	$0
35	FAMILY PACT PROGRAM ADMIN.	$1,207,000	$603,500	$603,500	$0
36	CALIFORNIA HEALTH INTERVIEW SURVEY	$1,000,000	$1,000,000	$0	$0
37	SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES	$950,000	$0	$950,000	$0
38	MMA - DSH ANNUAL INDEPENDENT AUDIT	$899,000	$449,500	$449,500	$0
39	DMC COUNTY UR & QA ADMIN	$6,156,000	$6,156,000	$0	$0
40	IRS REPORTING FOR MIN. ESSENTIAL COVERAGE	$1,024,000	$512,000	$512,000	$0
41	ENCRYPTION OF PHI DATA	$750,000	$375,000	$375,000	$0
42	MEDICARE BENEFICIARY IDENTIFIER	$1,280,000	$1,152,000	$128,000	$0
44	POSTAGE AND PRINTING - THIRD PARTY LIAB.	$740,000	$370,000	$370,000	$0
45	VENDOR FOR AAC RATE STUDY	$325,000	$162,500	$162,500	$0
46	CLINICAL DATA COLLECTION	$4,000,000	$3,525,000	$475,000	$0
47	ETL DATA SOLUTION	$334,000	$250,500	$83,500	$0
48	CCT OUTREACH - ADMINISTRATIVE COSTS	$348,000	$348,000	$0	$0
50	DENTAL PAPD PROJECT MANAGER	$125,000	$93,750	$31,250	$0
51	STATE CONTROLLER'S OFFICE INTERAGENCY AGREEMENT	$173,000	$129,750	$43,250	$0
52	CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT	$100,000	$100,000	$0	$0
54	TAR POSTAGE	$54,000	$27,000	$27,000	$0
57	ELECTRONIC ASSET VERIFICATION PROGRAM	$2,416,000	$1,208,000	$1,208,000	$0
58	MEDICAL INTERPRETERS	$5,205,000	$2,602,500	$2,602,500	$0
112	MANAGED CARE REGULATIONS - MENTAL HEALTH	$27,792,000	$18,528,000	$9,264,000	$0
115	TITLE XXI FEDERAL MATCH REDUCTION OTHER ADMIN	($1,927,000)	($11,720,000)	$9,793,000	$0
	DHCS-OTHER SUBTOTAL	**$1,335,480,000**	**$1,161,449,330**	**$171,722,670**	**$2,308,000**
	DHCS-MEDICAL FI				
59	MEDICAL FI OPERATIONS	$93,135,000	$62,899,000	$30,236,000	$0
60	MEDICAL FI COST REIMBURSEMENT	$35,664,000	$25,362,500	$10,301,500	$0
61	MEDICAL FI HOURLY REIMBURSEMENT	$27,546,000	$21,559,500	$5,986,500	$0
62	MEDICAL FI OTHER ESTIMATED COSTS	$11,280,000	$8,010,000	$3,270,000	$0

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2017-18

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	DHCS-MEDICAL FI				
64	MEDICAL FI MISCELLANEOUS EXPENSES	$2,075,000	$1,400,250	$674,750	$0
65	MEDICAL FI CHANGE ORDERS	$515,000	$386,250	$128,750	$0
66	MEDICAL FI OPTIONAL CONTRACTUAL SERVICES	$804,000	$723,600	$80,400	$0
	DHCS-MEDICAL FI SUBTOTAL	**$171,019,000**	**$120,341,100**	**$50,677,900**	**$0**
	DHCS-HEALTH CARE OPT				
68	HCO COST REIMBURSEMENT	$44,849,000	$23,277,600	$21,571,400	$0
69	HCO OPERATIONS	$40,650,000	$21,096,020	$19,553,980	$0
70	HCO - ENROLLMENT CONTRACTOR COSTS	$16,518,000	$8,572,880	$7,945,120	$0
71	HCO ESR HOURLY REIMBURSEMENT	$14,318,000	$7,431,080	$6,886,920	$0
72	HCO CCI - CAL MEDICONNECT AND MLTSS	$14,200,000	$7,100,000	$7,100,000	$0
73	HCO TAKEOVER	$3,664,000	$1,832,000	$1,832,000	$0
74	HCO TURNOVER	$865,000	$432,500	$432,500	$0
	DHCS-HEALTH CARE OPT SUBTOTAL	**$135,064,000**	**$69,742,080**	**$65,321,920**	**$0**
	DHCS-DENTAL FI				
75	DENTAL FI OPERATIONS	$52,000,000	$34,750,000	$17,250,000	$0
76	DENTAL NEW FI TAKEOVER	$15,616,000	$11,712,000	$3,904,000	$0
77	DENTAL FI HOURLY REIMBURSEMENT	$8,004,000	$6,003,000	$2,001,000	$0
78	DENTAL FI COST REIMBURSEMENT	$5,638,000	$3,012,750	$2,625,250	$0
79	DENTAL BENEFICIARY OUTREACH & ED PROGRAM - ADMIN	$4,133,000	$2,066,500	$2,066,500	$0
80	DENTAL ASO TAKEOVER	$2,947,000	$2,210,250	$736,750	$0
81	DENTAL TREATMENT AUTHORIZATION REQUEST PROCESSING	$2,044,000	$1,169,500	$874,500	$0
82	DENTAL FI FEDERAL RULE - REVALIDATION	$210,000	$105,000	$105,000	$0
83	DENTAL FI CD-MMIS COSTS	$2,196,000	$1,647,000	$549,000	$0
84	DENTAL FI FEDERAL RULE - DATABASE CHECKS	$175,000	$87,500	$87,500	$0
85	DENTAL FI HIPAA ADDENDUM SECURITY RISK ASSESSMENT	$137,000	$102,750	$34,250	$0
86	DENTAL FI CONLAN, SCHWARZMER, STEVENS V. BONTA	$134,000	$67,000	$67,000	$0
87	DENTAL ASO ADMINISTRATION	$18,953,000	$12,125,500	$6,827,500	$0
88	DENTAL NEW FI ADMINISTRATION	$10,598,000	$7,621,000	$2,977,000	$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-DENTAL FI SUBTOTAL	**$122,785,000**	**$82,679,750**	**$40,105,250**	**$0**
	OTHER DEPARTMENTS				
89	PERSONAL CARE SERVICES	$371,080,000	$371,080,000	$0	$0
90	HEALTH-RELATED ACTIVITIES - CDSS	$277,756,000	$277,756,000	$0	$0
91	CALHEERS DEVELOPMENT	$120,477,000	$97,063,980	$23,413,020	$0
92	CDDS ADMINISTRATIVE COSTS	$57,301,000	$57,301,000	$0	$0
93	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$28,553,000	$28,553,000	$0	$0
94	MATERNAL AND CHILD HEALTH	$35,201,000	$35,201,000	$0	$0
95	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	$29,829,000	$29,829,000	$0	$0
96	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	$14,645,000	$10,738,000	$0	$3,907,000
97	ACA OUTREACH AND ENROLLMENT COUNSELORS	$11,711,000	$5,855,500	$0	$5,855,500
98	CLPP CASE MANAGEMENT SERVICES	$4,200,000	$4,200,000	$0	$0
99	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$4,116,000	$4,116,000	$0	$0
100	CALIFORNIA SMOKERS' HELPLINE	$1,000,000	$1,000,000	$0	$0
101	VITAL RECORDS DATA	$961,000	$961,000	$0	$0
102	KIT FOR NEW PARENTS	$1,119,000	$1,119,000	$0	$0
103	VETERANS BENEFITS	$956,000	$956,000	$0	$0
104	CDPH I&E PROGRAM AND EVALUATION	$558,000	$558,000	$0	$0
105	CHHS AGENCY HIPAA FUNDING	$849,000	$849,000	$0	$0
106	MEDI-CAL INPATIENT SERVICES FOR INMATES	$813,000	$813,000	$0	$0
107	MERIT SYSTEM SERVICES FOR COUNTIES	$194,000	$97,000	$97,000	$0
108	CDDS DENTAL SERVICES - ADMIN	$120,000	$0	$0	$120,000
109	PIA EYEWEAR COURIER SERVICE	$341,000	$170,500	$170,500	$0
	OTHER DEPARTMENTS SUBTOTAL	**$961,780,000**	**$928,216,980**	**$23,680,520**	**$9,882,500**
	GRAND TOTAL	**$2,726,128,000**	**$2,362,429,240**	**$351,508,260**	**$12,190,500**

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2017 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2016 ESTIMATE
FISCAL YEAR 2016-17

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	2016-17 APPROPRIATION TOTAL FUNDS	2016-17 APPROPRIATION GENERAL FUNDS	NOV. 2016 EST. FOR 2016-17 TOTAL FUNDS	NOV. 2016 EST. FOR 2016-17 GENERAL FUNDS	MAY 2017 EST. FOR 2016-17 TOTAL FUNDS	MAY 2017 EST. FOR 2016-17 GENERAL FUNDS	DIFF. MAY TO APPROPRIATION TOTAL FUNDS	DIFF. MAY TO APPROPRIATION GENERAL FUNDS	DIFFERENCE MAY TO NOVEMBER TOTAL FUNDS	DIFFERENCE MAY TO NOVEMBER GENERAL FUNDS
		DHCS-OTHER										
1	1	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	$262,614,000	$0	$221,116,000	$0	$147,217,000	$0	($115,397,000)	$0	($73,899,000)	$0
2	2	CCS CASE MANAGEMENT	$190,482,000	$64,871,670	$191,217,000	$64,870,590	$191,546,000	$65,149,580	$1,064,000	$277,910	$329,000	$278,990
4	4	COUNTY SPECIALTY MENTAL HEALTH ADMIN	$109,391,000	$50,000	$110,672,000	$24,000	$110,963,000	$24,000	$1,572,000	($26,000)	$291,000	$0
5	5	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	$58,153,000	$0	$80,760,000	$0	$96,773,000	$0	$38,620,000	$0	$16,013,000	$0
6	6	EPSDT CASE MANAGEMENT	$33,962,000	$12,115,250	$33,962,000	$12,115,250	$33,962,000	$12,115,250	$0	$0	$0	$0
7	7	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	$28,871,000	$4,631,880	$31,057,000	$7,561,800	$30,329,000	$7,197,800	$1,458,000	$2,565,920	($728,000)	($364,000)
8	8	PAVE SYSTEM	$19,566,000	$2,917,350	$24,343,000	$3,135,850	$18,616,000	$2,453,200	($950,000)	($464,150)	($5,727,000)	($682,650)
9	9	SMH MAA	$11,736,000	$0	$21,056,000	$0	$31,681,000	$0	$19,945,000	$0	$10,625,000	$0
10	10	POSTAGE & PRINTING	$19,457,000	$9,870,000	$19,425,000	$9,873,000	$19,625,000	$9,905,000	$168,000	$35,000	$200,000	$32,000
11	11	SMHS COUNTY UR & QA ADMIN	$17,120,000	$215,000	$18,841,000	$0	$18,906,000	$0	$1,786,000	($215,000)	$65,000	$0
12	12	ARRA HITECH INCENTIVE PROGRAM	$24,504,000	$0	$18,617,000	$0	$18,178,000	$0	($6,326,000)	$0	($439,000)	$0
13	13	ACTUARIAL COSTS FOR RATE DEVELOPMENT	$16,872,000	$8,436,000	$16,872,000	$8,436,000	$16,222,000	$8,111,000	($650,000)	($325,000)	($650,000)	($325,000)
14	14	MIS/DSS CONTRACT	$14,481,000	$3,785,750	$14,481,000	$3,785,750	$14,481,000	$3,785,750	$0	$0	$0	$0
15	15	SURS AND MARS SYSTEM REPLACEMENT	$14,262,000	$2,935,500	$14,262,000	$2,935,500	$14,262,000	$2,935,500	$0	$0	$0	$0
16	16	INTERIM AND FINAL COST SETTLEMENTS-SMHS	$13,177,000	$0	$13,177,000	$0	$13,177,000	$0	$0	$0	$0	$0
17	17	CCI-ADMINISTRATIVE COSTS	$11,213,000	$5,606,500	$11,213,000	$5,606,500	$11,213,000	$5,606,500	$0	$0	$0	$0
18	18	PASRR	$11,151,000	$2,787,750	$11,151,000	$2,787,750	$10,248,000	$2,562,000	($903,000)	($225,750)	($903,000)	($225,750)
20	20	LITIGATION RELATED SERVICES	$9,980,000	$4,990,000	$9,980,000	$4,990,000	$9,980,000	$4,990,000	$0	$0	$0	$0
21	21	MEDI-CAL RECOVERY CONTRACTS	$5,741,000	$1,435,250	$9,014,000	$2,253,500	$7,915,000	$1,978,750	$2,174,000	$543,500	($1,099,000)	($274,750)
22	22	NEWBORN HEARING SCREENING PROGRAM	$7,700,000	$3,850,000	$7,700,000	$3,850,000	$7,105,000	$3,552,500	($595,000)	($297,500)	($595,000)	($297,500)
23	23	CA-MMIS GO-FORWARD OVERSIGHT	$9,193,000	$1,167,300	$5,687,000	$568,700	$5,318,000	$772,900	($3,875,000)	($394,400)	($369,000)	$204,200
24	24	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$5,291,000	$1,348,750	$5,291,000	$1,389,750	$5,291,000	$1,389,750	$0	$41,000	$0	$0
26	26	HIPAA CAPITATION PAYMENT REPORTING SYSTEM	$4,987,000	$1,246,750	$4,987,000	$1,246,750	$4,763,000	$1,190,750	($224,000)	($56,000)	($224,000)	($56,000)
27	27	DRUG MEDI-CAL COUNTY ADMINISTRATION	$3,197,000	$0	$4,590,000	$0	$4,710,000	$0	$1,513,000	$0	$120,000	$0
28	28	MEDS MODERNIZATION	$2,915,000	$377,000	$2,942,000	$379,700	$2,942,000	$379,700	$27,000	$2,700	$0	$0
29	29	SDMC SYSTEM M&O SUPPORT	$2,325,000	$1,162,500	$2,325,000	$1,162,500	$2,325,000	$1,162,500	$0	$0	$0	$0

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2017 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2016 ESTIMATE
FISCAL YEAR 2016-17

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	2016-17 APPROPRIATION TOTAL FUNDS	2016-17 APPROPRIATION GENERAL FUNDS	NOV. 2016 EST. FOR 2016-17 TOTAL FUNDS	NOV. 2016 EST. FOR 2016-17 GENERAL FUNDS	MAY 2017 EST. FOR 2016-17 TOTAL FUNDS	MAY 2017 EST. FOR 2016-17 GENERAL FUNDS	DIFF. MAY TO APPROPRIATION TOTAL FUNDS	DIFF. MAY TO APPROPRIATION GENERAL FUNDS	DIFFERENCE MAY TO NOVEMBER TOTAL FUNDS	DIFFERENCE MAY TO NOVEMBER GENERAL FUNDS
		DHCS-OTHER										
30	30	ENROLLMENT ASSIST FOR BHT INSTITUTIONALLY DEEMED	$2,200,000	$1,100,000	$2,200,000	$1,100,000	$2,200,000	$1,100,000	$0	$0	$0	$0
31	31	CA-MMIS GO-FORWARD STATE TRANSITION	$1,825,000	$238,400	$2,090,000	$209,000	$2,090,000	$303,800	$265,000	$65,400	$0	$94,800
32	32	MITA	$1,996,000	$199,600	$1,996,000	$199,600	$1,996,000	$199,600	$0	$0	$0	$0
33	33	SSA COSTS FOR HEALTH COVERAGE INFO.	$1,800,000	$900,000	$1,600,000	$800,000	$949,000	$474,500	($851,000)	($425,500)	($651,000)	($325,500)
34	34	MEDICARE BUY-IN QUALITY REVIEW PROJECT	$1,125,000	$562,500	$1,299,000	$649,500	$174,000	$87,000	($951,000)	($475,500)	($1,125,000)	($562,500)
35	35	FAMILY PACT PROGRAM ADMIN.	$1,207,000	$603,500	$1,207,000	$603,500	$1,207,000	$603,500	$0	$0	$0	$0
36	36	CALIFORNIA HEALTH INTERVIEW SURVEY	$1,000,000	$0	$1,000,000	$0	$1,373,000	$0	$373,000	$0	$373,000	$0
37	37	SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES	$950,000	$950,000	$950,000	$950,000	$950,000	$950,000	$0	$0	$0	$0
38	38	MMA - DSH ANNUAL INDEPENDENT AUDIT	$948,000	$474,000	$938,000	$469,000	$1,091,000	$545,500	$143,000	$71,500	$153,000	$76,500
39	39	DMC COUNTY UR & QA ADMIN	$18,537,000	$0	$206,000	$0	$111,000	$0	($18,426,000)	$0	($95,000)	$0
40	40	IRS REPORTING FOR MIN. ESSENTIAL COVERAGE	$1,400,000	$700,000	$816,000	$408,000	$376,000	$188,000	($1,024,000)	($512,000)	($440,000)	($220,000)
41	41	ENCRYPTION OF PHI DATA	$750,000	$375,000	$750,000	$375,000	$750,000	$375,000	$0	$0	$0	$0
42	42	MEDICARE BENEFICIARY IDENTIFIER	$0	$0	$747,000	$74,700	$335,000	$33,500	$335,000	$33,500	($412,000)	($41,200)
43	43	CA-MMIS PROCUREMENT CONSULTANTS	$1,832,000	$273,200	$729,000	$72,900	$478,000	$69,600	($1,354,000)	($203,600)	($251,000)	($3,300)
44	44	POSTAGE AND PRINTING - THIRD PARTY LIAB.	$753,000	$376,500	$699,000	$349,500	$710,000	$355,000	($43,000)	($21,500)	$11,000	$5,500
45	45	VENDOR FOR AAC RATE STUDY	$645,000	$322,500	$645,000	$322,500	$645,000	$322,500	$0	$0	$0	$0
46	46	CLINICAL DATA COLLECTION	$400,000	$40,000	$468,000	$46,800	$468,000	$46,800	$68,000	$6,800	$0	$0
47	47	ETL DATA SOLUTION	$387,000	$61,500	$406,000	$97,750	$363,000	$87,450	($24,000)	$25,950	($43,000)	($10,300)
48	48	CCT OUTREACH - ADMINISTRATIVE COSTS	$360,000	$0	$360,000	$0	$291,000	$0	($69,000)	$0	($69,000)	$0
50	50	DENTAL PAPD PROJECT MANAGER	$226,000	$56,500	$226,000	$56,500	$226,000	$56,500	$0	$0	$0	$0
51	51	STATE CONTROLLER'S OFFICE INTERAGENCY AGREEMENT	$0	$0	$134,000	$33,500	$32,000	$8,000	$32,000	$8,000	($102,000)	($25,500)
52	52	CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT	$100,000	$0	$100,000	$0	$100,000	$0	$0	$0	$0	$0
53	53	PREVENTION OF CHRONIC DISEASE GRANT PROJECT	$80,000	$0	$80,000	$0	$80,000	$0	$0	$0	$0	$0
54	54	TAR POSTAGE	$58,000	$29,000	$56,000	$28,000	$54,000	$27,000	($4,000)	($2,000)	($2,000)	($1,000)
55	55	ACA EXPANSION ADMIN COSTS	$0	$0	$55,000	$27,500	$86,000	$43,000	$86,000	$43,000	$31,000	$15,500

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2017 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2016 ESTIMATE
FISCAL YEAR 2016-17

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	2016-17 APPROPRIATION TOTAL FUNDS	2016-17 APPROPRIATION GENERAL FUNDS	NOV. 2016 EST. FOR 2016-17 TOTAL FUNDS	NOV. 2016 EST. FOR 2016-17 GENERAL FUNDS	MAY 2017 EST. FOR 2016-17 TOTAL FUNDS	MAY 2017 EST. FOR 2016-17 GENERAL FUNDS	DIFF. MAY TO APPROPRIATION TOTAL FUNDS	DIFF. MAY TO APPROPRIATION GENERAL FUNDS	DIFFERENCE MAY TO NOVEMBER TOTAL FUNDS	DIFFERENCE MAY TO NOVEMBER GENERAL FUNDS
		DHCS-OTHER										
56	56	EPOCRATES	$48,000	$24,000	$9,000	$4,500	$9,000	$4,500	($39,000)	($19,500)	$0	$0
3	--	MH/UCD & BTR – LIHP – ADMINISTRATIVE COSTS	$59,024,000	$0	$119,816,000	$0	$0	$0	($59,024,000)	$0	($119,816,000)	$0
19	--	PERFORMANCE OUTCOMES SYSTEM	$13,637,000	$6,818,500	$10,174,000	$5,087,000	$0	$0	($13,637,000)	($6,818,500)	($10,174,000)	($5,087,000)
25	--	CA-MMIS MEDCOMPASS SOLUTION	$5,000,000	$500,000	$5,000,000	$500,000	$0	$0	($5,000,000)	($500,000)	($5,000,000)	($500,000)
49	--	UNIVERSAL ASSESSMENT TOOL	$250,000	$0	$249,000	$0	$0	$0	($250,000)	$0	($249,000)	$0
58	--	MEDICAL INTERPRETERS	$6,000,000	$3,000,000	$6,000,000	$3,000,000	$0	$0	($6,000,000)	($3,000,000)	($6,000,000)	($3,000,000)
--	--	RECOVERY AUDIT CONTRACTOR COSTS	$138,000	$69,000	$0	$0	$0	$0	($138,000)	($69,000)	$0	$0
		DHCS-OTHER SUBTOTAL	**$1,031,017,000**	**$151,473,900**	**$1,065,743,000**	**$152,437,640**	**$864,892,000**	**$141,143,180**	**($166,125,000)**	**($10,330,720)**	**($200,851,000)**	**($11,294,460)**
		DHCS-MEDICAL FI										
59	59	MEDICAL FI OPERATIONS	$91,354,000	$29,677,750	$94,273,000	$30,699,500	$94,123,000	$30,557,750	$2,769,000	$880,000	($150,000)	($141,750)
60	60	MEDICAL FI COST REIMBURSEMENT	$37,843,000	$11,319,300	$36,539,000	$10,137,300	$38,228,000	$9,970,700	$385,000	($1,348,600)	$1,689,000	($166,600)
61	61	MEDICAL FI HOURLY REIMBURSEMENT	$27,546,000	$6,135,000	$27,551,000	$5,987,750	$27,551,000	$5,987,750	$5,000	($147,250)	$0	$0
62	62	MEDICAL FI OTHER ESTIMATED COSTS	$9,740,000	$2,885,000	$16,980,000	$4,695,000	$11,280,000	$3,270,000	$1,540,000	$385,000	($5,700,000)	($1,425,000)
63	63	MEDICAL FI GO-FORWARD AND CLOSE OUT ACTIVITIES	$5,000,000	$1,250,000	$5,000,000	$500,000	$5,000,000	$727,300	$0	($522,700)	$0	$227,300
64	64	MEDICAL FI MISCELLANEOUS EXPENSES	$2,152,000	$723,000	$2,120,000	$691,000	$2,100,000	$681,000	($52,000)	($42,000)	($20,000)	($10,000)
65	65	MEDICAL FI CHANGE ORDERS	$1,580,000	$415,000	$633,000	$173,750	$486,000	$137,000	($1,094,000)	($278,000)	($147,000)	($36,750)
67	67	CA-MMIS XEROX SETTLEMENT AGREEMENT	($41,320,000)	($41,320,000)	($41,320,000)	($41,320,000)	($41,320,000)	($41,320,000)	$0	$0	$0	$0
66	--	MEDICAL FI OPTIONAL CONTRACTUAL SERVICES	$804,000	$80,400	$804,000	$80,400	$0	$0	($804,000)	($80,400)	($804,000)	($80,400)
		DHCS-MEDICAL FI SUBTOTAL	**$134,699,000**	**$11,165,450**	**$142,580,000**	**$11,644,700**	**$137,448,000**	**$10,011,500**	**$2,749,000**	**($1,153,950)**	**($5,132,000)**	**($1,633,200)**
		DHCS-HEALTH CARE OPT										
68	68	HCO COST REIMBURSEMENT	$46,094,000	$22,170,340	$41,644,000	$20,029,700	$41,644,000	$20,029,700	($4,450,000)	($2,140,640)	$0	$0
69	69	HCO OPERATIONS	$39,189,000	$18,851,600	$39,189,000	$18,851,600	$39,189,000	$18,851,600	$0	$0	$0	$0
70	70	HCO - ENROLLMENT CONTRACTOR COSTS	$10,262,000	$4,936,440	$15,560,000	$7,484,740	$15,560,000	$7,484,740	$5,298,000	$2,548,300	$0	$0
71	71	HCO ESR HOURLY REIMBURSEMENT	$14,013,000	$6,740,120	$14,013,000	$6,740,120	$14,013,000	$6,740,120	$0	$0	$0	$0

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2017 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2016 ESTIMATE
FISCAL YEAR 2016-17

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	2016-17 APPROPRIATION TOTAL FUNDS	2016-17 APPROPRIATION GENERAL FUNDS	NOV. 2016 EST. FOR 2016-17 TOTAL FUNDS	NOV. 2016 EST. FOR 2016-17 GENERAL FUNDS	MAY 2017 EST. FOR 2016-17 TOTAL FUNDS	MAY 2017 EST. FOR 2016-17 GENERAL FUNDS	DIFF. MAY TO APPROPRIATION TOTAL FUNDS	DIFF. MAY TO APPROPRIATION GENERAL FUNDS	DIFFERENCE MAY TO NOVEMBER TOTAL FUNDS	DIFFERENCE MAY TO NOVEMBER GENERAL FUNDS
		DHCS-HEALTH CARE OPT										
72	72	HCO CCI - CAL MEDICONNECT AND MLTSS	$11,665,000	$5,832,500	$13,514,000	$6,757,000	$13,514,000	$6,757,000	$1,849,000	$924,500	$0	$0
		DHCS-HEALTH CARE OPT SUBTOTAL	**$121,223,000**	**$58,531,000**	**$123,920,000**	**$59,863,160**	**$123,920,000**	**$59,863,160**	**$2,697,000**	**$1,332,160**	**$0**	**$0**
		DHCS-DENTAL FI										
75	75	DENTAL FI OPERATIONS	$81,305,000	$26,183,750	$101,593,000	$34,021,500	$98,000,000	$32,500,000	$16,695,000	$6,316,250	($3,593,000)	($1,521,500)
76	76	DENTAL NEW FI TAKEOVER	$0	$0	$7,808,000	$1,952,000	$7,808,000	$1,952,000	$7,808,000	$1,952,000	$0	$0
77	77	DENTAL FI HOURLY REIMBURSEMENT	$12,643,000	$3,160,750	$12,765,000	$3,191,250	$12,765,000	$3,191,250	$122,000	$30,500	$0	$0
78	78	DENTAL FI COST REIMBURSEMENT	$8,636,000	$4,135,750	$9,910,000	$4,597,500	$10,951,000	$5,118,000	$2,315,000	$982,250	$1,041,000	$520,500
79	79	DENTAL BENEFICIARY OUTREACH & ED PROGRAM - ADMIN	$3,064,000	$1,325,000	$4,086,000	$2,043,000	$681,000	$340,500	($2,383,000)	($984,500)	($3,405,000)	($1,702,500)
80	80	DENTAL ASO TAKEOVER	$0	$0	$1,473,000	$368,250	$1,473,000	$368,250	$1,473,000	$368,250	$0	$0
81	81	DENTAL TREATMENT AUTHORIZATION REQUEST PROCESSING	$2,068,000	$967,500	$2,028,000	$870,500	$744,000	$324,250	($1,324,000)	($643,250)	($1,284,000)	($546,250)
82	82	DENTAL FI FEDERAL RULE - REVALIDATION	$1,474,000	$737,000	$1,200,000	$600,000	$400,000	$200,000	($1,074,000)	($537,000)	($800,000)	($400,000)
83	83	DENTAL FI CD-MMIS COSTS	$1,096,000	$274,000	$137,000	$34,250	$137,000	$34,250	($959,000)	($239,750)	$0	$0
84	84	DENTAL FI FEDERAL RULE - DATABASE CHECKS	$400,000	$200,000	$410,000	$205,000	$340,000	$170,000	($60,000)	($30,000)	($70,000)	($35,000)
85	85	DENTAL FI HIPAA ADDENDUM SECURITY RISK ASSESSMENT	$320,000	$80,000	$260,000	$65,000	$260,000	$65,000	($60,000)	($15,000)	$0	$0
86	86	DENTAL FI CONLAN, SCHWARZMER, STEVENS V. BONTA	$205,000	$102,500	$255,000	$127,500	$255,000	$127,500	$50,000	$25,000	$0	$0
		DHCS-DENTAL FI SUBTOTAL	**$111,211,000**	**$37,166,250**	**$141,925,000**	**$48,075,750**	**$133,814,000**	**$44,391,000**	**$22,603,000**	**$7,224,750**	**($8,111,000)**	**($3,684,750)**
		OTHER DEPARTMENTS										
89	89	PERSONAL CARE SERVICES	$298,285,000	$0	$367,891,000	$0	$364,530,000	$0	$66,245,000	$0	($3,361,000)	$0
90	90	HEALTH-RELATED ACTIVITIES - CDSS	$262,375,000	$0	$272,795,000	$0	$270,590,000	$0	$8,215,000	$0	($2,205,000)	$0
91	91	CALHEERS DEVELOPMENT	$133,649,000	$27,100,850	$131,870,000	$26,756,340	$131,661,000	$26,708,510	($1,988,000)	($392,340)	($209,000)	($47,830)
92	92	CDDS ADMINISTRATIVE COSTS	$44,254,000	$0	$49,290,000	$0	$54,966,000	$0	$10,712,000	$0	$5,676,000	$0

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2017 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2016 ESTIMATE
FISCAL YEAR 2016-17

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	2016-17 APPROPRIATION TOTAL FUNDS	2016-17 APPROPRIATION GENERAL FUNDS	NOV. 2016 EST. FOR 2016-17 TOTAL FUNDS	NOV. 2016 EST. FOR 2016-17 GENERAL FUNDS	MAY 2017 EST. FOR 2016-17 TOTAL FUNDS	MAY 2017 EST. FOR 2016-17 GENERAL FUNDS	DIFF. MAY TO APPROPRIATION TOTAL FUNDS	DIFF. MAY TO APPROPRIATION GENERAL FUNDS	DIFFERENCE MAY TO NOVEMBER TOTAL FUNDS	DIFFERENCE MAY TO NOVEMBER GENERAL FUNDS
		OTHER DEPARTMENTS										
93	93	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$29,976,000	$0	$27,676,000	$0	$27,676,000	$0	($2,300,000)	$0	$0	$0
94	94	MATERNAL AND CHILD HEALTH	$29,893,000	$0	$29,049,000	$0	$29,049,000	$0	($844,000)	$0	$0	$0
95	95	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	$29,829,000	$0	$29,829,000	$0	$29,829,000	$0	$0	$0	$0	$0
96	96	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	$15,281,000	$0	$10,638,000	$0	$14,641,000	$0	($640,000)	$0	$4,003,000	$0
97	97	ACA OUTREACH AND ENROLLMENT COUNSELORS	$6,305,000	$0	$11,931,000	$0	$14,032,000	$0	$7,727,000	$0	$2,101,000	$0
98	98	CLPP CASE MANAGEMENT SERVICES	$4,200,000	$0	$4,818,000	$0	$4,818,000	$0	$618,000	$0	$0	$0
99	99	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$4,085,000	$0	$3,907,000	$0	$3,910,000	$0	($175,000)	$0	$3,000	$0
100	100	CALIFORNIA SMOKERS' HELPLINE	$1,000,000	$0	$1,287,000	$0	$1,287,000	$0	$287,000	$0	$0	$0
101	101	VITAL RECORDS DATA	$883,000	$0	$1,141,000	$0	$856,000	$0	($27,000)	$0	($285,000)	$0
102	102	KIT FOR NEW PARENTS	$1,119,000	$0	$1,119,000	$0	$1,119,000	$0	$0	$0	$0	$0
103	103	VETERANS BENEFITS	$956,000	$0	$956,000	$0	$956,000	$0	$0	$0	$0	$0
104	104	CDPH I&E PROGRAM AND EVALUATION	$946,000	$0	$686,000	$0	$686,000	$0	($260,000)	$0	$0	$0
105	105	CHHS AGENCY HIPAA FUNDING	$849,000	$0	$849,000	$0	$849,000	$0	$0	$0	$0	$0
106	106	MEDI-CAL INPATIENT SERVICES FOR INMATES	$1,017,000	$0	$813,000	$0	$813,000	$0	($204,000)	$0	$0	$0
107	107	MERIT SYSTEM SERVICES FOR COUNTIES	$195,000	$97,500	$198,000	$99,000	$198,000	$99,000	$3,000	$1,500	$0	$0
108	108	CDDS DENTAL SERVICES - ADMIN	$120,000	$0	$120,000	$0	$120,000	$0	$0	$0	$0	$0
109	109	PIA EYEWEAR COURIER SERVICE	$382,000	$191,000	$385,000	$192,500	$341,000	$170,500	($41,000)	($20,500)	($44,000)	($22,000)
		OTHER DEPARTMENTS SUBTOTAL	**$865,599,000**	**$27,389,350**	**$947,248,000**	**$27,047,840**	**$952,927,000**	**$26,978,010**	**$87,328,000**	**($411,340)**	**$5,679,000**	**($69,830)**
		OTHER ADMINISTRATION TOTAL	**$2,263,749,000**	**$285,725,950**	**$2,421,416,000**	**$299,069,090**	**$2,213,001,000**	**$282,386,850**	**($50,748,000)**	**($3,339,100)**	**($208,415,000)**	**($16,682,240)**
		GRAND TOTAL COUNTY AND OTHER ADMINISTRATION	**$4,536,190,000**	**$968,304,950**	**$4,686,223,000**	**$979,760,590**	**$4,477,026,000**	**$968,187,350**	**($59,164,000)**	**($117,600)**	**($209,197,000)**	**($11,573,240)**

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2017 ESTIMATE COMPARED TO NOVEMBER 2016 ESTIMATE
FISCAL YEAR 2017-18

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2016 EST. FOR 2017-18		MAY 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	$419,225,000	$0	$495,234,000	$0	$76,009,000	$0
2	2	CCS CASE MANAGEMENT	$180,745,000	$58,682,750	$196,000,000	$66,690,000	$15,255,000	$8,007,250
--	3	MH/UCD & BTR – LIHP – ADMINISTRATIVE COSTS	$0	$0	$119,816,000	$0	$119,816,000	$0
4	4	COUNTY SPECIALTY MENTAL HEALTH ADMIN	$114,382,000	$121,000	$115,824,000	$121,000	$1,442,000	$0
5	5	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	$73,655,000	$0	$76,169,000	$0	$2,514,000	$0
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	$33,704,000	$8,166,720	$0	$0
8	8	PAVE SYSTEM	$6,660,000	$1,317,600	$18,562,000	$2,686,150	$11,902,000	$1,368,550
9	9	SMH MAA	$21,551,000	$0	$32,512,000	$0	$10,961,000	$0
10	10	POSTAGE & PRINTING	$19,466,000	$9,893,500	$19,820,000	$10,002,500	$354,000	$109,000
11	11	SMHS COUNTY UR & QA ADMIN	$20,606,000	$415,000	$20,876,000	$415,000	$270,000	$0
12	12	ARRA HITECH INCENTIVE PROGRAM	$16,077,000	$0	$18,729,000	$0	$2,652,000	$0
13	13	ACTUARIAL COSTS FOR RATE DEVELOPMENT	$16,872,000	$8,436,000	$16,872,000	$8,119,000	$0	($317,000)
14	14	MIS/DSS CONTRACT	$11,379,000	$3,013,750	$11,379,000	$3,013,750	$0	$0
15	15	SURS AND MARS SYSTEM REPLACEMENT	$10,790,000	$1,977,050	$10,790,000	$1,977,050	$0	$0
--	16	INTERIM AND FINAL COST SETTLEMENTS-SMHS	$0	$0	($25,692,000)	$0	($25,692,000)	$0
17	17	CCI-ADMINISTRATIVE COSTS	$11,213,000	$5,606,500	$11,213,000	$5,606,500	$0	$0
18	18	PASRR	$10,846,000	$2,711,500	$11,699,000	$2,924,750	$853,000	$213,250
19	19	PERFORMANCE OUTCOMES SYSTEM	$13,637,000	$6,818,500	$14,952,000	$6,190,000	$1,315,000	($628,500)
20	20	LITIGATION RELATED SERVICES	$9,980,000	$4,990,000	$9,980,000	$4,990,000	$0	$0
21	21	MEDI-CAL RECOVERY CONTRACTS	$9,136,000	$2,284,000	$10,218,000	$2,554,500	$1,082,000	$270,500
22	22	NEWBORN HEARING SCREENING PROGRAM	$7,700,000	$3,850,000	$7,800,000	$3,900,000	$100,000	$50,000

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2017 ESTIMATE COMPARED TO NOVEMBER 2016 ESTIMATE
FISCAL YEAR 2017-18

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2016 EST. FOR 2017-18		MAY 2017 EST. FOR 2017-18		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		DHCS-OTHER						
24	24	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$5,291,000	$1,389,750	$5,291,000	$1,389,750	$0	$0
25	25	CA-MMIS MEDCOMPASS SOLUTION	$1,380,000	$138,000	$1,803,000	$262,500	$423,000	$124,500
26	26	HIPAA CAPITATION PAYMENT REPORTING SYSTEM	$4,987,000	$1,246,750	$4,931,000	$1,232,750	($56,000)	($14,000)
27	27	DRUG MEDI-CAL COUNTY ADMINISTRATION	$3,251,000	$0	$3,310,000	$0	$59,000	$0
29	29	SDMC SYSTEM M&O SUPPORT	$2,325,000	$1,162,500	$2,325,000	$1,162,500	$0	$0
32	32	MITA	$2,750,000	$275,000	$2,750,000	$275,000	$0	$0
33	33	SSA COSTS FOR HEALTH COVERAGE INFO.	$1,700,000	$850,000	$1,500,000	$750,000	($200,000)	($100,000)
34	34	MEDICARE BUY-IN QUALITY REVIEW PROJECT	$1,875,000	$937,500	$200,000	$100,000	($1,675,000)	($837,500)
35	35	FAMILY PACT PROGRAM ADMIN.	$1,207,000	$603,500	$1,207,000	$603,500	$0	$0
36	36	CALIFORNIA HEALTH INTERVIEW SURVEY	$1,000,000	$0	$1,000,000	$0	$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	$908,000	$454,000	$899,000	$449,500	($9,000)	($4,500)
39	39	DMC COUNTY UR & QA ADMIN	$5,951,000	$0	$6,156,000	$0	$205,000	$0
40	40	IRS REPORTING FOR MIN. ESSENTIAL COVERAGE	$584,000	$292,000	$1,024,000	$512,000	$440,000	$220,000
41	41	ENCRYPTION OF PHI DATA	$750,000	$375,000	$750,000	$375,000	$0	$0
42	42	MEDICARE BENEFICIARY IDENTIFIER	$1,280,000	$128,000	$1,280,000	$128,000	$0	$0
44	44	POSTAGE AND PRINTING - THIRD PARTY LIAB.	$699,000	$349,500	$740,000	$370,000	$41,000	$20,500
--	45	VENDOR FOR AAC RATE STUDY	$0	$0	$325,000	$162,500	$325,000	$162,500
46	46	CLINICAL DATA COLLECTION	$4,000,000	$400,000	$4,000,000	$475,000	$0	$75,000
47	47	ETL DATA SOLUTION	$312,000	$78,000	$334,000	$83,500	$22,000	$5,500
48	48	CCT OUTREACH - ADMINISTRATIVE COSTS	$348,000	$0	$348,000	$0	$0	$0

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2017 ESTIMATE COMPARED TO NOVEMBER 2016 ESTIMATE
FISCAL YEAR 2017-18

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2016 EST. FOR 2017-18		MAY 2017 EST. FOR 2017-18		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		DHCS-OTHER						
--	50	DENTAL PAPD PROJECT MANAGER	$0	$0	$125,000	$31,250	$125,000	$31,250
51	51	STATE CONTROLLER'S OFFICE INTERAGENCY AGREEMENT	$72,000	$18,000	$173,000	$43,250	$101,000	$25,250
52	52	CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT	$100,000	$0	$100,000	$0	$0	$0
54	54	TAR POSTAGE	$56,000	$28,000	$54,000	$27,000	($2,000)	($1,000)
57	57	ELECTRONIC ASSET VERIFICATION PROGRAM	$2,416,000	$1,208,000	$2,416,000	$1,208,000	$0	$0
--	58	MEDICAL INTERPRETERS	$0	$0	$5,205,000	$2,602,500	$5,205,000	$2,602,500
112	112	MANAGED CARE REGULATIONS - MENTAL HEALTH	$27,978,000	$9,326,000	$27,792,000	$9,264,000	($186,000)	($62,000)
--	115	TITLE XXI FEDERAL MATCH REDUCTION OTHER ADMIN	$0	$0	($1,927,000)	$9,793,000	($1,927,000)	$9,793,000
		DHCS-OTHER SUBTOTAL	**$1,113,756,000**	**$150,608,620**	**$1,335,480,000**	**$171,722,670**	**$221,724,000**	**$21,114,050**
		DHCS-MEDICAL FI						
59	59	MEDICAL FI OPERATIONS	$92,683,000	$30,142,750	$93,135,000	$30,236,000	$452,000	$93,250
60	60	MEDICAL FI COST REIMBURSEMENT	$35,896,000	$10,689,500	$35,664,000	$10,301,500	($232,000)	($388,000)
61	61	MEDICAL FI HOURLY REIMBURSEMENT	$27,546,000	$5,986,500	$27,546,000	$5,986,500	$0	$0
62	62	MEDICAL FI OTHER ESTIMATED COSTS	$16,980,000	$4,695,000	$11,280,000	$3,270,000	($5,700,000)	($1,425,000)
64	64	MEDICAL FI MISCELLANEOUS EXPENSES	$2,095,000	$684,750	$2,075,000	$674,750	($20,000)	($10,000)
65	65	MEDICAL FI CHANGE ORDERS	$693,000	$173,250	$515,000	$128,750	($178,000)	($44,500)
--	66	MEDICAL FI OPTIONAL CONTRACTUAL SERVICES	$0	$0	$804,000	$80,400	$804,000	$80,400
		DHCS-MEDICAL FI SUBTOTAL	**$175,893,000**	**$52,371,750**	**$171,019,000**	**$50,677,900**	**($4,874,000)**	**($1,693,850)**
		DHCS-HEALTH CARE OPT						
68	68	HCO COST REIMBURSEMENT	$44,849,000	$21,571,400	$44,849,000	$21,571,400	$0	$0
69	69	HCO OPERATIONS	$40,650,000	$19,553,980	$40,650,000	$19,553,980	$0	$0
70	70	HCO - ENROLLMENT CONTRACTOR COSTS	$16,518,000	$7,945,120	$16,518,000	$7,945,120	$0	$0

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2017 ESTIMATE COMPARED TO NOVEMBER 2016 ESTIMATE
FISCAL YEAR 2017-18

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2016 EST. FOR 2017-18		MAY 2017 EST. FOR 2017-18		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		DHCS-HEALTH CARE OPT						
71	71	HCO ESR HOURLY REIMBURSEMENT	$14,318,000	$6,886,920	$14,318,000	$6,886,920	$0	$0
72	72	HCO CCI - CAL MEDICONNECT AND MLTSS	$14,200,000	$7,100,000	$14,200,000	$7,100,000	$0	$0
73	73	HCO TAKEOVER	$3,664,000	$1,832,000	$3,664,000	$1,832,000	$0	$0
74	74	HCO TURNOVER	$856,000	$428,000	$865,000	$432,500	$9,000	$4,500
		DHCS-HEALTH CARE OPT SUBTOTAL	**$135,055,000**	**$65,317,420**	**$135,064,000**	**$65,321,920**	**$9,000**	**$4,500**
		DHCS-DENTAL FI						
75	75	DENTAL FI OPERATIONS	$52,601,000	$17,618,750	$52,000,000	$17,250,000	($601,000)	($368,750)
76	76	DENTAL NEW FI TAKEOVER	$15,616,000	$3,904,000	$15,616,000	$3,904,000	$0	$0
77	77	DENTAL FI HOURLY REIMBURSEMENT	$7,642,000	$1,910,500	$8,004,000	$2,001,000	$362,000	$90,500
78	78	DENTAL FI COST REIMBURSEMENT	$5,175,000	$2,404,000	$5,638,000	$2,625,250	$463,000	$221,250
79	79	DENTAL BENEFICIARY OUTREACH & ED PROGRAM - ADMIN	$4,138,000	$2,069,000	$4,133,000	$2,066,500	($5,000)	($2,500)
80	80	DENTAL ASO TAKEOVER	$2,947,000	$736,750	$2,947,000	$736,750	$0	$0
81	81	DENTAL TREATMENT AUTHORIZATION REQUEST PROCESSING	$349,000	$174,500	$2,044,000	$874,500	$1,695,000	$700,000
82	82	DENTAL FI FEDERAL RULE - REVALIDATION	$616,000	$308,000	$210,000	$105,000	($406,000)	($203,000)
83	83	DENTAL FI CD-MMIS COSTS	$2,196,000	$549,000	$2,196,000	$549,000	$0	$0
84	84	DENTAL FI FEDERAL RULE - DATABASE CHECKS	$211,000	$105,500	$175,000	$87,500	($36,000)	($18,000)
85	85	DENTAL FI HIPAA ADDENDUM SECURITY RISK ASSESSMENT	$130,000	$32,500	$137,000	$34,250	$7,000	$1,750
86	86	DENTAL FI CONLAN, SCHWARZMER, STEVENS V. BONTA	$127,000	$63,500	$134,000	$67,000	$7,000	$3,500
87	87	DENTAL ASO ADMINISTRATION	$20,251,000	$7,321,750	$18,953,000	$6,827,500	($1,298,000)	($494,250)
88	88	DENTAL NEW FI ADMINISTRATION	$11,302,000	$3,172,500	$10,598,000	$2,977,000	($704,000)	($195,500)
		DHCS-DENTAL FI SUBTOTAL	**$123,301,000**	**$40,370,250**	**$122,785,000**	**$40,105,250**	**($516,000)**	**($265,000)**

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2017 ESTIMATE COMPARED TO NOVEMBER 2016 ESTIMATE
FISCAL YEAR 2017-18

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2016 EST. FOR 2017-18		MAY 2017 EST. FOR 2017-18		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER DEPARTMENTS						
89	89	PERSONAL CARE SERVICES	$374,475,000	$0	$371,080,000	$0	($3,395,000)	$0
90	90	HEALTH-RELATED ACTIVITIES - CDSS	$285,731,000	$0	$277,756,000	$0	($7,975,000)	$0
91	91	CALHEERS DEVELOPMENT	$120,477,000	$23,413,020	$120,477,000	$23,413,020	$0	$0
92	92	CDDS ADMINISTRATIVE COSTS	$58,629,000	$0	$57,301,000	$0	($1,328,000)	$0
93	93	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$28,553,000	$0	$28,553,000	$0	$0	$0
94	94	MATERNAL AND CHILD HEALTH	$29,886,000	$0	$35,201,000	$0	$5,315,000	$0
95	95	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	$29,829,000	$0	$29,829,000	$0	$0	$0
96	96	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	$10,665,000	$0	$14,645,000	$0	$3,980,000	$0
97	97	ACA OUTREACH AND ENROLLMENT COUNSELORS	$11,776,000	$0	$11,711,000	$0	($65,000)	$0
98	98	CLPP CASE MANAGEMENT SERVICES	$4,200,000	$0	$4,200,000	$0	$0	$0
99	99	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$4,116,000	$0	$4,116,000	$0	$0	$0
100	100	CALIFORNIA SMOKERS' HELPLINE	$1,000,000	$0	$1,000,000	$0	$0	$0
101	101	VITAL RECORDS DATA	$901,000	$0	$961,000	$0	$60,000	$0
102	102	KIT FOR NEW PARENTS	$1,119,000	$0	$1,119,000	$0	$0	$0
103	103	VETERANS BENEFITS	$1,100,000	$0	$956,000	$0	($144,000)	$0
104	104	CDPH I&E PROGRAM AND EVALUATION	$558,000	$0	$558,000	$0	$0	$0
105	105	CHHS AGENCY HIPAA FUNDING	$849,000	$0	$849,000	$0	$0	$0
106	106	MEDI-CAL INPATIENT SERVICES FOR INMATES	$813,000	$0	$813,000	$0	$0	$0
107	107	MERIT SYSTEM SERVICES FOR COUNTIES	$194,000	$97,000	$194,000	$97,000	$0	$0
108	108	CDDS DENTAL SERVICES - ADMIN	$120,000	$0	$120,000	$0	$0	$0
109	109	PIA EYEWEAR COURIER SERVICE	$385,000	$192,500	$341,000	$170,500	($44,000)	($22,000)

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2017 ESTIMATE COMPARED TO NOVEMBER 2016 ESTIMATE
FISCAL YEAR 2017-18

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2016 EST. FOR 2017-18		MAY 2017 EST. FOR 2017-18		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER DEPARTMENTS SUBTOTAL	$965,376,000	$23,702,520	$961,780,000	$23,680,520	($3,596,000)	($22,000)
		OTHER ADMINISTRATION TOTAL	$2,513,381,000	$332,370,560	$2,726,128,000	$351,508,260	$212,747,000	$19,137,700
		GRAND TOTAL COUNTY AND OTHER ADMINISTRATION	$4,796,802,000	$1,011,752,060	$4,997,575,000	$1,115,098,760	$200,773,000	$103,346,700

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2016-17 AND 2017-18

NO.	POLICY CHANGE TITLE	MAY 2017 EST. FOR 2016-17		MAY 2017 EST. FOR 2017-18		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	DHCS-OTHER						
1	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	$147,217,000	$0	$495,234,000	$0	$348,017,000	$0
2	CCS CASE MANAGEMENT	$191,546,000	$65,149,580	$196,000,000	$66,690,000	$4,454,000	$1,540,420
3	MH/UCD & BTR – LIHP – ADMINISTRATIVE COSTS	$0	$0	$119,816,000	$0	$119,816,000	$0
4	COUNTY SPECIALTY MENTAL HEALTH ADMIN	$110,963,000	$24,000	$115,824,000	$121,000	$4,861,000	$97,000
5	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	$96,773,000	$0	$76,169,000	$0	($20,604,000)	$0
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	$30,329,000	$7,197,800	$33,704,000	$8,166,720	$3,375,000	$968,920
8	PAVE SYSTEM	$18,616,000	$2,453,200	$18,562,000	$2,686,150	($54,000)	$232,950
9	SMH MAA	$31,681,000	$0	$32,512,000	$0	$831,000	$0
10	POSTAGE & PRINTING	$19,625,000	$9,905,000	$19,820,000	$10,002,500	$195,000	$97,500
11	SMHS COUNTY UR & QA ADMIN	$18,906,000	$0	$20,876,000	$415,000	$1,970,000	$415,000
12	ARRA HITECH INCENTIVE PROGRAM	$18,178,000	$0	$18,729,000	$0	$551,000	$0
13	ACTUARIAL COSTS FOR RATE DEVELOPMENT	$16,222,000	$8,111,000	$16,872,000	$8,119,000	$650,000	$8,000
14	MIS/DSS CONTRACT	$14,481,000	$3,785,750	$11,379,000	$3,013,750	($3,102,000)	($772,000)
15	SURS AND MARS SYSTEM REPLACEMENT	$14,262,000	$2,935,500	$10,790,000	$1,977,050	($3,472,000)	($958,450)
16	INTERIM AND FINAL COST SETTLEMENTS-SMHS	$13,177,000	$0	($25,692,000)	$0	($38,869,000)	$0
17	CCI-ADMINISTRATIVE COSTS	$11,213,000	$5,606,500	$11,213,000	$5,606,500	$0	$0
18	PASRR	$10,248,000	$2,562,000	$11,699,000	$2,924,750	$1,451,000	$362,750
19	PERFORMANCE OUTCOMES SYSTEM	$0	$0	$14,952,000	$6,190,000	$14,952,000	$6,190,000
20	LITIGATION RELATED SERVICES	$9,980,000	$4,990,000	$9,980,000	$4,990,000	$0	$0
21	MEDI-CAL RECOVERY CONTRACTS	$7,915,000	$1,978,750	$10,218,000	$2,554,500	$2,303,000	$575,750
22	NEWBORN HEARING SCREENING PROGRAM	$7,105,000	$3,552,500	$7,800,000	$3,900,000	$695,000	$347,500
23	CA-MMIS GO-FORWARD OVERSIGHT	$5,318,000	$772,900	$0	$0	($5,318,000)	($772,900)
24	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$5,291,000	$1,389,750	$5,291,000	$1,389,750	$0	$0

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2016-17 AND 2017-18

NO.	POLICY CHANGE TITLE	MAY 2017 EST. FOR 2016-17		MAY 2017 EST. FOR 2017-18		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	DHCS-OTHER						
25	CA-MMIS MEDCOMPASS SOLUTION	$0	$0	$1,803,000	$262,500	$1,803,000	$262,500
26	HIPAA CAPITATION PAYMENT REPORTING SYSTEM	$4,763,000	$1,190,750	$4,931,000	$1,232,750	$168,000	$42,000
27	DRUG MEDI-CAL COUNTY ADMINISTRATION	$4,710,000	$0	$3,310,000	$0	($1,400,000)	$0
28	MEDS MODERNIZATION	$2,942,000	$379,700	$0	$0	($2,942,000)	($379,700)
29	SDMC SYSTEM M&O SUPPORT	$2,325,000	$1,162,500	$2,325,000	$1,162,500	$0	$0
30	ENROLLMENT ASSIST FOR BHT INSTITUTIONALLY DEEMED	$2,200,000	$1,100,000	$0	$0	($2,200,000)	($1,100,000)
31	CA-MMIS GO-FORWARD STATE TRANSITION	$2,090,000	$303,800	$0	$0	($2,090,000)	($303,800)
32	MITA	$1,996,000	$199,600	$2,750,000	$275,000	$754,000	$75,400
33	SSA COSTS FOR HEALTH COVERAGE INFO.	$949,000	$474,500	$1,500,000	$750,000	$551,000	$275,500
34	MEDICARE BUY-IN QUALITY REVIEW PROJECT	$174,000	$87,000	$200,000	$100,000	$26,000	$13,000
35	FAMILY PACT PROGRAM ADMIN.	$1,207,000	$603,500	$1,207,000	$603,500	$0	$0
36	CALIFORNIA HEALTH INTERVIEW SURVEY	$1,373,000	$0	$1,000,000	$0	($373,000)	$0
37	SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES	$950,000	$950,000	$950,000	$950,000	$0	$0
38	MMA - DSH ANNUAL INDEPENDENT AUDIT	$1,091,000	$545,500	$899,000	$449,500	($192,000)	($96,000)
39	DMC COUNTY UR & QA ADMIN	$111,000	$0	$6,156,000	$0	$6,045,000	$0
40	IRS REPORTING FOR MIN. ESSENTIAL COVERAGE	$376,000	$188,000	$1,024,000	$512,000	$648,000	$324,000
41	ENCRYPTION OF PHI DATA	$750,000	$375,000	$750,000	$375,000	$0	$0
42	MEDICARE BENEFICIARY IDENTIFIER	$335,000	$33,500	$1,280,000	$128,000	$945,000	$94,500
43	CA-MMIS PROCUREMENT CONSULTANTS	$478,000	$69,600	$0	$0	($478,000)	($69,600)
44	POSTAGE AND PRINTING - THIRD PARTY LIAB.	$710,000	$355,000	$740,000	$370,000	$30,000	$15,000
45	VENDOR FOR AAC RATE STUDY	$645,000	$322,500	$325,000	$162,500	($320,000)	($160,000)
46	CLINICAL DATA COLLECTION	$468,000	$46,800	$4,000,000	$475,000	$3,532,000	$428,200
47	ETL DATA SOLUTION	$363,000	$87,450	$334,000	$83,500	($29,000)	($3,950)
48	CCT OUTREACH - ADMINISTRATIVE COSTS	$291,000	$0	$348,000	$0	$57,000	$0
50	DENTAL PAPD PROJECT MANAGER	$226,000	$56,500	$125,000	$31,250	($101,000)	($25,250)

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2016-17 AND 2017-18

NO.	POLICY CHANGE TITLE	MAY 2017 EST. FOR 2016-17		MAY 2017 EST. FOR 2017-18		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	DHCS-OTHER						
51	STATE CONTROLLER'S OFFICE INTERAGENCY AGREEMENT	$32,000	$8,000	$173,000	$43,250	$141,000	$35,250
52	CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT	$100,000	$0	$100,000	$0	$0	$0
53	PREVENTION OF CHRONIC DISEASE GRANT PROJECT	$80,000	$0	$0	$0	($80,000)	$0
54	TAR POSTAGE	$54,000	$27,000	$54,000	$27,000	$0	$0
55	ACA EXPANSION ADMIN COSTS	$86,000	$43,000	$0	$0	($86,000)	($43,000)
56	EPOCRATES	$9,000	$4,500	$0	$0	($9,000)	($4,500)
57	ELECTRONIC ASSET VERIFICATION PROGRAM	$0	$0	$2,416,000	$1,208,000	$2,416,000	$1,208,000
58	MEDICAL INTERPRETERS	$0	$0	$5,205,000	$2,602,500	$5,205,000	$2,602,500
112	MANAGED CARE REGULATIONS - MENTAL HEALTH	$0	$0	$27,792,000	$9,264,000	$27,792,000	$9,264,000
115	TITLE XXI FEDERAL MATCH REDUCTION OTHER ADMIN	$0	$0	($1,927,000)	$9,793,000	($1,927,000)	$9,793,000
	DHCS-OTHER SUBTOTAL	**$864,892,000**	**$141,143,180**	**$1,335,480,000**	**$171,722,670**	**$470,588,000**	**$30,579,490**
	DHCS-MEDICAL FI						
59	MEDICAL FI OPERATIONS	$94,123,000	$30,557,750	$93,135,000	$30,236,000	($988,000)	($321,750)
60	MEDICAL FI COST REIMBURSEMENT	$38,228,000	$9,970,700	$35,664,000	$10,301,500	($2,564,000)	$330,800
61	MEDICAL FI HOURLY REIMBURSEMENT	$27,551,000	$5,987,750	$27,546,000	$5,986,500	($5,000)	($1,250)
62	MEDICAL FI OTHER ESTIMATED COSTS	$11,280,000	$3,270,000	$11,280,000	$3,270,000	$0	$0
63	MEDICAL FI GO-FORWARD AND CLOSE OUT ACTIVITIES	$5,000,000	$727,300	$0	$0	($5,000,000)	($727,300)
64	MEDICAL FI MISCELLANEOUS EXPENSES	$2,100,000	$681,000	$2,075,000	$674,750	($25,000)	($6,250)
65	MEDICAL FI CHANGE ORDERS	$486,000	$137,000	$515,000	$128,750	$29,000	($8,250)
66	MEDICAL FI OPTIONAL CONTRACTUAL SERVICES	$0	$0	$804,000	$80,400	$804,000	$80,400
67	CA-MMIS XEROX SETTLEMENT AGREEMENT	($41,320,000)	($41,320,000)	$0	$0	$41,320,000	$41,320,000
	DHCS-MEDICAL FI SUBTOTAL	**$137,448,000**	**$10,011,500**	**$171,019,000**	**$50,677,900**	**$33,571,000**	**$40,666,400**

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2016-17 AND 2017-18

NO.	POLICY CHANGE TITLE	MAY 2017 EST. FOR 2016-17 TOTAL FUNDS	MAY 2017 EST. FOR 2016-17 GENERAL FUNDS	MAY 2017 EST. FOR 2017-18 TOTAL FUNDS	MAY 2017 EST. FOR 2017-18 GENERAL FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE GENERAL FUNDS
	DHCS-HEALTH CARE OPT						
68	HCO COST REIMBURSEMENT	$41,644,000	$20,029,700	$44,849,000	$21,571,400	$3,205,000	$1,541,700
69	HCO OPERATIONS	$39,189,000	$18,851,600	$40,650,000	$19,553,980	$1,461,000	$702,380
70	HCO - ENROLLMENT CONTRACTOR COSTS	$15,560,000	$7,484,740	$16,518,000	$7,945,120	$958,000	$460,380
71	HCO ESR HOURLY REIMBURSEMENT	$14,013,000	$6,740,120	$14,318,000	$6,886,920	$305,000	$146,800
72	HCO CCI - CAL MEDICONNECT AND MLTSS	$13,514,000	$6,757,000	$14,200,000	$7,100,000	$686,000	$343,000
73	HCO TAKEOVER	$0	$0	$3,664,000	$1,832,000	$3,664,000	$1,832,000
74	HCO TURNOVER	$0	$0	$865,000	$432,500	$865,000	$432,500
	DHCS-HEALTH CARE OPT SUBTOTAL	**$123,920,000**	**$59,863,160**	**$135,064,000**	**$65,321,920**	**$11,144,000**	**$5,458,760**
	DHCS-DENTAL FI						
75	DENTAL FI OPERATIONS	$98,000,000	$32,500,000	$52,000,000	$17,250,000	($46,000,000)	($15,250,000)
76	DENTAL NEW FI TAKEOVER	$7,808,000	$1,952,000	$15,616,000	$3,904,000	$7,808,000	$1,952,000
77	DENTAL FI HOURLY REIMBURSEMENT	$12,765,000	$3,191,250	$8,004,000	$2,001,000	($4,761,000)	($1,190,250)
78	DENTAL FI COST REIMBURSEMENT	$10,951,000	$5,118,000	$5,638,000	$2,625,250	($5,313,000)	($2,492,750)
79	DENTAL BENEFICIARY OUTREACH & ED PROGRAM - ADMIN	$681,000	$340,500	$4,133,000	$2,066,500	$3,452,000	$1,726,000
80	DENTAL ASO TAKEOVER	$1,473,000	$368,250	$2,947,000	$736,750	$1,474,000	$368,500
81	DENTAL TREATMENT AUTHORIZATION REQUEST PROCESSING	$744,000	$324,250	$2,044,000	$874,500	$1,300,000	$550,250
82	DENTAL FI FEDERAL RULE - REVALIDATION	$400,000	$200,000	$210,000	$105,000	($190,000)	($95,000)
83	DENTAL FI CD-MMIS COSTS	$137,000	$34,250	$2,196,000	$549,000	$2,059,000	$514,750
84	DENTAL FI FEDERAL RULE - DATABASE CHECKS	$340,000	$170,000	$175,000	$87,500	($165,000)	($82,500)
85	DENTAL FI HIPAA ADDENDUM SECURITY RISK ASSESSMENT	$260,000	$65,000	$137,000	$34,250	($123,000)	($30,750)
86	DENTAL FI CONLAN, SCHWARZMER, STEVENS V. BONTA	$255,000	$127,500	$134,000	$67,000	($121,000)	($60,500)
87	DENTAL ASO ADMINISTRATION	$0	$0	$18,953,000	$6,827,500	$18,953,000	$6,827,500
88	DENTAL NEW FI ADMINISTRATION	$0	$0	$10,598,000	$2,977,000	$10,598,000	$2,977,000
	DHCS-DENTAL FI SUBTOTAL	**$133,814,000**	**$44,391,000**	**$122,785,000**	**$40,105,250**	**($11,029,000)**	**($4,285,750)**

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2016-17 AND 2017-18

NO.	POLICY CHANGE TITLE	MAY 2017 EST. FOR 2016-17 TOTAL FUNDS	MAY 2017 EST. FOR 2016-17 GENERAL FUNDS	MAY 2017 EST. FOR 2017-18 TOTAL FUNDS	MAY 2017 EST. FOR 2017-18 GENERAL FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE GENERAL FUNDS
	OTHER DEPARTMENTS						
89	PERSONAL CARE SERVICES	$364,530,000	$0	$371,080,000	$0	$6,550,000	$0
90	HEALTH-RELATED ACTIVITIES - CDSS	$270,590,000	$0	$277,756,000	$0	$7,166,000	$0
91	CALHEERS DEVELOPMENT	$131,661,000	$26,708,510	$120,477,000	$23,413,020	($11,184,000)	($3,295,490)
92	CDDS ADMINISTRATIVE COSTS	$54,966,000	$0	$57,301,000	$0	$2,335,000	$0
93	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$27,676,000	$0	$28,553,000	$0	$877,000	$0
94	MATERNAL AND CHILD HEALTH	$29,049,000	$0	$35,201,000	$0	$6,152,000	$0
95	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	$29,829,000	$0	$29,829,000	$0	$0	$0
96	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	$14,641,000	$0	$14,645,000	$0	$4,000	$0
97	ACA OUTREACH AND ENROLLMENT COUNSELORS	$14,032,000	$0	$11,711,000	$0	($2,321,000)	$0
98	CLPP CASE MANAGEMENT SERVICES	$4,818,000	$0	$4,200,000	$0	($618,000)	$0
99	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$3,910,000	$0	$4,116,000	$0	$206,000	$0
100	CALIFORNIA SMOKERS' HELPLINE	$1,287,000	$0	$1,000,000	$0	($287,000)	$0
101	VITAL RECORDS DATA	$856,000	$0	$961,000	$0	$105,000	$0
102	KIT FOR NEW PARENTS	$1,119,000	$0	$1,119,000	$0	$0	$0
103	VETERANS BENEFITS	$956,000	$0	$956,000	$0	$0	$0
104	CDPH I&E PROGRAM AND EVALUATION	$686,000	$0	$558,000	$0	($128,000)	$0
105	CHHS AGENCY HIPAA FUNDING	$849,000	$0	$849,000	$0	$0	$0
106	MEDI-CAL INPATIENT SERVICES FOR INMATES	$813,000	$0	$813,000	$0	$0	$0
107	MERIT SYSTEM SERVICES FOR COUNTIES	$198,000	$99,000	$194,000	$97,000	($4,000)	($2,000)
108	CDDS DENTAL SERVICES - ADMIN	$120,000	$0	$120,000	$0	$0	$0
109	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 2016-17 AND 2017-18

NO.	POLICY CHANGE TITLE	MAY 2017 EST. FOR 2016-17		MAY 2017 EST. FOR 2017-18		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER DEPARTMENTS SUBTOTAL	$952,927,000	$26,978,010	$961,780,000	$23,680,520	$8,853,000	($3,297,490)
	OTHER ADMINISTRATION TOTAL	$2,213,001,000	$282,386,850	$2,726,128,000	$351,508,260	$513,127,000	$69,121,410
	GRAND TOTAL COUNTY AND OTHER ADMINISTRATION	$4,477,026,000	$968,187,350	$4,997,575,000	$1,115,098,760	$520,549,000	$146,911,410

MEDI-CAL OTHER ADMINISTRATION
POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	DHCS-OTHER
1	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES
2	CCS CASE MANAGEMENT
3	MH/UCD & BTR – LIHP – ADMINISTRATIVE COSTS
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	PAVE SYSTEM
9	SMH MAA
10	POSTAGE & PRINTING
11	SMHS COUNTY UR & QA ADMIN
12	ARRA HITECH INCENTIVE PROGRAM
13	ACTUARIAL COSTS FOR RATE DEVELOPMENT
14	MIS/DSS CONTRACT
15	SURS AND MARS SYSTEM REPLACEMENT
16	INTERIM AND FINAL COST SETTLEMENTS-SMHS
17	CCI-ADMINISTRATIVE COSTS
18	PASRR
19	PERFORMANCE OUTCOMES SYSTEM
20	LITIGATION RELATED SERVICES
21	MEDI-CAL RECOVERY CONTRACTS
22	NEWBORN HEARING SCREENING PROGRAM
23	CA-MMIS GO-FORWARD OVERSIGHT
24	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)
25	CA-MMIS MEDCOMPASS SOLUTION
26	HIPAA CAPITATION PAYMENT REPORTING SYSTEM
27	DRUG MEDI-CAL COUNTY ADMINISTRATION
28	MEDS MODERNIZATION
29	SDMC SYSTEM M&O SUPPORT
30	ENROLLMENT ASSIST FOR BHT INSTITUTIONALLY DEEMED
31	CA-MMIS GO-FORWARD STATE TRANSITION
32	MITA
33	SSA COSTS FOR HEALTH COVERAGE INFO.
34	MEDICARE BUY-IN QUALITY REVIEW PROJECT
35	FAMILY PACT PROGRAM ADMIN.
36	CALIFORNIA HEALTH INTERVIEW SURVEY
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	DMC COUNTY UR & QA ADMIN
40	IRS REPORTING FOR MIN. ESSENTIAL COVERAGE
41	ENCRYPTION OF PHI DATA
42	MEDICARE BENEFICIARY IDENTIFIER
43	CA-MMIS PROCUREMENT CONSULTANTS
44	POSTAGE AND PRINTING - THIRD PARTY LIAB.
45	VENDOR FOR AAC RATE STUDY
46	CLINICAL DATA COLLECTION
47	ETL DATA SOLUTION
48	CCT OUTREACH - ADMINISTRATIVE COSTS
50	DENTAL PAPD PROJECT MANAGER
51	STATE CONTROLLER'S OFFICE INTERAGENCY AGREEMENT
52	CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT
53	PREVENTION OF CHRONIC DISEASE GRANT PROJECT
54	TAR POSTAGE
55	ACA EXPANSION ADMIN COSTS
56	EPOCRATES
57	ELECTRONIC ASSET VERIFICATION PROGRAM
58	MEDICAL INTERPRETERS
112	MANAGED CARE REGULATIONS - MENTAL HEALTH
115	TITLE XXI FEDERAL MATCH REDUCTION OTHER ADMIN
	DHCS-MEDICAL FI
59	MEDICAL FI OPERATIONS
60	MEDICAL FI COST REIMBURSEMENT
61	MEDICAL FI HOURLY REIMBURSEMENT
62	MEDICAL FI OTHER ESTIMATED COSTS
63	MEDICAL FI GO-FORWARD AND CLOSE OUT ACTIVITIES
64	MEDICAL FI MISCELLANEOUS EXPENSES
65	MEDICAL FI CHANGE ORDERS
66	MEDICAL FI OPTIONAL CONTRACTUAL SERVICES
67	CA-MMIS XEROX SETTLEMENT AGREEMENT
	DHCS-HEALTH CARE OPT
68	HCO COST REIMBURSEMENT
69	HCO OPERATIONS
70	HCO - ENROLLMENT CONTRACTOR COSTS
71	HCO ESR HOURLY REIMBURSEMENT

MEDI-CAL OTHER ADMINISTRATION
POLICY CHANGE INDEX

MEDI-CAL OTHER ADMINISTRATION
POLICY CHANGE INDEX

SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 1
IMPLEMENTATION DATE: 7/1992
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 235

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$147,217,000	$495,234,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$147,217,000	$495,234,000

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.

SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 1

Reason for Change:
The net decrease from the prior estimate, for FY 2016-17, is mainly due to delays in the approval of the revised SMAA Manual and invoice template resulting in FY 2009-10 and FY 2010-11 backcasting payments to be shifted to FY 2017-18. In addition, FY 2014-15 Q2 increased based on actual payments.

The change from the prior estimate, for FY 2017-18, is an increase due to shifting FY 2009-10 and FY 2010-11 backcasting payments, and updated FY 2014-15 Q1 and Q2 backcasting payments.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to backcasting payments and additional quarterly payments that will be made in FY 2017-18.

Methodology:
The FY 2016-17 estimate includes:

1. An estimate of FY 2014-15 claims which are based on FY 2011-12 original claims data, plus a 5% inflation factor. The FY 2011-12 data is the most recent year that returned historically accurate claiming data. Invoices for subsequent fiscal years were significantly reduced through a revised invoice review process developed in response to a CMS Financial Management Review that resulted in the SMAA program being placed on deferral status. As a result, subsequent invoices are not representative of historic SMAA claiming.

2. The FY 2014-15 (Q2) settlement claims which are based on the FY 2013-14 Q2 claims per the 2014 CMS settlement agreement.

3. The FY 2014-15 (Q3) direct charge and non-settlement claims which are based on actual claims received.

4. The FY 2014-15 (Q3) and (Q4) non-settlement claims estimate which are based on the FY 2011-12 original claims increased by a 50% RMTS adjustment factor* in order to account for the new RMTS methodology.

The FY 2017-18 estimate includes:

5. The FY 2015-16 Q1-Q4 RMTS invoice amounts which are based on FY 2011-12 original invoice amounts, plus an additional increase of 50% RMTS adjustment factor* added to each quarter.

6. The backcasting amounts for FY 2009-10 through FY 2013-14 and FY 2014-15 (Q1) and (Q2) which are based on the unallowed amounts remaining for those fiscal years after the application of the 2014 CMS settlement agreement.

Unallowed 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.

SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 1

*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 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.

(Dollars in Thousands)

FY 2016-17	TF	FF
FY 2014-15 Q2 settlement amount	$9,796	$9,796
FY 2014-15 Q3 direct charge and non-settlement amount	$1,920	$1,920
FY 2014-15 Q3 and Q4 non-settlement estimate, plus RMTS adjustment factor of 50%	$135,501	$135,501
Total	**$147,217**	**$147,217**

(Dollars in Thousands)

FY 2017-18	TF	FF
FY 2015-16 (Q1)	$56,567	$56,567
FY 2015-16 (Q2)	$68,257	$68,257
FY 2015-16 (Q3)	$69,417	$69,417
FY 2015-16 (Q4)	$63,856	$63,856
Backcasting FY 2009-10	$9,859	$9,859
Backcasting FY 2010-11	$66,095	$66,095
Backcasting FY 2011-12	$86,614	$86,614
Backcasting FY 2012-13	$37,584	$37,584
Backcasting FY 2013-14	$24,529	$24,529
Backcasting 2014-15 Q1 and Q2	$12,456	$12,456
Total	**$495,234**	**$495,234**

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

CCS CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	2
IMPLEMENTATION DATE:	7/1999
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	230

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$191,546,000	$196,000,000
STATE FUNDS	$65,149,580	$66,690,000
FEDERAL FUNDS	$126,396,420	$129,310,000

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 51 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.

A portion of CCS case management transitioned into the Health Plan of San Mateo (HPSM) beginning April 2013.

Reason for Change:
The change from the prior estimate, for FY 2016-17, is an increase due to updated CMS Net amounts and PPC cost adjustments. The change from the prior estimate, for FY 2017-18, is an increase due to updated CMS Net amounts, PPC cost adjustments, and a delay in implementation of the Whole Child Model. The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to updated CMS Net amounts, PPC cost adjustments, and expected caseload changes.

Methodology:
1. The county administrative estimate for the budget year is updated every May based on additional data collected.

CCS CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 2

2. For FY 2016-17, the CCS case management costs are based on budgeted county expenditures of $155,160,000 in the November 2016 Estimate.

   For FY 2017-18, caseload is expected to increase 2.25% from FY 2016-17 to FY 2017-18.

   $155,160,000 x (1 + 2.25%) = $158,651,000

3. Assume administrative costs of $1,057,000 in both FY 2016-17 and FY 2017-18 for the Medi-Cal expansion of undocumented children which are funded at 100% GF.

4. For FY 2016-17, 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 $271,000 per one nurse and one clerk pair.
   - Of the eleven counties, eight 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.
   - PPC caseload will add 82 additional members and one new nurse and clerk pairs within the existing counties by the end of FY 2016-17.

     $271,000 x 8 (counties) = $2,168,000
     $271,000 x 2 (county) x 2 (pairs of nurse/clerk) = $1,084,000
     $271,000 x 1 (county) x 5 (pairs of nurse/clerk) = $1,355,000
     $2,168,000 + $1,084,000 + $1,355,000 = $4,607,000 costs prior to expansion
     $4,607,000 + $158,000 (expansion Nurse Liaison costs) = $4,765,000

5. 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 $271,000 per one nurse and one clerk pair.
   - Of the eleven counties, seven have 25 or less palliative care participants, three counties has 50 or less palliative care participants, and one counties has 125 or less palliative care participants.
   - PPC caseload will add 60 additional members and two new nurse and clerk pairs within the existing counties by the end of FY 2017-18.

     $271,000 x 7 (counties) = $1,897,000
     $271,000 x 3 (county) x 2 (pairs of nurse/clerk) = $1,626,000
     $271,000 x 1 (county) x 5 (pairs of nurse/clerk) = $1,355,000
     $1,897,000 + $1,626,000 + $1,355,000 = $4,878,000 costs prior to expansion
     $4,878,000 + $768,000 (expansion Nurse Liaison costs) = $5,646,000

6. County data processing costs associated with CMS Net for CCS Medi-Cal are estimated to be $2,089,000 in FY 2016-17 and $2,075,000 in FY 2017-18.

CCS CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 2

7. Medi-Cal Optional Targeted Low Income Children Program (OTLICP) costs are separate from other Medi-Cal costs. Total Medi-Cal OTLICP costs listed below do not include county share of cost:

	FY 2016-17	FY 2017-18
County Administration:	$31,729,000	$31,837,000
County share of cost:	($1,002,000)	($1,005,000)
Total Medi-Cal OTLICP:	$30,727,000	$30,832,000

8. County data processing costs associated with CMS Net for OTLICP are estimated to be $309,000 in FY 2016-17 and $300,000 in FY 2017-18.

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 2016-17: ($2,561,000) TF
FY 2017-18: ($2,561,000) TF

10. 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.

11. Enhanced, Title XIX (75% FFP), funding is available for Skilled Professional Medical Personnel (SPMP) for the Medi-Cal and OTLICP populations in FY 2016-17 and FY 2017-18.

FY 2016-17				
CCS Medi-Cal	**TF**	**GF**	**FF**	**CF***
CCS Case Management	$155,159,000	$58,340,000	$96,819,000	
Medi-Cal Expansion	$1,057,000	$1,057,000		
Pediatric Palliative Care	$4,765,000	$1,191,000	$3,574,000	
CMS Net	$2,090,000	$1,045,000	$1,045,000	
Subtotal	$163,071,000	$61,633,000	$101,438,000	
CCS Medi-Cal/OTLICP				
CCS Case Management	$30,728,000	$4,760,000	$25,968,000	$1,002,000
CMS Net	$309,000	$37,000	$272,000	
Subtotal	$31,037,000	$4,797,000	$26,240,000	$1,002,000
Health Plan of San Mateo	($2,562,000)	($1,281,000)	($1,281,000)	
Total	**$191,546,000**	**$65,149,000**	**$126,397,000**	$1,002,000

CCS CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 2

FY 2017-18				
CCS Medi-Cal	TF	GF	FF	CF*
CCS Case Management	$158,651,000	$59,653,000	$98,998,000	
Medi-Cal Expansion	$1,057,000	$1,057,000		
Pediatric Palliative Care	$5,646,000	$1,411,000	$4,235,000	
CMS Net	$2,076,000	$1,038,000	$1,038,000	
Subtotal	$167,430,000	$63,159,000	$104,271,000	
CCS Medi-Cal/OTLICP				
CCS Case Management	$30,832,000	$4,776,000	$26,056,000	$1,005,000
CMS Net	$300,000	$36,000	$264,000	
Subtotal	$31,132,000	$4,812,000	$26,320,000	$1,005,000
Health Plan of San Mateo	($2,562,000)	($1,281,000)	($1,281,000)	
Total	**$196,000,000**	**$66,690,000**	**$129,310,000**	$1,005,000

* County Funds are not included in the Total Fund

Funding:

FY 2016-17	TF	GF	FF	CF*
50% Title XIX / 50% GF (4260-101-0001/0890)	$77,730,000	$38,865,000	$38,865,000	
75% Title XIX / 25% GF (4260-101-0001/0890)	$96,754,000	$24,188,000	$72,566,000	
88% Title XXI / 12% GF (4260-113-0001/0890)	$309,000	$37,000	$272,000	
88% Title XXI / 6% GF / 6% CF (4260-113-0001/0890)	$15,696,000	$1,002,000	$14,694,000	$1,002,000
100% GF (4260-101-0001)	$1,057,000	$1,057,000		
Total	**$191,546,000**	**$65,149,000**	**$126,397,000**	$1,002,000

FY 2017-18	TF	GF	FF	CF*
50% Title XIX / 50% GF (4260-101-0001/0890)	$79,474,000	$39,737,000	$39,737,000	
75% Title XIX / 25% GF (4260-101-0001/0890)	$99,420,000	$24,855,000	$74,565,000	
88% Title XXI / 12% GF (4260-113-0001/0890)	$300,000	$36,000	$264,000	
88% Title XXI / 6% GF / 6% CF (4260-113-0001/0890)	$15,749,000	$1,005,000	$14,744,000	$1,005,000
100% GF (4260-101-0001)	$1,057,000	$1,057,000		
Total	**$196,000,000**	**$66,690,000**	**$129,310,000**	$1,005,000

* 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 2016-17	FY 2017-18
TOTAL FUNDS	$0	$119,816,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$119,816,000

DESCRIPTION

Purpose:
This policy change estimates federal funds for the administrative costs associated with the Health Care Coverage Initiative (HCCI) under the Medi-Cal/Uninsured Care Demonstration (MH/UCD) and the Low Income Health Program (LIHP) under the California Bridge to Reform (BTR) Demonstration.

Authority:
AB 342 (Chapter 723, Statutes of 2010)
AB 1066 (Chapter 86, Statutes of 2011)
California Bridge to Reform Section 1115(a) Medicaid Demonstration

Interdependent Policy Changes:
Not Applicable

Background:
Under the MH/UCD, $180 million in federal funds was available annually under the Safety Net Care Pool (SNCP) to expand health coverage to eligible low-income, uninsured persons for Demonstration Year (DY) 2007-08 through 2009-10. The federal funds available will reimburse the HCCI. The HCCI was replaced by the LIHP, effective November 1, 2010 through December 31, 2013, which consisted of two components, the Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI). The MCE covered eligibles with family incomes at or below 133% of the Federal Poverty Level (FPL). The HCCI covered those with family incomes above 133% through 200% of the FPL. Both were statewide county elective programs. The LIHP HCCI replaced the Coverage Initiative (CI) under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD) which was extended until October 31, 2010. AB 342 and AB 1066 authorized local LIHPs to provide health care services to eligible individuals.

The Centers for Medicare and Medicaid Services (CMS) provided uncapped federal funds to the local LIHPs at an amount equal to the regular Federal Medical Assistance Percentage (50%) for their administrative costs associated with the start-up, implementation, and close out administration of their approved LIHPs. The Department will use Certified Public Expenditures (CPEs) of the local government administrative costs to draw down federal funds and will distribute these funds to the local governments. The Department used the HCCI administrative activities cost claiming protocol for the HCCI under the MH/UCD, as the basis for providing reimbursement for the allowable administrative costs incurred from November 1, 2010 through September 30, 2011, as permitted by the Special Terms and Conditions for the Section 1115(a) BTR Demonstration. The Department received CMS approval of the BTR-LIHP administrative cost claiming protocol and time study on December 12, 2013.

MH/UCD & BTR – LIHP – ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 3

Reason for Change:
The change from the prior estimate, for FY 2016-17 and FY 2017-18, is due to the delay in completing the final reconciliations, which are now anticipated to occur in FY 2017-18.

Methodology:
1. Administrative payments were based on the CMS approved administrative cost claiming protocol and time study.

2. Administrative claiming is comprised of three payment categories.

- Start-up costs
- Regular program costs
- Close-out costs

3. Start-up and close-out costs will be included in the reconciliations.

4. Estimated final reconciliations are expected to be as follows:

(Dollars in Thousands)

FY 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 2016-17	FY 2017-18
TOTAL FUNDS	$110,963,000	$115,824,000
STATE FUNDS	$24,000	$121,000
FEDERAL FUNDS	$110,939,000	$115,703,000

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 certain 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 2016-17 and FY 2017-18, is a slight increase, due to updating growth trends applied to the FY 2016-17 and FY 2017-18 accrual years.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is also the result of updating the growth trends and including Foster Family Agency (FFA) costs beginning January 2017.

Methodology:
1. Mental Health administration costs are based on historical claims payment data. Below are the costs on an accrual basis for MC and CHIP.

COUNTY SPECIALTY MENTAL HEALTH ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 4

(Dollars in Thousands)

Fiscal Year	MC	CHIP	Total
FY 2014-15	$202,725	$6,843	$209,568
FY 2015-16	$208,807	$7,048	$215,855
FY 2016-17	$217,576	$7,344	$224,920
FY 2017-18	$224,321	$7,572	$231,893

2. Based on historical claims received, assume 22% of each fiscal year claims will be paid in the year the services occur, 69% is paid in the following year, and 9% in the third year.

(Dollars in Thousands)

Fiscal Year	Accrual	FY 2016-17	FY 2017-18
MC	$202,725	$18,245	$0
CHIP	$6,843	$616	$0
FY 2014-15	$209,568	$18,861	$0
MC	$208,807	$144,076	$18,793
CHIP	$7,048	$4,863	$634
FY 2015-16	$215,855	$148,939	$19,427
MC	$217,576	$47,867	$150,127
CHIP	$7,344	$1,616	$5,067
FY 2016-17	$224,920	$49,483	$155,194
MC	$224,321	$0	$49,351
CHIP	$7,572	$0	$1,666
FY 2017-18	$231,893	$0	$51,017
Total		$217,283	$225,638

3. There is an additional total funds cost of $47,000 in FY 2016-17 and $242,000 in FY 2017-18 for counties to certify 187 FFAs to provide SMHS, beginning in January 2017. This estimate assumes counties will need a total of 40 hours to complete each certification. Assume staff certifying the FFAs are paid $40 per hour and benefits are 45.296% of salaries and wages. It is also assumed that FFA claims would be paid based on the payment lags in Methodology #2.

(Dollars in Thousands)

FFA	Accrual	FY 2016-17	FY 2017-18
FY 2016-17	$214	$47	$148
FY 2017-18	$428	$0	$94
Total		$47	$242

COUNTY SPECIALTY MENTAL HEALTH ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 4

4. 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%. General funds are budgeted for the non-federal share of FFA costs.

(Dollars in Thousands)

Claim Type	FY 2016-17				FY 2017-18			
	TF	GF	FF	CF	TF	GF	FF	CF
MC	$210,188	$0	$105,094	$105,094	$218,271	$0	$109,136	$109,135
CHIP*	$7,095	$0	$5,822	$1,273	$7,367	$0	$6,446	$921
FFA	$47	$24	$23	$0	$242	$121	$121	$0
Total	$217,330	**$24**	**$110,939**	$106,367	$225,880	**$121**	**$115,703**	$110,056

Funding:
100% Title XIX FFP (4260-101-0890)
100% Title XXI FFP (4260-113-0890)*
100% GF (4260-101-0001)

COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 5
IMPLEMENTATION DATE: 7/1992
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 1963

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$96,773,000	$76,169,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$96,773,000	$76,169,000

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 CMAA Implementation Plan which included a new, statistically valid time survey methodology and a revised operational plan. 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 from the prior estimate for FY 2016-17, is a net increase due to changes to the CMAA estimate as follows:

- Shifting FY 2010-11 backcasting payments to FY 2017-18,
- Decreased FY 2013-14 payments based on actual invoices,
- Adjusting the growth factor from 2% to 13% with updated data trends for FY 2014-15, and
- Processing a portion of FY 2015-16 payments in FY 2016-17.

COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 5

The change from the prior estimate for FY 2017-18, is a net increase due to changes to the CMAA estimate as follows:

- Adjusting the growth factor from 2% to 9% with updated data trends for FY 2015-16,
- Increased backcasting estimate for FY 2010-11 and FY 2011-12,
- FY 2010-11 backcasting payments shifted from FY 2016-17,
- Including additional FY 2013-14 and FY 2014-15 payments, and
- No longer including FY 2012-13 backcasting payments in the estimate.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is a decrease due to additional regular CMAA payments occurring in FY 2016-17.

Methodology:
County Medi-Cal Administrative Activities

1. On September 2016, the Department submitted to CMS for 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 by FY 2017-18.

2. All remaining unpaid FY 2013-14 claims are expected to be paid in FY 2016-17 and FY 2017-18. In addition, all FY 2014-15 claims are expected to be paid in FY 2016-17 and FY 2017-18. The FY 2014-15 estimated base payments assumes a 13% growth, based on the actual growth from FY 2013-14 to FY 2014-15. The FY 2015-16 estimated base payments assumes a 9% growth, based on the average growth from FY 2012-13 to FY 2014-15.

   Estimated CMAA FY 2014-15: $66,462,000 + 13% growth factor **= $74,788,000**

   Estimated CMAA FY 2015-16: $74,788,000 + 9% growth factor **= $81,519,000**

CMAA FY 2016-17 Estimated Payments	
FY 2013-14	$5,017,000
FY 2014-15	$70,270,000
FY 2015-16	$20,380,000
Total	**$95,667,000**

3. The CMAA FY 2017-18 estimate includes backcasting amounts for FY 2010-11 and FY 2011-12. In addition, all remaining FY 2013-14, FY 2014-15 and FY 2015-16 claims will be paid in FY 2017-18.

CMAA FY 2017-18 Estimated Payments	
FY 2010-11 Backcasting	$2,062,000
FY 2011-12 Backcasting	$2,062,000
FY 2013-14	$4,582,000
FY 2014-15	$4,518,000
FY 2015-16	$61,139,000
Total	**$74,363,000**

COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 5

Tribal Medi-Cal Administrative Activities

4. The TMAA FY 2016-17 estimate includes the remaining unpaid FY 2014-15 claims. In addition, FY 2015-16 claims are expected to be paid in FY 2016-17 and FY 2017-18. The FY 2015-16 estimated base payments assumes a 9% growth, based on the average growth from FY 2012-13 to FY 2014-15.

   FY 2015-16: $1,041,000 + 9% growth factor = $1,135,000

TMAA FY 2016-17 Estimated Payments	
FY 2014-15	$539,000
FY 2015-16	$567,000
Total	**$1,106,000**

5. In addition, FY 2016-17 claims are expected to be paid in FY 2017-18. The estimated base payments assumes a 9% growth, based on the average growth from FY 2012-13 to FY 2014-15.

   TMAA FY 2016-17: $1,135,000 + 9% growth factor = **$1,237,000**

TMAA FY 2017-18 Estimated Payments	
FY 2015-16	$568,000
FY 2016-17	$1,237,000
Total	**$1,805,000**

6. Total CMAA and TMAA reimbursements for FY 2016-17 and FY 2017-18 on a cash basis are:

(Dollars in Thousands)

FY 2016-17	TF	FF
County MAA	$95,667	$95,667
Tribal MAA	$1,106	$1,106
Total	**$96,773**	**$96,773**

(Dollars in Thousands)

FY 2017-18	TF	FF
County MAA	$74,364	$74,364
Tribal MAA	$1,805	$1,805
Total	**$76,169**	**$76,169**

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

EPSDT CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	6
IMPLEMENTATION DATE:	7/1996
ANALYST:	Sasha Jetton
FISCAL REFERENCE NUMBER:	229

	FY 2016-17	FY 2017-18
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 2016-17 or FY 2017-18. There is no change between fiscal years 2016-17 and 2017-18.

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 2016-17	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 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**

OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	**7**
IMPLEMENTATION DATE:	**1/2013**
ANALYST:	**Katy Clay**
FISCAL REFERENCE NUMBER:	**1748**

	FY 2016-17	FY 2017-18
TOTAL FUNDS	**$30,329,000**	**$33,704,000**
STATE FUNDS	**$7,197,800**	**$8,166,720**
FEDERAL FUNDS	**$23,131,200**	**$25,537,280**

DESCRIPTION

Purpose:
This policy change estimates the contract costs and other administrative vendor services for the Optional Targeted Low Income Children Program (OTLICP), Medi-Cal Access Program (MCAP), and Medi-Cal special populations.

Authority:
AB 1494 (Chapter 28, Statutes of 2012)
Health Services Advisory Group, Inc. Contract 15-92200
Maximus Contract 12-89315 A06

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2013, the Managed Risk Medical Insurance Board (MRMIB) contracted with MAXIMUS for Single Point of Entry (SPE) application services and other administrative vendor services for the Healthy Families Program (HFP), Access for Infants and Mothers (AIM) and Child Health and Disability Prevention (CHDP) Gateway.

HFP subscribers began transitioning into Medi-Cal as OTLICP starting January 1, 2013. Completed applications were sent to the SPE for screening and forwarded to the county welfare departments (CWD) for a Medi-Cal eligibility determination for the children's percent programs or to the new OTLICP.

The AIM infants above 250% of the federal poverty level began transitioning into Medi-Cal Access Infants Program beginning November 1, 2013. The transition ended on February 1, 2014. The AIM Program was transitioned from MRMIB to the Department as of July 1, 2014, and renamed MCAP.

The Department instructed MAXIMUS to close out SPE for HFP and CHDP Gateway effective as of January 1, 2014, and to refer applicants to the application portal and toll-free line at Covered California. Maximus completed the shutdown process in FY 2013-14.

Also effective as of July 1, 2014, all MRMIB programs, including the MAXIMUS contract, transitioned to the Department. Since the transition, MAXIMUS has provided administrative vendor services for MCAP and OTLICP. Due to applications still available in the community, Maximus forwards any HFP applications it receives to the appropriate County Welfare Department for a determination without the benefit of screening for accelerated enrollment.

The Department transitioned the HFP and Children's Health Insurance Program (CHIP) into the Medi-

OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 7

Cal program in September 2013. The Title XXI CHIP program requires the State to contract with an External Quality Review Organization (ERQO) 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 OA 60 Cost Reimbursement.

Reason for Change:
The decrease from the prior estimate, for FY 2016-17, is due the implementation date change from October 2016 to January 1, 2017 for the Medi-Cal Special Populations publications costs. There is no change from the prior estimate for FY 2017-18. The increase from FY 2016-17 to FY 2017-18, in the current estimate, is due to several factors. First, FY 2017-18 shows the addition of $1.5M for full year contract costs for the Special Populations publication costs. Second, the Department anticipates additional costs for redetermination processing effective FY 2017-18 to transition beneficiaries into OTLICP MAGI Medi-Cal programs from non-MAGI Medi-Cal programs and restricted-scope Medi-Cal programs. Finally, costs for the MCAP program decreased due to the integration of MCAP into the Medi-Cal Fee-for-Service delivery system.

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 2016-17	FY 2017-18
OTLICP	$ 24,901	$ 26,868
MCAP	$ 3,970	$ 3,920
Medi-Cal Special Populations	$ 1,458	$ 2,916

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 2016-17	TF	GF	FF
Contract Costs	$ 21,965	$ 3,016	$ 18,949
Applications Processing, Printing and Courier Services, Letters and Notices, Transaction Forwarding Fee, Pregnancy Materials	$ 1,020	$ 510	$ 510
Call Minute Rate per Minute	$ 1,886	$ 943	$ 943
Implementation Costs	$ 4,000	$ 2,000	$ 2,000
Special Populations Publications	$ 1,458	$ 729	$ 729
Total	**$ 30,329**	**$ 7,198**	**$ 23,131**

FY 2017-18	TF	GF	FF
Contract Costs	$ 23,856	$ 3,243	$ 20,613
Applications Processing, Printing and Courier Services, Letters and Notices, Transaction Forwarding Fee, Pregnancy Materials	$ 990	$ 495	$ 495
Call Minute Rate per Minute	$ 1,942	$ 971	$ 971
Implementation Costs	$ 4,000	$ 2,000	$ 2,000
Special Populations Publications	$ 2,916	$ 1,458	$ 1,458
Total	**$ 33,704**	**$ 8,167**	**$ 25,537**

Funding:

(Dollars in Thousands)

FY 2016-17	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890/0001)	$ 9,364	$ 4,682	$ 4,682
88% Title XXI / 12% GF (4260-113-0890/0001)	$ 20,965	$ 2,516	$ 18,449
Total	**$ 30,329**	**$ 7,198**	**$ 23,131**

FY 2017-18	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890/0001)	$ 10,848	$ 5,424	$ 5,424
88% Title XXI / 12% GF (4260-113-0890/0001)	$ 22,856	$ 2,743	$ 20,113
Total	**$ 33,704**	**$ 8,167**	**$ 25,537**

PAVE SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER:	8
IMPLEMENTATION DATE:	4/2016
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	1932

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$18,616,000	$18,562,000
STATE FUNDS	$2,453,200	$2,686,150
FEDERAL FUNDS	$16,162,800	$15,875,850

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

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, estimated to be in July 2017. Prior to PAVE, provider enrollment utilized a paper-based process.

Reason for Change:
The change from the prior estimate, for FY 2016-17, is a decrease due to a delay in the project schedule and a shift with the updated project work plan. The change from the prior estimate, for FY 2017-18, is an increase due to additional costs needed for PAVE and costs shifting from FY 2016-17 to FY 2017-18.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due additional costs needed and the cost shift in FY 2017-18.

PAVE SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 8

Methodology:

1. FY 2016-17 and FY 2017-18 costs are as follows:

FY 2016-17	TF	GF	FF
Implementation	$12,574,000	$1,257,000	$11,317,000
Consultants	$2,098,000	$210,000	$1,888,000
Operations*	$3,944,000	$986,000	$2,958,000
Total	**$18,616,000**	**$2,453,000**	**$16,163,000**

FY 2017-18	TF	GF	FF
Implementation	$10,679,000	$1,068,000	$9,611,000
Consultants	$2,350,000	$235,000	$2,115,000
Operations*	$5,533,000	$1,384,000	$4,149,000
Total	**$18,562,000**	**$2,687,000**	**$15,875,000**

Funding:

75% Title XIX / 25% GF (4260-101-0001/0890)*
90% Title XIX / 10% GF (4260-101-0001/0890)

SMH MAA

OTHER ADMIN. POLICY CHANGE NUMBER:	9
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1722

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$31,681,000	$32,512,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$31,681,000	$32,512,000

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 2016-17 and FY 2017-18, is due to:

- Including payments to Marin County in FY 2016-17 for claims from prior fiscal years, following a recently approved claiming plan.
- An influx of claims from Alameda County.
- Updating the average annual increase in mental health (MH) MAA claims from 2.35% to 9.06% based on actuals through FY 2015-16.
- Updating the percentage of skilled professional medical personnel and other personnel based on actual FY 2015-16 claims.
- Updating the payment lags based on FY 2015-16 claims.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to the addition of claims to be paid in FY 2017-18 based on projected costs.

Methodology:
1. County mental health plans submit claims for reimbursement on a quarterly basis. Claims may be submitted up to six months after the close of a fiscal year.

2. Based on actual claims from FY 2010-11 through FY 2015-16, the average annual increase in MH MAA FFP reimbursements was 9.06%.

SMH MAA

OTHER ADMIN. POLICY CHANGE NUMBER: 9

3. Assume total MH MAA claims will increase by 9.06% each fiscal year.

4. For FY 2015-16, the Department projects to receive $51,182,000 TF in MH MAA claims on an accrual basis.

(Dollars in Thousands)

Fiscal Years	Expenditures	Growth	Increase
2015-16	$51,182	9.06%	$4,635
2016-17	$55,819	9.06%	$5,057
2017-18	$60,876	9.06%	$5,515

5. Based on historical claims received, assume 8.98% of fiscal year claims will be paid in the year the services occur. The remaining 91.02% will be paid in the following year.

(Dollars in Thousands)

Fiscal Years	Accrual	FY 2016-17	FY 2017-18
2015-16	$51,182	$46,586	$0
2016-17	$55,819	$5,012	$50,807
2017-18	$60,876	$0	$5,467
Total	$167,877	$51,598	$56,274

6. MH MAA total expenditures are shared between federal funds (FF) and county funds (CF).

7. Marin County will be reimbursed $1,870,000 FF for multiple years of MH MAA claims in FY 2016-17. Marin County's claiming plan has been approved, allowing the claims to be paid.

(Dollars in Thousands)

Cash Basis	FY 2016-17		
Expenditures	TF	FF	CF
Medical (75/25)	$1,301	$976	$325
Other (50/50)	$1,788	$894	$894
Total	$3,089	$1,870	$1,219

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 2015-16, assume 31.10% of costs are eligible for 75% reimbursement and the remaining 68.90% are eligible for 50% reimbursement.

(Dollars in Thousands)

	FY 2016-17			FY 2017-18		
Expenditures	TF	FF	CF	TF	FF	CF
Medical (75/25)	$17,349	$13,012	$4,337	$17,502	$13,126	$4,376
Other (50/50)	$37,338	$18,669	$18,669	$38,772	$19,386	$19,386
Total	$54,687	**$31,681**	$23,006	$56,274	**$32,512**	$23,762

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

POSTAGE & PRINTING

OTHER ADMIN. POLICY CHANGE NUMBER:	10
IMPLEMENTATION DATE:	7/1993
ANALYST:	Jason Moody
FISCAL REFERENCE NUMBER:	231

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$19,625,000	$19,820,000
STATE FUNDS	$9,905,000	$10,002,500
FEDERAL FUNDS	$9,720,000	$9,817,500

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 2016-17, is an increase due to the inclusion of NFRA mailings. 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 the inclusion of NFRA mailings. The change from FY 2016-17 to FY 2017-18, in the current estimate, is an overall increase due to an increase in per unit cost for reprinted and corrected 1095-B mailings, fewer NFRA notices, and the removal of overnight mailing costs.

POSTAGE & PRINTING

OTHER ADMIN. POLICY CHANGE NUMBER: 10

Methodology:

1. Assume that 14,890,000 1095-B mailings are conducted in each FY. Assume that the cost per mailing is $0.56.

   14,890,000 mailings x $0.56 per mailing = $8,338,000 (rounded)

2. Assume that 15% 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 $0.646 per unit in FY 2016-17 and $0.754 per unit in FY 2017-18. The increase in cost per unit is calculated based on non-bulk mailing rates.

   15% x 14,890,000 = 2,233,500 returned mailings

   FY 2016-17: 2,233,500 returned mailings x $0.646 per unit = $1,443,000 (rounded)

   FY 2017-18: 2,233,500 returned mailings x $0.754 per unit = $1,684,000 (rounded)

3. For FY 2016-17, The Department will use an overnight mailing service to return forms to county offices. Costs for the use of this service are estimated to be $6,000. For FY 2017-18, the Department will implement an automated process for the return mail and the cost of this process will be absorbed by the vendor's current base contract amount.

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. FY 2016-17 includes 2015 and 2016 tax year information while FY 2017-18 includes 2017 tax year information.

   FY 2016-17: 400,000 x $0.594 per unit = $238,000 (rounded)

   FY 2017-18: 200,000 x $0.594 per unit = $119,000 (rounded)

5. The Department estimates the printing and postage costs for FY 2016-17 and FY 2017-18 are:

FY 2016-17	TF	GF	FF
Base Mass Mailing*	$7,000,000	$3,592,000	$3,408,000
1095B			
1095 Mailings	$8,338,000	$4,169,000	$4,169,000
Reprinted/Corrected Form 1095-B	$1,443,000	$721,000	$722,000
Overnight mail to County Offices	$6,000	$3,000	$3,000
Notice for Requested Action	$238,000	$119,000	$119,000
1095 B Subtotal	$10,025,000	$5,012,000	$5,013,000
Emergency Mailings	$2,600,000	$1,300,000	$1,300,000
Total	**$19,625,000**	**$9,904,000**	**$9,721,000**

POSTAGE & PRINTING

OTHER ADMIN. POLICY CHANGE NUMBER: 10

FY 2017-18	TF	GF	FF
Base Mass Mailing*	$7,000,000	$3,592,000	$3,408,000
1095B			
1095 Mailings	$8,338,000	$4,169,000	$4,169,000
Reprinted/Corrected Form 1095-B	$1,684,000	$842,000	$842,000
Overnight mail to County Offices	$0	$0	$0
Notice for Requested Action	$119,000	$60,000	$59,000
1095 B Subtotal	$10,141,000	$5,071,000	$5,070,000
Other Mailings	$79,000	$40,000	$39,000
Emergency Mailings	$2,600,000	$1,300,000	$1,300,000
Total	**$19,820,000**	**$10,003,000**	**$9,817,000**

Totals may differ due to rounding.

Funding:
50 % Title XIX FF/ 50 % GF (4260-101-0001/0890)
100 % 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 2016-17	FY 2017-18
TOTAL FUNDS	$18,906,000	$20,876,000
STATE FUNDS	$0	$415,000
FEDERAL FUNDS	$18,906,000	$20,461,000

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 Specialty Mental Health Services 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 2016-17 and FY 2017-18, is due to updated growth trends applied to the FY 2016-17 and FY 2017-18 accrual years. The change, from FY 2016-17 and FY 2017-18, in the current estimate, is due to Special Terms and Conditions (STC) expenditures expected to occur in FY 2017-18 and the growth trend for the FY 2017-18 accrual year.

Methodology:
1. UR and QA expenditures are shared between federal funds (FF) and county funds (CF).

2. Based on historical claims received, assume 29% of each fiscal year claims will be paid in the year the services occur. Assume 68% is paid in the following year and 3% is paid in the third year.

SMHS COUNTY UR & QA ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 11

(Dollars in Thousands)

Fiscal Year	Accrual	FY 2016-17	FY 2017-18
FY 2014-15	$26,400	$792	$0
FY 2015-16	$27,192	$18,490	$816
FY 2016-17	$28,334	$8,217	$19,267
FY 2017-18	$29,212	$0	$8,471
Total		$27,499	$28,554

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. FY 2017-18 includes an estimate for additional work, at the county level, to collect and report data elements and post Mental Health Plan (MHP) data on the county's website as specified by the STC related to the SMHS waiver. Assume 54% of claims will be paid in FY 2017-18.

(Dollars in Thousands)

STC	Accrual	FY 2017-18
FY 2017-18	$3,075	$1,660

6. On a cash basis, the estimated payments in FY 2016-17 and FY 2017-18 are:

(Dollars in Thousands)

FY 2016-17			
Personnel	**TF**	**FF**	**CF**
SPMP	$20,625	$15,469	$5,156
Other	$6,874	$3,437	$3,437
Total	$27,499	**$18,906**	$8,593

(Dollars in Thousands)

FY 2017-18				
Personnel	**TF**	**FF**	**CF**	**GF**
SPMP	$21,416	$16,062	$5,354	$0
Other	$7,138	$3,569	$3,569	$0
STC	$1,660	$830	$415	$415
Total	$30,214	**$20,461**	$9,338	**$415**

Funding:
100% Title XIX FF (4260-101-0890)
100% GF (4260-101-0001)

ARRA HITECH INCENTIVE PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 12
IMPLEMENTATION DATE: 7/2010
ANALYST: Sharisse DeLeon
FISCAL REFERENCE NUMBER: 1370

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$18,178,000	$18,729,000
STATE FUNDS	$1,599,000	$1,624,000
FEDERAL FUNDS	$16,579,000	$17,105,000

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 66 Medical FI Optional Contractual Services
PC 174 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 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.

ARRA HITECH INCENTIVE PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 12

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). The CAIR 2.0 project will transform the existing CAIR infrastructure and software to fully support MU data exchange among EHRs.

Beginning in FY 2017-18, the Department and the California Department of Public Health (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 effort is pending the approval of CMS.

In addition to CAIR 2.0, the Department will administer the following projects to support MU of EHRs by eligible Medi-Cal professionals and hospitals:

- The Department and CDPH partnered on the California Reportable Disease Information Exchange (CalREDIE) project to provide technical support to implement a computer application system for web-based disease reporting and surveillance.

- 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 will be used to facilitate Health Information Exchange and EHR adoption for Medi-Cal. The next periodic survey will be conducted in FY 2016-17.

ARRA HITECH INCENTIVE PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 12

- 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 is anticipated to reoccur at a later date in FY 2016-17. 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 2016-17, is a decrease due to:

- A revised California Physician's Use of EHR Survey project schedule that shifted work from FY 2016-17 to FY 2017-18, and
- A decrease in the California HIT/HIE Summit costs due to change in the project schedule and a change to the funding of these costs where the non-federal share will be provided by outside entities.

The change from the prior estimate, for FY 2017-18, is an increase due to including new CAIR and CalREDIE contracts and the shift in work for the California Physician's Use of EHR Survey project from FY 2016-17 to FY 2017-18.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to updated costs in FY 2016-17 based on actual CTAP payments and revising the contract costs for CAIR and CalREDIE based on new contracts.

Methodology:
1. The ARRA HITECH Incentive Program is eligible for Title XIX 90% FF.

2. For the CAIR 2.0 and CalREDIE 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 for the CAIR 2.0 and CalREDIE 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.

4. For the California HIT/HIE Stakeholder Summit, the 10% non-federal share will be provided by outside entities.

5. In FY 2016-17 and FY 2017-18, the 10% non-federal share for the other projects will be provided by outside entities.

ARRA HITECH INCENTIVE PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 12

6. The medical FI projects are eligible for ARRA HITECH funding under the FI contract.

FY 2016-17	TF	Reimburs.	SF	FF
CAIR 2.0 (90% FF/10% GF)	$1,715,000	$0	$0	$1,715,000
CalREDIE (90% FF/10% GF)	$469,000	$0	$0	$469,000
Provider Technical Assist. (90% FF/10% SF)*	$14,219,000	$0	$1,422,000	$12,797,000
California HIT/HIE Summit (90% FF/10% GF)	$75,000	$7,000	$0	$68,000
California Physician's EHR Survey (90% FF/10% GF)	$165,000	$16,000	$0	$149,000
Other projects (90% FF/10% GF)	$1,535,000	$154,000	$0	$1,381,000
Total	**$18,178,000**	**$177,000**	**$1,422,000**	**$16,579,000**
	TF	**GF**	**SF**	**FF**
Medical FI Optional Contractual Services (OA 66)	$0	$0	$0	$0
Total FY 2016-17	$18,178,000	$177,000	$1,422,000	$16,579,000

FY 2017-18	TF	Reimburs.	SF	FF
CAIR 2.0 (90% FF/10% GF)	$1,400,000	$0	$0	$1,400,000
CalREDIE (90% FF/10% GF)	$1,087,000	$0	$0	$1,087,000
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)	$165,000	$16,000	$0	$149,000
Other projects (90% FF/10% GF)	$1,535,000	$154,000	$0	$1,381,000
Total	**$18,729,000**	**$205,000**	**$1,419,000**	**$17,105,000**
	TF	**GF**	**SF**	**FF**
Medical FI Optional Contractual Services (OA 66)	$804,000	$80,400	$0	$723,600
Total FY 2017-18	$19,533,000	$285,400	$1,419,000	$17,829,600

ARRA HITECH INCENTIVE PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 12

Funding:
100% Title XIX (4260-101-0890)
100% Reimbursement (4260-601-0995)
100% Major Risk Medical Insurance Fund (4260-602-0313)*
100% Health Care Services Plans Fines and Penalties Fund (4260-602-3311)**

ACTUARIAL COSTS FOR RATE DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 13
IMPLEMENTATION DATE: 8/2015
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1937

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$16,222,000	$16,872,000
STATE FUNDS	$8,111,000	$8,436,000
FEDERAL FUNDS	$8,111,000	$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 that we meet our responsibilities to develop actuarially sound capitation rates.

Reason for Change:
The change from the prior estimate, for FY 2016-17, is a decrease due to an implementation date change for the Health Homes Program. This program is scheduled to begin no sooner than July 1, 2018.

There is no change from the prior estimate for FY 2017-18.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to starting rate development for the Health Homes Program in FY 2017-18.

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.

ACTUARIAL COSTS FOR RATE DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 13

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 needed as these, and other new programs are integrated into the overall managed care delivery system rate setting process.

The FY 2016-17 and FY 2017-18 amounts on an accrual basis are estimated to be:

PC #	PC Title	FY 2016-17	FY 2017-18
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	$0	$650,000
N/A	Ongoing Actuarial Services	$15,100,000	$15,100,000
	Total	**$16,627,000**	**$17,277,000**

The FY 2016-17 and FY 2017-18 amounts on a cash basis are estimated to be:

(Dollars in Thousands)

	TF	GF	HHP Fund	FF
FY 2016-17	**$16,222**	$8,111	$0	$8,111
FY 2017-18	**$16,872**	$8,119	$317	$8,436

Funding:
50% Title XIX FF / 50% GF (4260-101-0890/0001)
50% HHP Fund (4260-601-0942)

MIS/DSS CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER:	14
IMPLEMENTATION DATE:	7/2002
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	252

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$14,481,000	$11,379,000
STATE FUNDS	$3,785,750	$3,013,750
FEDERAL FUNDS	$10,695,250	$8,365,250

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 throughout the contract to help maintain peak performance and control support costs.

Reason for Change:
There is no change from the prior estimate for FY 2016-17 and FY 2017-18. The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to a decrease in the required software and hardware refreshes and variable costs in FY 2017-18.

MIS/DSS CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 14

Methodology:

1. It is estimated that the contractor will be paid the following amounts:

FY 2016-17	TF	GF	FF
Fixed Costs (75% FF / 25% GF)	$10,796,000	$2,699,000	$8,097,000
Additional Fixed Costs (50% FF / 50% GF)	$662,000	$331,000	$331,000
Variable Costs (75% FF / 25% GF)	$3,023,000	$756,000	$2,267,000
Total	**$14,481,000**	**$3,786,000**	**$10,695,000**

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**

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)
75% Title XIX / 25% GF (4260-101-0001/0890)

SURS AND MARS SYSTEM REPLACEMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	15
IMPLEMENTATION DATE:	7/2016
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	1980

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$14,262,000	$10,790,000
STATE FUNDS	$2,935,500	$1,977,050
FEDERAL FUNDS	$11,326,500	$8,812,950

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 also 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.

Reason for Change:
There is no change from the prior estimate for FY 2016-17 and FY 2017-18. The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to the removal of hardware and software costs. Moving into the implementation of the SURS and MARS will still require DD&I and operational costs in FY 2017-18.

SURS AND MARS SYSTEM REPLACEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 15

Methodology:

1. The estimated breakdown of the SURS and MARS costs are:

SURS

FY 2016-17	TF	GF	FF
DD&I Costs (90% FF / 10% GF)	$3,285,000	$329,000	$2,956,000
Hardware/Software Costs (75% FF / 25% GF)	$4,398,000	$1,099,000	$3,299,000
Operational Costs (75% FF / 25% GF)	$1,064,000	$266,000	$798,000
Total	$8,747,000	$1,694,000	$7,053,000

MARS

FY 2016-17	TF	GF	FF
DD&I Costs (90% FF / 10% GF)	$915,000	$91,000	$824,000
Hardware/Software Costs (75% FF / 25% GF)	$4,600,000	$1,150,000	$3,450,000
Total	$5,515,000	$1,241,000	$4,274,000

SURS

FY 2017-18	TF	GF	FF
DD&I Costs (90% FF / 10% GF)	$838,000	$84,000	$754,000
Operational Costs (75% FF / 25% GF)	$5,287,000	$1,322,000	$3,965,000
Total	$6,125,000	$1,406,000	$4,719,000

MARS

FY 2017-18	TF	GF	FF
DD&I Costs (90% FF / 10% GF)	$3,965,000	$397,000	$3,568,000
Operational Costs (75% FF / 25% GF)	$700,000	$175,000	$525,000
Total	$4,665,000	$572,000	$4,093,000

2. The estimated total costs are as follows:

SURS and MARS

FY 2016-17	TF	GF	FF
DD&I Costs (90% FF / 10% GF)	$4,200,000	$420,000	$3,780,000
Hardware/Software and Operational Costs (75% FF / 25% GF)	$10,062,000	$2,515,000	$7,547,000
Total	**$14,262,000**	**$2,935,000**	**$11,327,000**

SURS and MARS

FY 2017-18	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	**$10,790,000**	**$1,978,000**	**$8,812,000**

Funding:

75% Title XIX / 25% GF (4260-101-0001/0890)
90% Title XIX / 10% GF (4260-101-0001/0890)

INTERIM AND FINAL COST SETTLEMENTS-SMHS

OTHER ADMIN. POLICY CHANGE NUMBER:	16
IMPLEMENTATION DATE:	7/2016
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1757

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$13,177,000	-$25,692,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$13,177,000	-$25,692,000

DESCRIPTION

Purpose:
This policy change estimates the federal funds (FF) for the interim and final cost settlements on specialty mental health services (SMHS) administrative expenditures.

Authority:
Welfare & Institution Code 14705(c)

Interdependent Policy Changes:
Not Applicable

Background:
The Department reconciles interim payments to county cost reports for mental health plans (MHPs) for utilization review/quality assurance (UR/QA), mental health Medi-Cal administrative activities (MH MAA), and administration. The Department completes these interim settlements within two years of the end of the fiscal year. Final settlements are completed within three years of the last amended cost report the county MHPs submit to the Department.

The reconciliation process for each fiscal year may result in an overpayment or an underpayment to the county and will be handled as follows:

- For counties that have been determined to be overpaid, the Department will recoup any overpayments.
- For counties that have been determined to be underpaid, the Department will reimburse the federal funds.

Reason for Change:
There is no change from the prior estimate for FY 2016-17.

The change from the prior estimate, for FY 2017-18, is due to the addition of estimated payments for cost settlements to be paid in FY 2017-18.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to cost settlements resulting in net recoupments in FY 2017-18. The recoupments are mostly expected from the results on the FY 2011-12 cost settlements.

INTERIM AND FINAL COST SETTLEMENTS-SMHS

OTHER ADMIN. POLICY CHANGE NUMBER: 16

Methodology:

1. Interim cost settlements are based on the difference between each county MHP's filed cost report and the payments they received from the Department.

2. Final cost settlements are based on the difference between each county MHP's final audited cost report and the payments they received from the Department.

3. Cost settlements for administration, UR/QA, and MH MAA are each determined separately.

Interim Settlements			
FY 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	$52,000	($878,000)	($826,000)
UR/QA	$593,000	$0	$593,000
HFP Admin*	$9,000	$0	$9,000
Total FY 2009-10	$654,000	($878,000)	($224,000)
FY 2010-11	**Underpaid**	**Overpaid**	**Net FF**
SMH Admin	$12,088,000	($3,649,000)	$8,439,000
UR/QA	$5,384,000	($719,000)	$4,665,000
MH MAA	$730,000	($925,000)	($195,000)
MCHIP*	$81,000	($12,000)	$69,000
HFP Admin*	$178,000	($1,000)	$177,000
Total FY 2010-11	$18,461,000	($5,306,000)	$13,155,000
Total FY 2016-17	$19,361,000	($6,184,000)	**$13,177,000**

INTERIM AND FINAL COST SETTLEMENTS-SMHS

OTHER ADMIN. POLICY CHANGE NUMBER: 16

Interim Settlements			
FY 2009-10	**Underpaid**	**Overpaid**	**Net FF**
SMH Admin	$0	($5,000)	($5,000)
UR/QA	$198,000	($128,000)	$70,000
MH MAA	$132,000	($111,000)	$21,000
HFP Admin*	$7,000	$0	$7,000
Total FY 2009-10	$337,000	($244,000)	$93,000
FY 2010-11	**Underpaid**	**Overpaid**	**Net FF**
SMH Admin	$0	($1,999,000)	($1,999,000)
UR/QA	$2,197,000	$0	$2,197,000
MH MAA	$0	($1,638,000)	($1,638,000)
MCHIP*	$309,000	$0	$309,000
HFP Admin*	$714,000	$0	$714,000
Total FY 2010-11	$3,220,000	($3,637,000)	($417,000)
FY 2011-12	**Underpaid**	**Overpaid**	**Net FF**
SMH Admin	$3,144,000	$0	$3,144,000
UR/QA	$354,000	$0	$354,000
MH MAA	$0	($950,000)	($950,000)
MCHIP*	$31,000	$0	$31,000
HFP Admin*	$0	($27,947,000)	($27,947,000)
Total FY 2011-12	$3,529,000	($28,897,000)	($25,368,000)
Total FY 2017-18	$7,086,000	($32,778,000)	**($25,692,000)**

4. The net FF to be reimbursed and/or recouped in FY 2016-17 and FY 2017-18 are shown below:

FF	FY 2016-17	FY 2017-18
100% Title XIX FF (4260-101-0890)	$12,914,000	$1,194,000
100% Title XXI FF (4260-113-0890)*	$263,000	($26,886,000)
Total	**$13,177,000**	**($25,692,000)**

Funding:
100% Title XIX FF (4260-101-0890)
100% Title XXI FF (4260-113-0890)*

CCI-ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	17
IMPLEMENTATION DATE:	7/2012
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1677

	FY 2016-17	FY 2017-18
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 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.

CCI-ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 17

Reason for Change:
For FY 2016-17 and FY 2017-18, there is no change from the previous estimate. There is no change from FY 2016-17 to FY 2017-18.

Methodology:
1. The CCI development, implementation and operation costs began July 2012 and will continue through FY 2017-18.

2. All costs for FY 2016-17and FY 2017-18 will be funded at 50/50 FMAP.

FY 2016-17	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 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**

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

PASRR

OTHER ADMIN. POLICY CHANGE NUMBER:	18
IMPLEMENTATION DATE:	7/2013
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1720

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$10,248,000	$11,699,000
STATE FUNDS	$2,562,000	$2,924,750
FEDERAL FUNDS	$7,686,000	$8,774,250

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.

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 automation project replaced a mainframe database with a database that meets the Department's architecture, infrastructure, and security requirements. The Department is saving money not contracting with a consultant to support the old mainframe and by hosting the new application in-house. The new IT system:

- Allows NFs, hospitals, and evaluators to submit electronic 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: 18

The initial contract began September 24, 2015 and concluded on August 31, 2016. In April 2017, the Department will execute a contract for the system build-out for the following enhancements:

- Addressing issues or defects identified post implementation.
- Developing a Reconsideration Letter feature that ensures facilities and the Department have complete records for patient care plans.
- Providing PASRR automated system users with the ability to activate, deactivate, and reset user accounts directly from the new application instead of using the Web Admin tool.
- Developing the "build-out" that extends the existing functionality of the system to allow exchange of PASRR information between hospitals and NFs.
- Creating a reporting structure that provides options for defining selection criteria, data ranges, and report output.

The Department will also provide electronic trainings to NFs and general acute care hospitals on the new automated system. Recruitment for a contractor to design the electronic trainings will begin July 1, 2017. The Department plans to have the training available on the PASRR website by June 30, 2018.

Reason for Change:
The change in the prior estimate, for FY 2016-17 and FY 2017-18, and the change in the current estimate, from FY 2016-17 and FY 2017-18, is due to:

- Revised system buildout costs and shifting a portion of the system buildouts costs to FY 2017-18 based on the new contract starting April 2017,
- Shifting the M&O costs to FY 2017-18,
- Delaying recruitment of the training design contractor from October 2016 to July 2017. The posting of the electronic web training is also delayed from June 2017 to June 2018.

Methodology:

1. A Level II evaluations contractor payments began in February 2015. Assume the contract will be renewed using the two one-year option to renew.

2. Beginning in FY 2016-17, the system build-out contract, implements changes to the PASRR system that will allow general acute care hospitals and NFs to exchange PASRR information. The system build-out began in October 2015, with the previous contract. In April 2017, the contract extends the existing functionality for the system and continues system build-out. The contract cost is expected to be $500,000 in FY 2016-17 and $1,150,000 in FY 2017-18.

3. Electronic training costs for the NFs and general acute care hospitals are based on an industry-wide survey. The electronic training costs will begin October 2017 and continue until June 30, 2018. Payment for the electronic training is expected to be made in FY 2017-18.

4. The PASRR IT system requires ongoing M&O. An M&O contract will be awarded in FY 2017-18.

PASRR

OTHER ADMIN. POLICY CHANGE NUMBER: 18

The PASRR payments on a cash basis are estimated at:

FY 2016-17	TF	GF	FF
Evaluations	$9,748,000	$2,437,000	$7,311,000
System Build Out	$500,000	$125,000	$375,000
Total	**$10,248,000**	**$2,562,000**	**$7,686,000**

FY 2017-18	TF	GF	FF
Evaluations	$10,093,000	$2,523,000	$7,570,000
Electronic Training	$106,000	$26,000	$80,000
Ongoing M&O Costs	$350,000	$88,000	$262,000
System Build Out	$1,150,000	$288,000	$862,000
Total	**$11,699,000**	**$2,925,000**	**$8,774,000**

Funding:
75% Title XIX / 25% GF (4260-101-0001/0890)

PERFORMANCE OUTCOMES SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER:	19
IMPLEMENTATION DATE:	7/2017
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1948

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$0	$14,952,000
STATE FUNDS	$0	$6,190,000
FEDERAL FUNDS	$0	$8,762,000

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, a Quality Assurance/Improvement team will be needed at the county level to collect, manage, use and report information obtained from the additional functional assessment data collected. This will require modifying existing data systems including installation of new software and upgrading existing hardware to accommodate the new software program for the new functional assessment tools. This will also require increasing staff resources or enhancing current staffing levels to implement the functional assessments and to implement the Quality Improvement Plan. A combination of County Information Technology (IT) staff and Information Technology contractors will be required to install upgrades to hardware, install the software programs for the new functional assessment tools, program the management information system (MIS) to accommodate the new software programs, and to conduct system validation testing.

PERFORMANCE OUTCOMES SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 19

The Department has selected the Pediatric Symptom Checklist (PSC 35) and the Child and Adolescents Needs and Strengths (CANS) to be the tools that best to measure child and youth functional outcomes. This was after a study of the functional assessment tools and a recommendation by UCLA. 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.

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 2016-17, is shifting all expenditures to FY 2017-18. The change from the prior estimate, for FY 2017-18, is adjusting expenditures for the training costs and excluding the estimate for the functional assessment tools, since the tools have been selected. The change between FY 2016-17 and FY 2017-18, for the current estimate, reflects all costs starting in FY 2017-18.

Methodology:
1. Training:
   County personnel costs for training are 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.
   - Assume 3,925 clinical staff will need to be registered at a fee of $10 per person annually.
   - Assume 88 training sessions will be needed at $2,400 per session.
   - For FY 2017-18, Total training costs are estimated to be $1,934,000 million TF ($1,684,000 + $39,000+ $211,000).

Training	Number of Staff (A)	In-Person Training (6 hours) (B)	Online Training (5 Hours) (C)	Hourly Wage (D)	Cost E=((B+C) x D)
First year	3,925	23,550	19,625	$39.00	$1,684,000
Ongoing	794	4,764	3,970	$39.00	$341,000

Training	Number of Staff (A)	Annual Registration Fee (B)	Cost (C =A x B)
Ongoing	3,925	$10.00	$39,000

Training	Number of Training Sessions (A)	Cost per Training Session (B)	Cost (C =A x B)
Ongoing	88	$2,400	$211,000

PERFORMANCE OUTCOMES SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 19

(Dollars in Thousands)

POS Cost	FY 2017-18
Training Costs (rounded)	$1,934

2. Costs for IT work:
IT work includes costs for new hardware and software and modifications to the Management Information System (MIS). Total costs for IT work are estimated at $7,212,000 TF ($420,000 + $6,792,000).

DHCS Hardware and Software costs:

- 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 will be paid in FY 2017-18.

IT Staff Hours (A)	Hourly Rate (B)	Cost (C =A x B)
4,000	$105	$420,000

MIS modification costs:

- 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 $6,792,000 will be paid for MIS modifications in FY 2017-18.

Modification Type	Counties (A)	Hours (B)	Hourly Rate (C)	Cost (D=AxBxC)
PSC Modification	56	728	$105	$4,280,640
CANS Modification	23	1040	$105	$2,511,600
Total				$6,792,240

(Dollars in Thousands)

IT Costs	FY 2017-18
DHCS Hardware and Software	$420
MIS modifications	$6,792
Total (rounded)	$7,212

3. Costs to staff county POS:
Clinical Staff:

- Assume 152,345 beneficiaries will be assessed annually by clinical staff and will be assessed multiple times per year, for 30 minutes at each time.
- Assume clinical staff are paid at $39 per hour for Assessments (Assmt.) with 45.296% of salaries and wages in benefits.

PERFORMANCE OUTCOMES SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 19

Clinical Staff Costs - Rounded

(Dollars in Thousands)

Assmt. Period	No. of Benes (A)	Minutes Per Assmt (B)	Hours Per Assmt. (C = (AxB) /60 min)	Hourly Rate (D)	Staff Costs (E=CxD)	Benefit Costs 45.296% (F=Ex45.296%)	Total Annual Costs (G=E+F)
First time	152,345	30	76,173	$39.00	$2,971	$1,346	$4,316
Second time (2 to 3 mos.)	93,526	30	46,763	$39.00	$1,824	$826	$2,650
Third time (3 to 6 mos.)	67,932	30	33,966	$39.00	$1,325	$600	$1,925
Fourth time (6 to 9 mos.)	49,438	30	24,719	$39.00	$964	$437	$1,401
Total					$7,084	$3,208	$10,292

Data Entry Staff:

- Assume data for 363,241 beneficiaries must be keyed annually into the POS and it takes 10 minutes, at $15 per hour with 45.296% of salaries and wages in benefits.

Data Entry Staff Costs- Rounded

(Dollars in Thousands)

	No. of Benes (A)	Minutes Per Assmt. (B)	Hours Per Assmt. (C = (AxB) /60 min)	Hourly Rate (D)	Staff Cost (E=CxD)	Benefit Costs 45.296% (F=Ex45.296%)	Total Annual Costs (G=E+F)
Data Entry	363,241	10	60,540	$15.00	$908	$411	$1,319

- The estimated annual salaries and benefits cost for staffing is $10,292,000 for clinical staff and $1,319,000 for data entry staff.
- Assume 50% of staffing costs will be paid in FY 2017-18. The costs for clinical staff and data entry staff will be $5,146,000 and $660,000, respectively in FY 2017-18.

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
Clinical Staff (75% FF / 25% GF)	$5,146
Data Entry (50% FF / 50% GF)	$660
Total	$5,806

PERFORMANCE OUTCOMES SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 19

5. The estimated total FY 2017-18 costs are:

(Dollars in Thousands)

POS Costs	TF	GF	FF
Training	$1,934	$967	$967
IT Costs	$7,212	$3,606	$3,606
County Staffing Costs	$5,806	$1,617	$4,189
Total FY 2017-18	**$14,952**	**$6,190**	**$8,762**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
75% Title XIX / 25% GF (4260-101-0001/0890)

LITIGATION RELATED SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 20
IMPLEMENTATION DATE: 7/2009
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1381

	FY 2016-17	FY 2017-18
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 2016-17 and FY 2017-18. There is no change from FY 2016-17 to FY 2017-18 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 2016-17, and $7,880,000 for FY 2017-18.

2. Based on prior actuary costs and the Department's projected workload, costs will be $2,100,000 in FY 2016-17 and $2,100,000 in FY 2017-18.

(Dollars in Thousands)

FY 2016-17	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: 20

(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**

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

MEDI-CAL RECOVERY CONTRACTS

OTHER ADMIN. POLICY CHANGE NUMBER: 21
IMPLEMENTATION DATE: 2/2008
ANALYST: Ila Zapanta
FISCAL REFERENCE NUMBER: 1551

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$7,915,000	$10,218,000
STATE FUNDS	$1,978,750	$2,554,500
FEDERAL FUNDS	$5,936,250	$7,663,500

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)	14-90130
Dept. of Industrial Relations – EAMS	17-94002
Dept. of Industrial Relations – Worker's Compensation Information System (WCIS)	14-90133 A01
Department of Social Services	15-92000
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
Department of Public Health	14-90132 A01

Interdependent Policy Changes:
Not Applicable

Background:
Since Medi-Cal is the payer of last resort, all legally responsible third parties must first be billed before the Medi-Cal program. The above contracts provide:

- Data matches between the Department's Medi-Cal 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, and
- Cost avoidance activities.

MEDI-CAL RECOVERY CONTRACTS

OTHER ADMIN. POLICY CHANGE NUMBER: 21

Current legislation eliminated the previously existing sunset date for the contract with the Department of Industrial Relations; access to the non-contested WC cases is no longer limited. 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 from the prior estimate, for FY 2016-17, for HI is a decrease due to temporarily suspending recovery activities with the contractor while the contract is being reviewed and amended. The change from the prior estimate, for FY 2017-18, for HI is an increase due to the shift of recoveries from the FY 2016-17 to FY 2017-18 and a projected increase in recoveries from the contractor. The change from FY 2016-17 to FY 2017-18, in the current estimate, for HI is due to resumed recoveries from the contractor shifting from FY 2016-17 to FY 2017-18.

The change from the prior estimate, for FY 2016-17 and FY 2017-18, for WC is a decrease due to an older contract with the contractor ending and lower projected recoveries based on an average of historical actuals. The change from FY 2016-17 to FY 2017-18, in the current estimate, for WC is due to a decreasing caseload retained by the contractor.

There is no change from the prior estimate for both FY 2016-17 and FY 2017-18 for Online Database Contracts. The change from FY 2016-17 to FY 2017-18, in the current estimate, for Online Database Contracts is due to a full year projection for the Lexis-Nexis contract.

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.

   Recoveries x Contingency Fee % = Total Contingency Fee

Contractor	FY 2016-17 Recoveries	FY 2017-18 Recoveries	Contingency Fee %	FY 2016-17 Contingency Fee	FY 2017-18 Contingency Fee
HMS 13	$87,676,000	$116,255,000	8.5%	$7,452,000	$9,882,000

2. The amounts paid to the HMS contractor for WC is contingent upon recoveries. The HMS contract will expire 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

MEDI-CAL RECOVERY CONTRACTS

OTHER ADMIN. POLICY CHANGE NUMBER: 21

Contractor	FY 2016-17 Recoveries	FY 2017-18 Recoveries	Contingency Fee %	FY 2016-17 Contingency Fee	FY 2017-18 Contingency Fee
HMS 03	$14,000	$0	15%	$2,000	$0
HMS 07	$511,000	$146,000	21%	$107,000	$31,000
HMS 12	$875,000	$654,000	23.75%	$208,000	$155,000
Total				$317,000	$186,000

3. The amounts paid to the Online Database contractors is based upon usage:

Online Database Contracts	FY 2016-17	FY 2017-18
Department of Industrial Relations - EAMS	$5,000	$4,000
Department of Industrial Relations – WCIS	$2,000	$2,000
Department of Social Services	$11,000	$11,000
Lexis-Nexis	$111,000	$116,000
CA Department of Public Health	$17,000	$17,000
Total	$146,000	$150,000

4. The payments shown below include recent recovery activity.

FY 2016-17	TF	GF	FF
Health Insurance	$7,452,000	$1,863,000	$5,589,000
Worker's Compensation	$317,000	$79,000	$238,000
Online Database Contracts	$146,000	$37,000	$109,000
Total	**$7,915,000**	**$1,979,000**	**$5,936,000**

FY 2017-18	TF	GF	FF
Health Insurance	$9,882,000	$2,471,000	$7,411,000
Worker's Compensation	$186,000	$46,000	$140,000
Online Database Contracts	$150,000	$37,000	$113,000
Total*	**$10,218,000**	**$2,554,000**	**$7,664,000**

*Difference due to rounding.

Funding:
75% Title XIX / 25% GF (4260-101-0001/0890)

NEWBORN HEARING SCREENING PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER:	**22**
IMPLEMENTATION DATE:	**7/2014**
ANALYST:	**Shannon Hoerner**
FISCAL REFERENCE NUMBER:	**1824**

	FY 2016-17	FY 2017-18
TOTAL FUNDS	**$7,105,000**	**$7,800,000**
STATE FUNDS	**$3,552,500**	**$3,900,000**
FEDERAL FUNDS	**$3,552,500**	**$3,900,000**

DESCRIPTION

Purpose:
This policy change estimates the Newborn Hearing Screening Program's (NHSP) contract service costs.

Authority:
AB 2780 (Chapter 310, Statutes of 1998)
Health & Safety Code Section 123975 and Sections 124115 - 124120.5

Interdependent Policy Changes:
Not Applicable

Background:
The NHSP contracts with both the Hearing Coordination Centers (HCC) and the Infant Data Management Service (IDMS). The HCCs 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 needs follow-up to assure they receive the needed services and referrals.

The IDMS supports the reporting, tracking, monitoring and quality assurance activities of the NHSP. The IDMS provides information and data to effectively plan, establish, monitor, and evaluate the NHSP. This includes screening, follow-up, and the comprehensive system of services of newborns and infants who are deaf or hard-of-hearing and their families.

The IDMS and HCC contract breakdowns are as follows:

- IDMS contract
  - IDMS 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 after November 30, 2016, the Department reinstated the use of the Infant Reporting Form until an automated solution is identified and a new IDMS contract is procured in the second quarter of FY 2017-18.
  - The Department will procure an IT Project Management contractor in FY 2016-17 and FY 2017-18 to evaluate automated solution options and to oversee the coding, testing, and implementation of a new IDMS contract and an automated data management system.

- HCC contract #15-92041 began July 1, 2015, has a five year term, and expires May 31, 2020.

NEWBORN HEARING SCREENING PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 22

Reason for Change:
The change from the prior estimate, for FY 2016-17, is due to the November 30, 2016 expiration of IDMS contract #14-90182 and additional costs for an IT Project Management contractor, resulting in an overall decrease of costs.

The change from the prior estimate, for FY 2017-18, is due to the implementation of a new IDMS contract in the second quarter of FY 2017-18 and additional costs for an IT Project Management contractor, resulting in an overall increase of costs.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to the implementation of a new IDMS contract in the second quarter of FY 2017-18 and an increase in costs for the IT Project Management contractor.

Methodology:
1. The estimated costs for FY 2016-17 and FY 2017-18 are as follows:

FY 2016-17	TF	GF	FF
HCC contract	$6,500,000	$3,250,000	$3,250,000
IDMS contract	$500,000	$250,000	$250,000
IT Project Management	$105,000	$52,500	$52,500
Total	**$7,105,000**	**$3,552,500**	**$3,552,500**

FY 2017-18	TF	GF	FF
HCC contract	$6,500,000	$3,250,000	$3,250,000
IDMS contract	$900,000	$450,000	$450,000
IT Project Management	$400,000	$200,000	$200,000
Total	**$7,800,000**	**$3,900,000**	**$3,900,000**

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

CA-MMIS GO-FORWARD OVERSIGHT

OTHER ADMIN. POLICY CHANGE NUMBER: 23
IMPLEMENTATION DATE: 10/2007
ANALYST: Ila Zapanta
FISCAL REFERENCE NUMBER: 1278

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$5,318,000	$0
STATE FUNDS	$772,900	$0
FEDERAL FUNDS	$4,545,100	$0

DESCRIPTION

Purpose:
This policy change estimates the cost of contractors who assist with the oversight of the transition and transformation of the California Medicaid Management Information System (CA-MMIS).

Authority:
Title XIX of the Federal Social Security Act 1903(a)(3)

Interdependent Policy Changes:
Not Applicable

Background:
CA-MMIS is the claims processing system used for Medi-Cal. As a result of the System Replacement Project (SRP) settlement agreement, the contractual responsibilities for the SRP have been removed from the Medical Fiscal Intermediary (FI) contract. In response, the Department must now focus on modernizing CA-MMIS' functionality in its present and future states. Towards these efforts, the Department will continue to contract with various vendors to provide oversight activities in support of the Department's Go-Forward Plan Work Streams one (1) through three (3) below:

1. Procure IT System Maintenance and Operation Services and FI Business Operations Services
2. Transform CA-MMIS Enterprise
3. Transition the SRP

Oversight activities, documentation of business rules, technical architecture, federal certification management, project management, transition management, user acceptance testing, business process re-engineering (BPR), and independent verification and validation services during transition and replacement of CA-MMIS is needed to support the Go-Forward Plan Work Streams.

Reason for Change:
The change from the prior estimate, for FY 2016-17, is a decrease in costs due to the removal contractor costs that were determined unnecessary. In addition, the funding splits have been updated based on the approved Implementation Advance Planning Document Update (IAPDU).

There was no change from the prior estimate for FY 2017-18. The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to no local assistance funding budgeted in FY 2017-18.

CA-MMIS GO-FORWARD OVERSIGHT

OTHER ADMIN. POLICY CHANGE NUMBER: 23

Methodology:

1. The estimated costs are based upon the contract provisions.

FY 2016-17	TF	GF	FF
50% Title XIX / 50% GF	$353,000	$177,000	$176,000
90% Title XIX / 10% GF	$4,854,000	$485,000	$4,369,000
100% GF	$111,000	$111,000	$0
Total	**$5,318,000**	**$773,000**	**$4,545,000**

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 ELIGIBILITY DATA SYSTEM (MEDS)

OTHER ADMIN. POLICY CHANGE NUMBER:	24
IMPLEMENTATION DATE:	7/2009
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	1441

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$5,291,000	$5,291,000
STATE FUNDS	$1,756,750	$1,756,750
FEDERAL FUNDS	$3,534,250	$3,534,250

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, and
- Reconciling county eligibility data used to support the counties in Medi-Cal eligibility determination responsibilities.

The M&O funding is required for the Business Objects software application tool that enables the counties to perform online statistics and MEDS-alert reporting. The reporting system tracks and reports all county worker transactions for MEDS. These system development and M&O costs are offset by reimbursements made from other departments.

MEDS supports the Advance Premium Tax Credit and Cost Share Reduction programs with Covered California and respective interfaces with California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) and county consortia. The MEDS Statewide Client Index generates the Client Index Number (CIN) for each beneficiary.

MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)

OTHER ADMIN. POLICY CHANGE NUMBER: 24

Reason for Change:
There is no change from the prior estimate for FY 2016-17 and FY 2017-18. There is no change from FY 2016-17 to FY 2017-18 in the current estimate.

Methodology:
1. The projected costs for FY 2016-17 and FY 2017-18 are:

FY 2016-17	TF	GF	FF	Reimbursement
System Development (50% FF / 50% GF)	$635,000	$317,500	$317,500	$0
Maintenance & Operations (75% FF / 25% GF)	$4,289,000	$1,072,000	$3,217,000	$0
Other Department Reimbursement (100% Reimbursement)	$367,000	$0	$0	$367,000
Total	**$5,291,000**	**$1,389,500**	**$3,534,500**	**$367,000**

FY 2017-18	TF	GF	FF	Reimbursement
System Development (50% FF / 50% GF)	$635,000	$317,500	$317,500	$0
Maintenance & Operations (75% FF / 25% GF)	$4,289,000	$1,072,000	$3,217,000	$0
Other Department Reimbursement (100% Reimbursement)	$367,000	$0	$0	$367,000
Total	**$5,291,000**	**$1,389,500**	**$3,534,500**	**$367,000**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
75% Title XIX / 25% GF (4260-101-0001/0890)
100% Reimbursement (4260-601-0995)

CA-MMIS MEDCOMPASS SOLUTION

OTHER ADMIN. POLICY CHANGE NUMBER: 25
IMPLEMENTATION DATE: 7/2017
ANALYST: Ila Zapanta
FISCAL REFERENCE NUMBER: 1982

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$0	**$1,803,000**
STATE FUNDS	$0	**$262,500**
FEDERAL FUNDS	$0	**$1,540,500**

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), whereby all development and implementation was not completed by the SRP vendor. As a result, the Department contracted directly with a new vendor to complete the remaining development and implement functionality to complete the outstanding requirements.

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 enhancing the services provided to them.

CA-MMIS MEDCOMPASS SOLUTION

OTHER ADMIN. POLICY CHANGE NUMBER: 25

Reason for Change:
The change from the prior estimate, for FY 2016-17, is a decrease due to the delay with signing the contract with the vendor. All FY 2016-17 costs have been shifted to FY 2017-18.

The change from the prior estimate, for FY 2017-18, is an increase due to the delay in the implementation date and revising the contractor costs.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to the implementation of the MedCompass solution contract beginning in FY 2017-18.

Methodology:
1. The estimated costs are based upon the contract provisions.

FY 2017-18	TF	GF	FF
50% Title XIX / 50% GF	$120,000	$60,000	$60,000
90% Title XIX / 10% GF	$1,645,000	$165,000	$1,480,000
100% GF	$38,000	$38,000	$0
Total	**$1,803,000**	**$263,000**	**$1,540,000**

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)

HIPAA CAPITATION PAYMENT REPORTING SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 26
IMPLEMENTATION DATE: 10/2012
ANALYST: Sharisse DeLeon
FISCAL REFERENCE NUMBER: 1318

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$4,763,000	$4,931,000
STATE FUNDS	$1,190,750	$1,232,750
FEDERAL FUNDS	$3,572,250	$3,698,250

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 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 January 2015, the Functional/Architect/Manager and a Technical/Lead were replaced using a different vendor. No additional costs were incurred.

Reason for Change:
The change from the prior estimate, for FY 2016-17, is a decrease due to updated actual payments and revised contract amounts for FY 2016-17.

The change from the prior estimate, for FY 2017-18, is a decrease due to revised contract amounts for FY 2017-18.

HIPAA CAPITATION PAYMENT REPORTING SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 26

The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to revised contract amounts.

Methodology:

1. Total contract costs are $22,662,740, with $9,693,500 expected to be paid out over FY 2016-17 and FY 2017-18:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2016-17	$4,763	$1,191	$3,572
FY 2017-18	$4,931	$1,233	$3,698

Funding:

75% HIPAA FFP / 25% HIPAA Fund (4260-117-0001/0890)

DRUG MEDI-CAL COUNTY ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER:	**27**
IMPLEMENTATION DATE:	**7/2014**
ANALYST:	**Joel Singh**
FISCAL REFERENCE NUMBER:	**1813**

	FY 2016-17	FY 2017-18
TOTAL FUNDS	**$4,710,000**	**$3,310,000**
STATE FUNDS	$0	$0
FEDERAL FUNDS	**$4,710,000**	**$3,310,000**

DESCRIPTION

Purpose:
This policy change estimates the administrative costs for counties who provide Drug Medi-Cal (DMC) services under the State Plan and under the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver.

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 2016-17 and FY 2017-18, is due to a higher number of county claims received for FY 2015-16, and updated payment projections for FY 2016-17 and FY 2017-18 claims.

The change in the current estimate, from FY 2016-17 to FY 2017-18, is due to lower projections for FY 2016-17 and FY 2017-18 claims in FY 2017-18.

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 cost for FY 2016-17 and FY 2017-18 is:

FY 2016-17	County Admin Cost	Title XIX	County Funds
FY 2015-16 Claims, Q4	$4,732,000	$2,366,000	$2,366,000
FY 2016-17 Claims, Q1-Q3	$4,687,000	$2,344,000	$2,343,000
Total	$9,419,000	**$4,710,000**	$4,709,000

FY 2017-18	County Admin Cost	Title XIX	County Funds
FY 2016-17 Claims, Q4	$1,655,000	$827,000	$828,000
FY 2017-18 Claims, Q1-Q3	$4,965,000	$2,483,000	$2,482,000
Total	$6,620,000	**$3,310,000**	$3,310,000

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

MEDS MODERNIZATION

OTHER ADMIN. POLICY CHANGE NUMBER:	**28**
IMPLEMENTATION DATE:	**2/2013**
ANALYST:	**Ila Zapanta**
FISCAL REFERENCE NUMBER:	**1731**

	FY 2016-17	FY 2017-18
TOTAL FUNDS	**$2,942,000**	**$0**
STATE FUNDS	**$379,700**	**$0**
FEDERAL FUNDS	**$2,562,300**	**$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.

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. A recently 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.

Reason for Change:
There is no change from the prior estimate for FY 2016-17. There are no local assistance funds allocated to this project in FY 2017-18.

Methodology:
1. Project planning, project support, 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.

3. PAL Assessment fee costs are based on the set charge of $4,500 per month beginning with the start of PAL Stage Gate 2 activities.

MEDS MODERNIZATION

OTHER ADMIN. POLICY CHANGE NUMBER: 28

4. Operating Expense and Equipment (OE&E) costs are based on an estimate of $1,000 per consultant resource per month.

5. Costs are shared between federal funds (FF) and general funds (GF).

FY 2016-17	TF	GF	FF
BRE Software Maintenance*	$570,000	$142,000	$428,000
Project Planning Consultants	$531,000	$53,000	$478,000
Project Support Consultants	$540,000	$54,000	$486,000
Alternative Analysis Consultants	$1,000,000	$100,000	$900,000
County Welfare Director's Association Consultants	$190,000	$19,000	$171,000
PAL Assessment Fees	$27,000	$3,000	$24,000
Operating Expense and Equipment	$84,000	$8,000	$76,000
Total	**$2,942,000**	**$379,000**	**$2,563,000**

Funding:
75% Title XIX / 25% GF (4260-101-0001/0890)*
90% Title XIX / 10% GF (4260-101-0001/0890)

SDMC SYSTEM M&O SUPPORT

OTHER ADMIN. POLICY CHANGE NUMBER:	29
IMPLEMENTATION DATE:	7/2013
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	1732

	FY 2016-17	FY 2017-18
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

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.

Reason for Change:
There is no change from the prior estimate for FY 2016-17 and FY 2017-18. There is no change from FY 2016-17 to FY 2017-18 in the current estimate.

Methodology:
1. The estimated contractor cost for the four-year contract is $8,000,000 and will end in June 2018.

2. Projections include the cost of ongoing M&O to process SMHS and SUDS claims payments.

FY 2016-17	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**

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**

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

ENROLLMENT ASSIST FOR BHT INSTITUTIONALLY DEEMED

OTHER ADMIN. POLICY CHANGE NUMBER: 30
IMPLEMENTATION DATE: 7/2016
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 1983

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$2,200,000	$0
STATE FUNDS	$1,100,000	$0
FEDERAL FUNDS	$1,100,000	$0

DESCRIPTION

Purpose:
The Department provides health insurance application enrollment assistance for the 157 current participants on the Home and Community Based Services (HCBS) Developmentally Disabled (DD) Waiver who will lose their Medi-Cal eligibility in March 2017. This program allows case managers to help transition these institutionally certifiable beneficiaries to other health care coverage by March 2017 to avoid gaps in coverage.

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 Behavioral Health Treatment (BHT) services to a state plan benefit, 157 DD Waiver participants, who only receive BHT services through the waiver, will lose Medi-Cal eligibility. This population was able to gain 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 are no longer receiving at least one HCBS waiver service and will no longer be Medi-Cal eligible under institutional deeming.

Reason for Change:
There is no change from the prior estimate for FY 2016-17.

Methodology:
1. Assume 157 participants will lose coverage.

2. Implementation of this program began in July 2016.

3. The Medi-Cal contracted application enrollment assistance cost is estimated to be $2,200,000 TF ($1,100,000 GF).

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

CA-MMIS GO-FORWARD STATE TRANSITION

OTHER ADMIN. POLICY CHANGE NUMBER: 31
IMPLEMENTATION DATE: 5/2010
ANALYST: Ila Zapanta
FISCAL REFERENCE NUMBER: 1322

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$2,090,000	$0
STATE FUNDS	$303,800	$0
FEDERAL FUNDS	$1,786,200	$0

DESCRIPTION

Purpose:
This policy change estimates the transition cost related to replacement and transition of the California Medicaid Management Information System (CA-MMIS).

Authority:
Title XIX of the Federal Social Security Act 1903(a)(3)

Interdependent Policy Changes:
Not Applicable

Background:
CA-MMIS is the claims processing system used for Medi-Cal. The transition costs incurred for CA-MMIS Replacement activities include interfacing with other Departmental mission critical systems such as Medi-Cal Eligibility Data System (MEDS); Management Information System and Decision Support System (MIS/DSS); and the California Healthcare Eligibility, Enhancement and Retention System (CALHEERS). As a result of the System Replacement Project (SRP) settlement agreement, the contractual responsibilities for the SRP have been removed from the Medical FI contract. Transition activities will continue to be required to support the following Go-Forward Work Streams:

1. Procure IT System Maintenance and Operation Services and FI Business Operations Services
2. Transform CA-MMIS Enterprise
3. Transition the SRP

The existing production and test regions will be needed to continue to support the current contract. Network configurations, testing environments (including system, user acceptance and parallel), testing tools, support for expansion enhancements, and new communication interfaces will be needed to run a parallel system. Consultative contractors and other resources are required to continue the SRP assessment.

Reason for Change:
There is no change in the Total Funds estimate from the prior estimate for FY 2016-17 and FY 2017-18. The funding splits in FY 2016-17, however, have been updated based on the approved Implementation Advance Planning Document Update (IAPDU).

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to no costs allocated in FY 2017-18.

CA-MMIS GO-FORWARD STATE TRANSITION

OTHER ADMIN. POLICY CHANGE NUMBER: 31

Methodology:

1. The estimated costs are based on contract provisions.

2. Advanced planning documents for these activities provide the basis for these estimates.

FY 2016-17	TF	GF	FF
50% Title XIX / 50% GF	$138,000	$69,000	$69,000
90% Title XIX / 10% GF	$1,908,000	$191,000	$1,717,000
100% GF	$44,000	$44,000	$0
Total	**$2,090,000**	**$304,000**	**$1,786,000**

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:	**Sharisse DeLeon**
FISCAL REFERENCE NUMBER:	**1137**

	FY 2016-17	FY 2017-18
TOTAL FUNDS	**$1,996,000**	**$2,750,000**
STATE FUNDS	**$199,600**	**$275,000**
FEDERAL FUNDS	**$1,796,400**	**$2,475,000**

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:
There is no change from the prior estimate for both FY 2016-17 and FY 2017-18. The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to increased costs associated with the expansion of the MITA initiative throughout the Department in order to meet federal regulations and guidelines.

MITA

OTHER ADMIN. POLICY CHANGE NUMBER: 32

Methodology:

1. The MITA project will employ contracted positions to continue the implementation phase in FY 2016-17 and FY 2017-18. FY 2017-18 amounts include costs associated with two separate contracts.

2. The current contract is effective December 2015 through June 2017. Payments for this contract began in January 2016 and will take 18 months to complete.

3. The FY 2017-18 contract amounts are associated with the expansion of the MITA initiative throughout the Department in order to meet federal regulations and guidelines. The new contract will be effective July 2017 through December 2018. Payments for the new contract will begin August 2017.

4. The projected costs are:

Fiscal Year	TF	GF	FF
FY 2016-17	$1,996,000	$199,600	$1,796,400
FY 2017-18	$2,750,000	$275,000	$2,475,000

Funding:

90% Title XIX / 10% GF (4260-101-0001/0890)

SSA COSTS FOR HEALTH COVERAGE INFO.

OTHER ADMIN. POLICY CHANGE NUMBER:	33
IMPLEMENTATION DATE:	1/1989
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	237

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$949,000	$1,500,000
STATE FUNDS	$474,500	$750,000
FEDERAL FUNDS	$474,500	$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 from the prior estimate, for FY 2016-17, is a decrease due to actual invoices from SSA being lower than expected. The change from the prior estimate, for FY 2017-18, is a decrease due to a trend of lower actual billings from SSA. The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to FY 2017-18 being based on the projected average using actual data from previous fiscal years.

Methodology:
1. The following projections are based upon the most current actual billings from SSA.

Fiscal Year	TF	GF	FF
FY 2016-17	$949,000	$474,500	$475,500
FY 2017-18	$1,500,000	$750,000	$750,000

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

MEDICARE BUY-IN QUALITY REVIEW PROJECT

OTHER ADMIN. POLICY CHANGE NUMBER:	**34**
IMPLEMENTATION DATE:	**10/2012**
ANALYST:	**Ila Zapanta**
FISCAL REFERENCE NUMBER:	**1590**

	FY 2016-17	FY 2017-18
TOTAL FUNDS	**$174,000**	**$200,000**
STATE FUNDS	**$87,000**	**$100,000**
FEDERAL FUNDS	**$87,000**	**$100,000**

DESCRIPTION

Purpose:
This policy change estimates the cost of contracts with the University of Massachusetts (UMASS) to identify potential overpayments to Centers for Medicare and Medicaid Services (CMS) and Medicare providers related to the Medicare Buy-In process for Medicare/Medi-Cal dual eligibles.

Authority:
Welfare & Institutions Code 14124.92
Contract 10-87134 A01
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. After the contract ended, the Department entered into a new three-year contract 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 beneficiaries. UMASS will continue 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:
The change from the prior estimate, for FY 2016-17, is a decrease due to a delay of data transmittal to the contractor. The contractor was unable to attain recovery of overpayments in FY 2016-17. The final invoice from the previous contract, however, was paid in FY 2016-17.

The change from the prior estimate, for FY 2017-18, is a decrease due to revising the contractor's cost estimate based on historical data of the contractor's past performance.

MEDICARE BUY-IN QUALITY REVIEW PROJECT

OTHER ADMIN. POLICY CHANGE NUMBER: 34

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due completing payments for a prior contract in FY 2016-17. Projected expenditures for the current contract is not expected until FY 2017-18.

Methodology:

1. The cost of the contractor is 10% of the amount recovered.

2. A final invoice from the previous contract was paid in July 2016 in the amount of $174, 000.

3. Assume the estimated amount recovered, in the new contract, will be $0 in FY 2016-17 and $2,000,000 in FY 2017-18. As a result, the contractor cost is estimated to be $0 in FY 2016-17 and $200,000 in FY 2017-18.

   FY 2016-17: $0 TF
   FY 2017-18: $2,000,000 x 10% = $200,000 TF

4. The estimated contractor costs are:

Fiscal Year	TF	GF	FF
FY 2016-17	$174,000	$87,000	$87,000
FY 2017-18	$200,000	$100,000	$100,000

Funding:

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

FAMILY PACT PROGRAM ADMIN.

OTHER ADMIN. POLICY CHANGE NUMBER:	35
IMPLEMENTATION DATE:	7/2012
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1675

	FY 2016-17	FY 2017-18
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 2016-17	$1,207,000	$603,500	$603,500
FY 2017-18	$1,207,000	$603,500	$603,500

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

CALIFORNIA HEALTH INTERVIEW SURVEY

OTHER ADMIN. POLICY CHANGE NUMBER:	**36**
IMPLEMENTATION DATE:	**7/2015**
ANALYST:	**Joel Singh**
FISCAL REFERENCE NUMBER:	**1902**

	FY 2016-17	FY 2017-18
TOTAL FUNDS	**$1,373,000**	**$1,000,000**
STATE FUNDS	**$0**	**$0**
FEDERAL FUNDS	**$1,373,000**	**$1,000,000**

DESCRIPTION

Purpose:
This policy change estimates the California Health Interview Survey (CHIS) contract services costs.

Authority:
Interagency Agreement (IA) 15-92271

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 had a shared contract with CDPH to provide federal funding for CHIS; this contract ended June 30, 2015. The contract with CDPH limited the Department's ability to increase survey contents necessary for program administration. The cost for this contract was budgeted in the Other Administrative policy change titled FFP for Department of Public Health Support Costs. Effective July 1, 2015, 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 will end on June 30, 2021.

Reason for Change:
The change from the prior estimate, for FY 2016-17, is due to FY 2015-16 claims being included in this estimate as a result of a delay in claims processing. The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to estimating FY 2016-17 and FY 2017-18 payment based on when invoices are expected to be received.

Methodology:
1. Assume UCLA will submit documentation of CPEs on the CHIS survey. Expenditures will consist of funds received by UCLA from non-federal sources.

CALIFORNIA HEALTH INTERVIEW SURVEY

OTHER ADMIN. POLICY CHANGE NUMBER: 36

2. On an accrual basis, the maximum reimbursable amount for California Health Interview Survey is $1,000,000 FF annually.

3. 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.

4. The estimated administrative costs reimbursements for FY 2016-17 and FY 2017-18, on a cash basis are:

FY 2016-17	TF	FF
FY 2015-16 Claims	$873,000	$873,000
FY 2016-17 Claims	$500,000	$500,000
Total	**$1,373,000**	**$1,373,000**

FY 2017-18	TF	FF
FY 2016-17 Claims	$500,000	$500,000
FY 2017-18 Claims	$500,000	$500,000
Total	**$1,000,000**	**$1,000,000**

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

SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER:	37
IMPLEMENTATION DATE:	7/2002
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	258

	FY 2016-17	FY 2017-18
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 2016-17 and FY 2017-18. There is no change from FY 2016-17 to FY 2017-18 in the current estimate.

Methodology:
1. Based on contract provisions, the administrative activities costs will be **$950,000** for **FY 2016-17** and **FY 2017-18**.

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 2016-17	FY 2017-18
TOTAL FUNDS	$1,091,000	$899,000
STATE FUNDS	$545,500	$449,500
FEDERAL FUNDS	$545,500	$449,500

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 150 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 31.

Reason for Change:
The change in FY 2016-17, from the prior estimate, is due to a delay in invoices received for the FY 2015-16 contract period, which are expected to be paid by June 30, 2017. The change in FY 2017-18, from the prior estimate, is due to a reduction in the anticipated invoice payments.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to the completion of FY 2015-16 contract payments in FY 2016-17, as well as lower invoice amounts expected to be paid in FY 2017-18.

MMA - DSH ANNUAL INDEPENDENT AUDIT

OTHER ADMIN. POLICY CHANGE NUMBER: 38

Methodology:

1. The new contract amount is $1,762,000 for two years with two optional twelve (12) month extensions.

2. The prior contract ended on December 31, 2015. On January 1, 2016, a new contractor took over starting with the FY 2012-13 audit.

3. In FY 2016-17, the Department will make final payment for the FY 2012-13 audit and partial payment for the FY 2013-14 audit.

4. In FY 2017-18, the Department will make final payment for the FY 2013-14 audit.

5. In FY 2017-18, the Department will issue the May and June 2017 invoice payments.

6. The contract is assumed to be extended through June 30, 2018.

Fiscal Years	TF	GF	FF
FY 2016-17	$1,091,000	$545,500	$545,500
FY 2017-18	$899,000	$449,500	$449,500

Funding:

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

DMC COUNTY UR & QA ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER:	39
IMPLEMENTATION DATE:	5/2017
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1871

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$111,000	$6,156,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$111,000	$6,156,000

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 64 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 to test a new paradigm 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.

For FY 2016-17 and FY 2017-18, the counties phase-in schedule is projected as follows and is contingent upon their implementation plan and rates approval:

- Seven counties (San Mateo, Riverside, Santa Cruz, Santa Clara, Marin, San Francisco, and Contra Costa) will begin DMC-ODS waiver services in FY 2016-17.
- Nine additional counties (for a total of 16 counties) will begin providing services in FY 2017-18.

DMC COUNTY UR & QA ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 39

DMC UR & QA administrative costs are only reimbursable for counties that opt-in to participate in the DMC-ODS waiver.

Reason for Change:
The change from the prior estimate, for FY 2016-17 and FY 2017-18, is due to the following:

- Decreased payments in FY 2016-17 due to updated DMC-ODS waiver implementation schedule for certain counties.
- The UR and QA estimated annual cost was revised, resulting in an increase in FY 2017-18.

The change in the current estimate, from FY 2016-17 to FY 2017-18, is due to the addition of nine counties that are projected to implement the waiver in FY 2017-18. Out of the seven counties implementing the waiver in FY 2016-17, five counties will start services in the fourth quarter. As a result, payments for these five counties will be realized in FY 2017-18.

Methodology:

1. Counties began their UR and QA upon implementation of the DMC-ODS waiver starting February 2017. Payments are estimated to begin May 2017 for counties that implemented the waiver in the third quarter of FY 2016-17.

2. UR and QA expenditures are shared between FF and county funds (CF).

3. The UR and QA estimated annual cost on an accrual basis is $22,667,000 TF.

4. UR and QA costs for SPMP will receive enhanced federal reimbursement of 75%. All other personnel will receive 50% federal reimbursement.

5. Assume 75% of the total claims are for SPMP costs and the remaining 25% are for other personnel costs.

6. 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.

7. The estimated UR and QA administrative cost for FY 2016-17 and FY 2017-18 are:

FY 2016-17	TF	FFP	CF
SPMP	$122,000	$91,000	$31,000
Other Personnel	$41,000	$20,000	$21,000
Total	$163,000	**$111,000**	$52,000
FY 2017-18	**TF**	**FFP**	**CF**
SPMP	$6,716,000	$5,037,000	$1,679,000
Other Personnel	$2,239,000	$1,119,000	$1,120,000
Total	$8,955,000	**$6,156,000**	$2,799,000

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

IRS REPORTING FOR MIN. ESSENTIAL COVERAGE

OTHER ADMIN. POLICY CHANGE NUMBER: 40
IMPLEMENTATION DATE: 3/2017
ANALYST: Ila Zapanta
FISCAL REFERENCE NUMBER: 1965

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$376,000	$1,024,000
STATE FUNDS	$188,000	$512,000
FEDERAL FUNDS	$188,000	$512,000

DESCRIPTION

Purpose:
The policy change estimates the costs associated with the system to communicate with the Internal Revenue System (IRS) in order to transmit the minimum essential coverage (MEC) data of Medi-Cal recipients.

Authority:
Internal Revenue Code Section 6055

Interdependent Policy Changes:
Not Applicable

Background:
As a provider of Medi-Cal MEC, the Department is required to report coverage information by filing information comprised months of coverage that meet MEC for individuals with the IRS and furnishing a statement to 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 Information Return (AIR) system.

The Department will procure a contractor with the specialized web-services and data modeling technical skills to assist with the IRS AIR system requirement changes and provide knowledge transfer to the Department. Additional costs for hardware and software costs are needed for new technical requirements. The contract is expected to begin March 2017 and end June 2018.

Reason for Change:
The change from the prior estimate, for FY 2016-17, is a decrease due to the delay in procuring a contractor and changing the contractor's start date from December 2016 to March 2017. The change from the prior estimate, for FY 2017-18, is an increase due to the delay in procuring a contractor and costs shifting to impact FY 2017-18. The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to a partial year of payments in FY 2016-17 and the remaining contract funding estimated to be paid in FY 2017-18.

Methodology:
1. Design, Development, and Implementation (DD&I) contracts will begin in FY 2016-17.

2. Costs are based on the current understanding of the IRS' AIR system, the project implementation enhancement to exchange data between the Department and IRS, and system stabilization.

IRS REPORTING FOR MIN. ESSENTIAL COVERAGE

OTHER ADMIN. POLICY CHANGE NUMBER: 40

3. Estimates were developed using analogous cost estimating, known system requirements, and industry standard system development expenses.

FY 2016-17	TF	GF	FF
Project Planning and Support	$150,000	$75,000	$75,000
Technical Consulting Services	$150,000	$75,000	$75,000
Hardware	$50,000	$25,000	$25,000
Software	$26,000	$13,000	$13,000
Total	**$376,000**	**$188,000**	**$188,000**

FY 2017-18	TF	GF	FF
Project Planning and Support	$400,000	$200,000	$200,000
Technical Consulting Services	$400,000	$200,000	$200,000
Hardware	$100,000	$50,000	$50,000
Software	$124,000	$62,000	$62,000
Total	**$1,024,000**	**$512,000**	**$512,000**

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

ENCRYPTION OF PHI DATA

OTHER ADMIN. POLICY CHANGE NUMBER: 41
IMPLEMENTATION DATE: 5/2010
ANALYST: Ila Zapanta
FISCAL REFERENCE NUMBER: 1452

	FY 2016-17	FY 2017-18
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 that are necessary to protect and secure electronic data stored on backup systems. The data on 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 its public image and integrity for protecting confidentiality and privacy of 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 continue to grow and support its virtualization infrastructure and to provide backup and recovery methods for this infrastructure.

The upgrade allows the Department to:

- Effectively and efficiently manage Department growth,
- Provide additional backup, recovery, and storage for the business programs, and
- Enhance data security and management.

ENCRYPTION OF PHI DATA

OTHER ADMIN. POLICY CHANGE NUMBER: 41

Reason for Change:
There is no change from the prior estimate for FY 2016-17 and FY 2017-18. There is no change from FY 2016-17 to FY 2017-18 in the current estimate.

Methodology:
1. The following amounts are based upon the latest projections of cost:

Fiscal Year	TF	GF	FF
FY 2016-17	$750,000	$375,000	$375,000
FY 2017-18	$750,000	$375,000	$375,000

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

MEDICARE BENEFICIARY IDENTIFIER

OTHER ADMIN. POLICY CHANGE NUMBER: 42
IMPLEMENTATION DATE: 4/2017
ANALYST: Sharisse DeLeon
FISCAL REFERENCE NUMBER: 1997

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$335,000	$1,280,000
STATE FUNDS	$33,500	$128,000
FEDERAL FUNDS	$301,500	$1,152,000

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 DHCS partners;

MEDICARE BENEFICIARY IDENTIFIER

OTHER ADMIN. POLICY CHANGE NUMBER: 42

- 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 2016-17, is a decrease due to delayed approval of the Implementation Advanced Planning Document (IAPD), resulting in payments shifting from December 2016 to April 2017.

There is no change from the prior estimate for FY 2017-18.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to partial year payments occurring in FY 2016-17 compared to a full year of payments in FY 2017-18.

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 contract costs are expected to be $3,200,000, with payments anticipated to begin in April 2017.

Fiscal Year	TF	GF	FF
FY 2016-17	$335,000	$33,500	$301,500
FY 2017-18	$1,280,000	$128,000	$1,152,000

Funding:
90% Title XIX / 10% GF (4260-101-0001/0890)

CA-MMIS PROCUREMENT CONSULTANTS

OTHER ADMIN. POLICY CHANGE NUMBER: 43
IMPLEMENTATION DATE: 7/2016
ANALYST: Ila Zapanta
FISCAL REFERENCE NUMBER: 1981

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$478,000	$0
STATE FUNDS	$69,600	$0
FEDERAL FUNDS	$408,400	$0

DESCRIPTION

Purpose:
The policy change estimates the associated cost of the procurement for vendors to assist with the development of the Request for Proposal (RFP) for the California Medicaid Management Information System (CA-MMIS) Medical Fiscal Intermediary (FI) contract, set to expire March 31, 2020.

Authority:
Not Applicable

Interdependent Policy Changes:
None

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.

As a result of the FI contract term ending March 31, 2020, the Department must ensure that the procurement of a new FI contractor occurs as efficiently as possible to allow for timely and accurate claims processing for Medi-Cal providers. The development of the RFP and subsequent procurement is anticipated to take a minimum of 36 months. Due to CA-MMIS' extremely complex nature and constantly evolving federal regulations, the Department has identified the need for vendors to assist with the procurement of a new FI contractor and assist with transforming the CA-MMIS enterprise. Procurement consultants will provide expert assistance in the development of more detailed RFPs. This will also support easily enforceable payment terms and conditions for each of the resulting contracts. Additionally, enterprise transition and integration support services vendors will assist with various procurement preparation activities including but not limited to project tool support, vendor management, integration resourcing, and business process reengineering.

Reason for Change:
The change from the prior estimate, for FY 2016-17, is a decrease due to less procurement consultants needed. In addition, the funding splits have been updated based on the approved Implementation Advance Planning Document Update (IAPDU).

There is no change from the prior estimate for FY 2017-18. The change from the FY 2016-17 to FY 2017-18, in the current estimate, is due to no costs allocated in FY 2017-18.

CA-MMIS PROCUREMENT CONSULTANTS

OTHER ADMIN. POLICY CHANGE NUMBER: 43

Methodology:

1. It is estimated that the contractor will be paid the following amounts:

FY 2016-17	TF	GF	FF
50% Title XIX / 50% GF	$32,000	$16,000	$16,000
90% Title XIX / 10% GF	$436,000	$44,000	$392,000
100% GF	$10,000	$10,000	$0
Total	**$478,000**	**$70,000**	**$408,000**

Funding:

FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 90% Title XIX / 10% GF (4260-101-0001/0890)
100% GF (4260-101-0001)

POSTAGE AND PRINTING - THIRD PARTY LIAB.

OTHER ADMIN. POLICY CHANGE NUMBER: 44
IMPLEMENTATION DATE: 7/1996
ANALYST: Ila Zapanta
FISCAL REFERENCE NUMBER: 240

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$710,000	$740,000
STATE FUNDS	$355,000	$370,000
FEDERAL FUNDS	$355,000	$370,000

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 from the prior estimate, for FY 2016-17, is an increase due to more mail outs for Personal Injury and printed forms for Estate Recovery. The change from the prior estimate, for FY 2017-18, is an increase due to more mail outs for Personal Injury and the inclusion of costs for a new document folder inserter. The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to the cost for a new document folder inserter in FY 2017-18.

Methodology:
1. The cost breakdown is shown below:

FY 2016-17	Postage	Printing	Other	Total
Personal Injury	$185,000	$28,000	$0	$213,000
Estate Recovery	$104,000	$377,000	$0	$481,000
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
Total	$302,000	$407,000	$1,000	**$710,000**

POSTAGE AND PRINTING - THIRD PARTY LIAB.

OTHER ADMIN. POLICY CHANGE NUMBER: 44

FY 2017-18	Postage	Printing	Other	Total
Personal Injury	$185,000	$28,000	$0	$213,000
Estate Recovery	$104,000	$377,000	$0	$481,000
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	$30,000	$30,000
Total	$302,000	$407,000	$31,000	**$740,000**

*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 2016-17	**$710,000**	**$355,000**	**$355,000**
FY 2017-18	**$740,000**	**$370,000**	**$370,000**

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

VENDOR FOR AAC RATE STUDY

OTHER ADMIN. POLICY CHANGE NUMBER:	45
IMPLEMENTATION DATE:	9/2015
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1483

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$645,000	$325,000
STATE FUNDS	$322,500	$162,500
FEDERAL FUNDS	$322,500	$162,500

DESCRIPTION

Purpose:
This policy change estimates the costs related to hiring two contractors; one for project management services and another 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.

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, the 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.

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 is from September 2015 to June 2017, which allows the Department to retain the contractor's services throughout the transition from the current Average Wholesale Price reimbursement to a new AAC based methodology.

VENDOR FOR AAC RATE STUDY

OTHER ADMIN. POLICY CHANGE NUMBER: 45

Due to the complexity of work, compacted timelines, and need for extensive coordination between the Department, Mercer, 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.

Reason for Change:
There is no change from the prior estimate for FY 2016-17. The change from the prior estimate, for FY 2017-18, is an increase due to extending the project management contract.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to the completion of the AAC Rate Study contract in FY 2016-17 and the addition of costs to extend the project management contract in FY 2017-18.

Methodology:
1. The contract for the AAC Rate Study, for $305,000, is from September 1, 2015 to June 30, 2017. Assume the survey and report aspects of the project is complete and the costs for the AAC contractor concludes June 30, 2017.

2. Assume the project management contract will be extended through FY 2017-18 for ongoing system changes and to continue the AAC implementation efforts. The contract costs are $340,000 for FY 2016-17 and $325,000 for FY 2017-18.

Contractor Costs	TF	GF	FF
FY 2016-17	$645,000	$322,500	$322,500
FY 2017-18	$325,000	$162,500	$162,500

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

CLINICAL DATA COLLECTION

OTHER ADMIN. POLICY CHANGE NUMBER:	46
IMPLEMENTATION DATE:	9/2016
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1972

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$468,000	$4,000,000
STATE FUNDS	$46,800	$475,000
FEDERAL FUNDS	$421,200	$3,525,000

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 Milliman Care Guidelines) are nationally recognized, evidence-based medical criteria. Medicare currently requires hospitals which service Medicare patients to use InterQual.

CLINICAL DATA COLLECTION

OTHER ADMIN. POLICY CHANGE NUMBER: 46

To allow the Department to collect and review clinical information for selected Medi-Cal members admitted to acute care hospitals, 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.

Reason for Change:
There is no change from the prior estimate for FY 2016-17.

The change from the prior estimate, for FY 2017-18, is due to an updated estimate to reflect Maintenance & Operation (M&O) and Independent Verification and Validation (IV&V) costs. The General Fund increased by $75,000 due to including M&O costs, which are funded at the 75% / 25% Federal Medical Assistance Percentage (FMAP).

The change from FY 2016-17 to FY 2017-18, in the current estimate is due to increased costs for the Internal and External SMEs; and the inclusion of costs for the DD&I and IV&V vendors, M&O, software, and hardware in FY 2017-18.

Methodology:
1. The effective date of the contract is August 2016. Payments began in September 2016.

2. Total costs are estimated to be $12.4 million TF over five years.

FY 2016-17	TF	GF	FF
Internal Technical SME	$229,000	$22,900	$206,100
External Business SME	$140,000	$14,000	$126,000
Acquisition Specialist	$99,000	$9,900	$89,100
Total FY 2016-17	**$468,000**	**$46,800**	**$421,200**

FY 2017-18	TF	GF	FF
Internal Technical SME	$250,000	$25,000	$225,000
External Business SME	$250,000	$25,000	$225,000
DD&I Vendor	$1,375,000	$137,500	$1,237,500
M&O*	$500,000	$125,000	$375,000
IV&V Vendor	$125,000	$12,500	$112,500
Software	$500,000	$50,000	$450,000
Hardware	$1,000,000	$100,000	$900,000
Total FY 2017-18	**$4,000,000**	**$475,000**	**$3,525,000**

Funding:
90% Title XIX / 10% GF (4260-101-0001/0890)
75% Title XIX / 25% GF (4260-101-0001/0890)*

ETL DATA SOLUTION

OTHER ADMIN. POLICY CHANGE NUMBER:	47
IMPLEMENTATION DATE:	9/2013
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	1768

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$363,000	$334,000
STATE FUNDS	$87,450	$83,500
FEDERAL FUNDS	$275,550	$250,500

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 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 project began production in January 2017. Additional costs for FY 2016-17 were approved in a new Implementation Advance Planning Document Update (IAPDU) to CMS system requirements. The Department also 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 with an expected completion date in September 2017. An additional maintenance and operations consulting resource to engage in troubleshooting and error report analysis was approved under the IAPDU. The need for this consultant will be determined in FY 2017-18, based on the status of the project.

Reason for Change:
The change from the prior estimate, for FY 2016-17, is a decrease due to delays in gaining approval of the IAPDU and exclusion of the M&O contract for troubleshooting/error report consultant. The change from the prior estimate, for FY 2017-18, is an increase due to the shift in expenditures from FY 2016-17 to FY 2017-18 caused by the delayed IAPDU. The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to DD&I ending in FY 2016-17 and revising M&O and software costs (based on procured contracts) in FY 2017-18.

ETL DATA SOLUTION

OTHER ADMIN. POLICY CHANGE NUMBER: 47

Methodology:

1. The contractor began DD&I work in August 2013 and continued through August 2016.

2. The M&O contract for server environment upgrade, operational recovery plan development, systems schema development, and documentation work began in January 2017.

3. Due to updated project plans, the M&O contract for a troubleshooting/error report consultant will not be needed in FY 2016-17. The project requirements and cost for this consultant are currently not included, but will be determined in FY 2017-18 based on the status of the project.

4. The initial Data Quality software was procured in December 2015. The software maintenance renewal for PowerCenter was procured in December 2016 to meet system requirements.

5. The Department developed an IAPDU that extended the project to meet the additional CMS requirements and ongoing support for M&O. The project advanced to production in April 2017.

FY 2016-17	TF	GF	FF
DD&I (90% FF / 10% GF)	$22,000	$2,000	$20,000
M&O (75% FF / 25% GF)	$106,000	$26,000	$80,000
Software (75% FF / 25% GF)	$235,000	$59,000	$176,000
Total	**$363,000**	**$87,000**	**$276,000**

FY 2017-18	TF	GF	FF
M&O (75% FF / 25% GF)	$84,000	$21,000	$63,000
Software (75% FF / 25% GF)	$250,000	$62,000	$188,000
Total	**$334,000**	**$83,000**	**$251,000**

Funding:

75% Title XIX / 25% GF (4260-101-0001/0890)
90% Title XIX / 10% GF (4260-101-0001/0890)

CCT OUTREACH - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	48
IMPLEMENTATION DATE:	4/2011
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1556

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$291,000	$348,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$291,000	$348,000

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 2016-17, is a decrease due to actual amounts reported were lower than expected. There is no change from the prior estimate for FY 2017-18. There is no significant change from FY 2016-17 to FY 2017-18 in the current estimate.

Methodology:
1. Assume $291,000 from the additional MFP grant funding is expected to be paid in FY 2016-17.

CCT OUTREACH - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 48

2. Assume $348,000 from the additional MFP grant funding is expected to be paid in FY 2017-18.

3. Estimated costs are based on 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 2016-17	TF	GF	FF
CCT Costs (PC 35):			
Total Non-DD GF costs and Total FFP	$19,545,000	$2,534,000	$17,011,000
CCT Savings:			
Total Non-DD savings and Total FFP*	($29,123,000)	($14,562,000)	($14,561,000)
QoL CCT Costs (PC 49)	$97,000	$0	$97,000
CCT Fund Transfer to CDSS & CDDS (PC 41)	$1,825,000	$0	$1,825,000
CCT Outreach - Admin costs (OA 48)	**$291,000**	**$0**	**$291,000**
Total of CCT PCs including pass through	($7,365,000)	($12,028,000)	$4,663,000

*The savings are included in the total, however, they are fully reflected in the base estimates.

FY 2017-18	TF	GF	FF
CCT Costs (PC 35):			
Total Non-DD GF costs and Total FFP	$19,680,000	$2,642,000	$17,038,000
CCT Savings:			
Total Non-DD savings and Total FFP*	($31,071,000)	($15,536,000)	($15,535,000)
CCT Fund Transfer to CDSS & CDDS (PC 41)	$2,458,000	$0	$2,458,000
CCT Outreach - Admin costs (OA 48)	**$348,000**	**$0**	**$348,000**
Total of CCT PCs including pass through	($8,585,000)	($12,894,000)	$4,309,000

*The savings are included in the total, however, they are fully reflected in the base estimates.

Funding:
MFP Federal Grant (4260-106-0890)

DENTAL PAPD PROJECT MANAGER

OTHER ADMIN. POLICY CHANGE NUMBER:	50
IMPLEMENTATION DATE:	7/2016
ANALYST:	Nikaela Ratliff
FISCAL REFERENCE NUMBER:	1739

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$226,000	$125,000
STATE FUNDS	$56,500	$31,250
FEDERAL FUNDS	$169,500	$93,750

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 is currently seeking approval on a contract extension amendment which will 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.

Reason for Change:
The change from the prior estimate is due to a pending contract extension which will add costs to FY

DENTAL PAPD PROJECT MANAGER

OTHER ADMIN. POLICY CHANGE NUMBER: 50

2017-18. The change from CY to BY is due to the CPM contract only extending for 6 months of FY 2017-18 pending the extension approval.

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 is currently seeking approval on a contract extension amendment which will extend the contract with the CPM through December 31, 2017.

Fiscal Year	TF	GF	FF
FY 2016-17	$226,000	$57,000	$169,000

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)

STATE CONTROLLER'S OFFICE INTERAGENCY AGREEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 51
IMPLEMENTATION DATE: 11/2016
ANALYST: Nikaela Ratliff
FISCAL REFERENCE NUMBER: 2001

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$32,000	$173,000
STATE FUNDS	$8,000	$43,250
FEDERAL FUNDS	$24,000	$129,750

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 the takeover of performing the check write function.

Reason for Change:
The change from the prior estimate is due to payments shifting from FY 2016-17 to FY 2017-18 as only expenditures for work performed in FY 2015/16 were invoiced and paid in December 2016. The change from FY 2016-17 to FY 2017-18 is due to all remaining expenses being paid in FY 2017-18.

Methodology:
1. Expenditures related to work performed in FY 2015-16 in the amount of $32,000 TF were paid in December 2016.

2. 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 2016-17	$32,000	$8,000	$24,000
FY 2017-18	$173,000	$43,250	$129,750

Funding:

STATE CONTROLLER'S OFFICE INTERAGENCY AGREEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 51

FI 75% Title XIX FF / 25% GF (4260-101-0001/0890)

CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	52
IMPLEMENTATION DATE:	7/2012
ANALYST:	Stephanie Hockman
FISCAL REFERENCE NUMBER:	1388

	FY 2016-17	FY 2017-18
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 2016-17 to FY 2017-18.

Methodology:
It is assumed that $100,000 will be drawn down with counties' CPE in FY 2016-17 and FY 2017-18.

Fiscal Year	FFP
FY 2016-17	$100,000
FY 2017-18	$100,000

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

PREVENTION OF CHRONIC DISEASE GRANT PROJECT

OTHER ADMIN. POLICY CHANGE NUMBER:	53
IMPLEMENTATION DATE:	2/2012
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1635

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$80,000	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$80,000	$0

DESCRIPTION

Purpose:
This policy change budgets the federal funds awarded to the Department by the Centers of Medicare and Medicaid Services (CMS) for the Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) grant project.

Authority:
Affordable Care Act (ACA), Section 4108

Interdependent Policy Changes:
Not Applicable

Background:
Section 4108 of the ACA authorized the five-year MIPCD grant project. California's MIPCD proposal created the Medi-Cal Incentives to Quit Smoking Project to use outreach and incentives to encourage access to smoking cessation services.

The Department contracted with the University of California San Francisco (UCSF) to implement, administer and evaluate the MIPCD program. The UCSF- California Medicaid Research Institute provides administrative support, coordination with key University of California (UC) partners, and contracts directly with the University of California San Diego (UCSD) to operate the California Smokers Helpline.

The California Smokers Helpline offers various incentives such as free counseling and nicotine replacement therapy to Medi-Cal beneficiaries. The MIPCD project also provides outreach services to Medi-Cal beneficiaries and Medi-Cal providers via the California Diabetes Program, which is administered by the Department of Public Health and UCSF.

The Department was awarded the MIPCD grant on September 13, 2011 by CMS and a contract with UCSF was secured on January 27, 2012. The MIPCD grant sunsets on September 12, 2016.

Reason for Change:
There is no change from the prior estimate.

Methodology:
1. Projected costs are based on proposed contract amounts with UCSF for administration, implementation and evaluations associated with the MIPCD grant project.

PREVENTION OF CHRONIC DISEASE GRANT PROJECT

OTHER ADMIN. POLICY CHANGE NUMBER: 53

2. On September 29, 2015, CMS approved the Department's request for a $206,000 carryover of unspent funds from Project Year 2014-15 (9/13/14 - 9/13/15) to be carried over into Project Year 2015-16 (9/13/15 – 9/12/16).

3. On September 3, 2015, CMS approved the Department's request for a $932,000 continuation for Project Year 2015-16 (9/13/15 – 9/12/16).

4. FY 20167-17 estimated expenditures total $80,000 for Project Year 2015-16 (7/1/2016 – 9/12/2016).

FY 2016-17	TF	FF
Project Year 2015-16	**$80,000**	**$80,000**

Funding:
MIPCD Federal Grant (4260-107-0890)

TAR POSTAGE

OTHER ADMIN. POLICY CHANGE NUMBER:	54
IMPLEMENTATION DATE:	7/2003
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	267

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$54,000	$54,000
STATE FUNDS	$27,000	$27,000
FEDERAL FUNDS	$27,000	$27,000

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 both FY 2016-17 and 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 2016-17 to FY 2017-18 in the current estimate.

Methodology:
1. TAR postage costs for Medi-Cal are assumed to be $54,000 for FY 2016-17 and FY 2017-18.

2. Estimates are based on actual expenditures from July 2015 through December 2016.

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

ACA EXPANSION ADMIN COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	55
IMPLEMENTATION DATE:	9/2013
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1795

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$86,000	$0
STATE FUNDS	$43,000	$0
FEDERAL FUNDS	$43,000	$0

DESCRIPTION

Purpose:
This policy change estimates the contract 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. Additionally, 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 mandatory expansions. The significant Medi-Cal growth necessitated additional testing resources to keep pace with the many enhancements to the Medi-Cal Eligibility Data Base mandated by eligibility changes.

This policy change estimates the contract costs associated with IT consultant services including:
- Providing technical expertise in preparing test cases, scenarios, data, and documentation,
- Ensuring quality controls are adhered to prior to implementing system changes,
- Coordinating quality assurance activities, enterprise testing, release management, and other levels of system testing, as well as providing technical assistance for the Department.

Reason for Change:
The increase from the prior estimate for FY 2016-17 is due to the final invoice amount being higher than previously expected.

Methodology:
1. The Department estimates IT consultant services for the ACA expansion population to be $86,000 TF ($43,000 GF) in FY 2016-17.

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

EPOCRATES

OTHER ADMIN. POLICY CHANGE NUMBER:	56
IMPLEMENTATION DATE:	4/2007
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1157

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$9,000	$0
STATE FUNDS	$4,500	$0
FEDERAL FUNDS	$4,500	$0

DESCRIPTION

Purpose:
This policy change estimates the cost of a contract with Epocrates Rx™.

Authority:
Contract # 10-87055

Interdependent Policy Changes:
Not Applicable

Background:
Epocrates Rx™ contains important drug list and clinical information for commercial health plans and Medicaid programs throughout the country.

The Department entered into a contract with Epocrates to place Medi-Cal's Contract Drug List (CDL) and up to three other departmental "formularies", for example, Family Planning, Access, and Treatment (Family PACT) or AIDS Drug Assistance Program (ADAP), in the Epocrates system for access by subscribers. The contract was not renewed as a result of Epocrates' decision to discontinue their formulary hosting line of business.

Epocrates provided the Department with an opportunity to reach a large network of health professionals via a unique point-of-care clinical reference solution for physicians and other health professionals accessible on both handheld devices and Internet based desktop computers.

Reason for Change:
There is no change from the prior estimate for both FY 2016-17 and FY 2017-18.

Methodology:
1. The contract ended in July 2016. The FY 2016-17 expense is $9,000 for the month of August 2016.

Fiscal Year	TF	GF	FF
FY 2016-17	$9,000	$4,500	$4,500

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

ELECTRONIC ASSET VERIFICATION PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER:	57
IMPLEMENTATION DATE:	10/2017
ANALYST:	Jason Moody
FISCAL REFERENCE NUMBER:	2002

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$0	**$2,416,000**
STATE FUNDS	$0	**$1,208,000**
FEDERAL FUNDS	$0	**$1,208,000**

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 will 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 will need to provide additional supporting documentation before an eligibility determination or redetermination is made.

The Department will reimburse financial institutions when obtaining information on asset amounts for ABD beneficiaries under the AVP. The reimbursements are expected to range between $3.00 and $5.00 per beneficiary, based on volume. There will be no startup costs.

Program expenditures may potentially be 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.

The Department is conducting 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 will

ELECTRONIC ASSET VERIFICATION PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 57

conclude in April, 2017, and the full implementation of the AVP is expected to occur in the fall of 2017.

Reason for Change:
There is no change from the prior estimate.

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. Using an average of $4.00 per beneficiary, the vendor cost for FY 2017-18 is:

    604,000 asset verifications x $4.00/beneficiary **= $2,416,000 TF ($1,208,000 GF)**

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

MEDICAL INTERPRETERS

OTHER ADMIN. POLICY CHANGE NUMBER:	58
IMPLEMENTATION DATE:	3/2018
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1990

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$0	**$5,205,000**
STATE FUNDS	$0	**$2,602,500**
FEDERAL FUNDS	$0	**$2,602,500**

DESCRIPTION

Purpose:
This policy change estimates the administrative costs for activities related to establishing a medical interpreter pilot project, study or both to assess the efficacy of current medical interpreter services and identify gaps in access and care.

Authority:
SB 826 (Chapter 23, Statutes of 2016)
AB 635 (Chapter 600, Statutes of 2016)

Interdependent Policy Changes:
Not Applicable

Background:
Medi-Cal beneficiaries are diverse and speak various languages. As a result, existing federal and state law mandate that Medi-Cal providers ensure medical interpretation services are available to eligible Medi-Cal beneficiaries as follows:

- Commercial health plans must assess their members' language preference and provide interpretation and translation services in threshold languages.
- Hospitals are to provide language services, interpreters, and/or bilingual staff, under specified circumstances, and identify and record beneficiary's primary languages in hospital records.
- State and local agencies that provide services to a substantial number of limited English proficiency (LEP) and non-English speaking people are to provide bilingual services.

SB 826 and AB 635 authorize the Department to establish a multi-county pilot project, study, or both for the support of activities related to medical interpreters for LEP Medi-Cal beneficiaries. The pilot project, study, or both is intended to assess the efficacy of current medical interpretation services and identify any gaps in access or shortcomings in care due to language barriers, which may cause beneficiaries to be misdiagnosed, not get appropriate/timely treatment, and/or cause medical errors that jeopardize safety.

Reason for Change:
The change from the prior estimate, for FY 2016-17 and FY 2017-18, is due to a cost shift from FY 2016-17 to FY 2017-18 as a result of the delay in procuring a contractor for the medical interpreter pilot project. In addition, the costs previously budgeted in this policy change has been revised to exclude the support costs.

The change in the current estimate, from FY 2016-17 to FY 2017-18, is due to no anticipated costs in current year.

MEDICAL INTERPRETERS

OTHER ADMIN. POLICY CHANGE NUMBER: 58

Methodology:

1. The Department will develop strategies for the establishment of the medical interpreter pilot project, study, or both pursuant to the provisions of AB 635.

2. The Department is currently in the process of establishing a competitive procurement process to contract with an external vendor to establish the pilot project, study, or both. The contract is expected to begin in January 2018.

3. Assume initial payments to the vendor will begin March 2018.

4. The vendor contract costs are estimated to be **$5,205,000 TF ($2,602,500 GF)** in FY 2017-18.

Funding:

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

MEDICAL FI OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER:	**59**
IMPLEMENTATION DATE:	**7/2015**
ANALYST:	**Ila Zapanta**
FISCAL REFERENCE NUMBER:	**1916**

	FY 2016-17	FY 2017-18
TOTAL FUNDS	**$94,123,000**	**$93,135,000**
STATE FUNDS	**$30,557,750**	**$30,236,000**
FEDERAL FUNDS	**$63,565,250**	**$62,899,000**

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 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 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: 59

- 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 2016-17, is a net decrease due to lower costs for General ACLs processed; however the ECL costs have been added. The change from the prior estimate, for FY 2017-18, is a net increase due to the inclusion of ECL costs; however the costs for General ACLs and Online ACLs have decreased.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to less General ACLs, Online ACLs, and ECLs projected in FY 2017-18.

Methodology:
1. Operations costs are fixed price rates based on volumes within 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.

4. 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: 59

FY 2016-17	TF	GF	FF
General ACLs (75% FF/25% GF, 50% FF/50% GF)	$62,277,000	$21,797,000	$40,480,000
Online ACLs (75% FF/25% GF, 50% FF/50% GF)	$2,243,000	$785,000	$1,458,000
Prospective DUR (75% FF/25% GF)	$320,000	$80,000	$240,000
Retrospective DUR (50% FF/50% GF)	$76,000	$38,000	$38,000
Encounter Claim Lines (75% FF/25% GF)	$890,000	$223,000	$667,000
CA-EVS/CMS Processing (75% FF/25% GF)	$4,900,000	$1,225,000	$3,675,000
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	**$94,123,000**	**$30,558,000**	**$63,565,000**

FY 2017-18	TF	GF	FF
General ACLs (75% FF/25% GF, 50% FF/50% GF)	$61,626,000	$21,569,000	$40,057,000
Online ACLs (75% FF/25% GF, 50% FF/50% GF)	$2,146,000	$751,000	$1,395,000
Prospective DUR (75% FF/25% GF)	$320,000	$80,000	$240,000
Retrospective DUR (50% FF/50% GF)	$76,000	$38,000	$38,000
Encounter Claim Lines (75% FF/25% GF)	$650,000	$163,000	$487,000
CA-EVS/CMS Processing (75% FF/25% GF)	$4,900,000	$1,225,000	$3,675,000
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	**$93,135,000**	**$30,236,000**	**$62,899,000**

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:	60
IMPLEMENTATION DATE:	7/2015
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	1917

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$38,228,000	$35,664,000
STATE FUNDS	$9,970,700	$10,301,500
FEDERAL FUNDS	$28,257,300	$25,362,500

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: 60

- 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, purchase 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: 60

Reason for Change:
The change from the prior estimate, for FY 2016-17, is a net increase in Total Funds (TF) due to costs based on actual expenditures instead of projections, additional costs for Change Orders due to the Operations Code Conversion, an increase in costs for consultant contracts, and an increase in other cost reimbursable items. The General Funds (GF) decrease is due to a higher federal share for the funding of the increased FY 2016-17 other cost reimbursable items, which are mostly funded at 90% Federal Financial Participation (FFP).

The change from the prior estimate, for FY 2017-18, is a net decrease due to expected expenditures being lower based on new projections. However, the additional costs for Change Orders due to the Operations Code Conversion have been added and consultant contracts have increased in FY 2017-18.

Although projections for several items increased, the net decrease from FY 2016-17 to FY 2017-18, in the current estimate, is due the SRP settlement agreement and SRP Release 1 transition costs not being applicable for FY 2017-18 causing the decrease in other cost reimbursable items.

Methodology:
1. Contract costs are shared between Federal Funds (FF) and General Funds (GF).

FY 2016-17	TF	GF	FF
Postage (50% FF/50% GF)	$1,914,000	$957,000	$957,000
Parcel Services & Common Carriers (50% FF/50% GF)	$96,000	$48,000	$48,000
Equipment/Services (75% FF/25% GF)	$5,148,000	$1,287,000	$3,861,000
Print/Distr. Center (75% FF/25% GF, 50% FF/50% GF)	$1,160,000	$464,000	$696,000
Other Direct Costs (50% FF/50% GF, 75% FF/25% GF)	$1,968,000	$738,000	$1,230,000
Facilities Improvement & Modification (50% FF/50% GF)	$586,000	$293,000	$293,000
Audits & Research (50% FF/50% GF)	$131,000	$66,000	$65,000
Change Orders (50% FF/50% GF)	$60,000	$30,000	$30,000
Sales Tax (75% FF/25% GF)	$5,348,000	$1,337,000	$4,011,000
Consultant Contracts (75% FF/25% GF, 90% FF/10%, 50% FF/50% GF)	$14,594,000	$3,616,000	$10,978,000
Telecommunication (75% FF / 25% GF)	$1,105,000	$276,000	$829,000
Other Cost Reim. Items (50% FF/50% GF,90% FF/10%)	$6,118,000	$859,000	$5,259,000
Total	**$38,228,000**	**$9,971,000**	**$28,257,000**

MEDICAL FI COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 60

FY 2017-18	TF	GF	FF
Postage (50% FF/50% GF)	$2,296,000	$1,148,000	$1,148,000
Parcel Services & Common Carriers (50% FF/50% GF)	$116,000	$58,000	$58,000
Equipment/Services (75% FF/25% GF)	$4,860,000	$1,215,000	$3,645,000
Print/Distr. Center (75% FF/25% GF, 50% FF/50% GF)	$1,393,000	$557,000	$836,000
Other Direct Costs (50% FF/50% GF, 75% FF/25% GF)	$2,360,000	$885,000	$1,475,000
Facilities Improvement & Modification (50% FF/50% GF)	$704,000	$352,000	$352,000
Audits & Research (50% FF/50% GF)	$176,000	$88,000	$88,000
Change Orders (50% FF/50% GF)	$62,000	$31,000	$31,000
Sales Tax (75% FF/25% GF)	$5,326,000	$1,332,000	$3,994,000
Consultant Contracts (75% FF/25% GF, 90% FF/10%, 50% FF/50% GF)	$16,304,000	$3,934,000	$12,370,000
Telecommunication (75% FF / 25% GF)	$1,325,000	$331,000	$994,000
Other Cost Reim. Items (50% FF/50% GF)	$742,000	$371,000	$371,000
Total	**$35,664,000**	**$10,302,000**	**$25,362,000**

Funding:
FI 50% Title XIX/ 50% GF (4260-101-0001/0890)
FI 75% Title XIX/ 25% GF (4260-101-0001/0890)
FI 90% Title XIX/ 10% GF (4260-101-0001/0890)
FI 50% HIPAA FF/ 50% GF (4260-117-0001/0890)
FI 75% HIPAA FF/ 25% GF (4260-117-0001/0890)
FI 90% HIPAA FF/ 10% GF (4260-117-0001/0890)

MEDICAL FI HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	61
IMPLEMENTATION DATE:	7/2015
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	1918

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$27,551,000	$27,546,000
STATE FUNDS	$5,987,750	$5,986,500
FEDERAL FUNDS	$21,563,250	$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 2016-17 and FY 2017-18. The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to a slight decrease to the hourly reimbursement rate for FOAG pharmacists based on contract provisions and anticipated shifts in funding categories for HIPAA and Non-HIPAA SG billable hours.

MEDICAL FI HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 61

Methodology:

1. SG costs are based on the contract bid price for SG Hourly Reimbursements and the System Replacement Project settlement agreement.

2. Costs are shared between Federal Funds (FF) and General Funds (GF), based on the fixed price Base Volume Method of Payment (BVMP) bid rates.

FY 2016-17	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)	$551,000	$138,000	$413,000
Total Hourly Reimbursement	**$27,551,000**	**$5,988,000**	**$21,563,000**

FY 2017-18	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	$137,000	$409,000
Total Hourly Reimbursement	**$27,546,000**	**$5,987,000**	**$21,559,000**

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:	62
IMPLEMENTATION DATE:	7/2015
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	1921

	FY 2016-17	FY 2017-18
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 10th Revision (ICD-10).

MEDICAL FI OTHER ESTIMATED COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 62

Reason for Change:
The change from the prior estimate, for FY 2016-17 and FY 2017-18, is a decrease due to less costs needed for RAIS MCO than previously estimated. The previous estimated RAIS MCO costs were higher due to a one-time spike in volume. The updated RAIS MCO costs are based on current volumes, invoiced amounts, and actual processed claims from the FI. There is no change from FY 2016-17 to FY 2017-18 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 ACL volume.

FY 2016-17	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 2016-17	**$11,280,000**	**$3,270,000**	**$8,010,000**

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**

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 75% Title XIX / 25% GF (4260-101-0001/0890)

MEDICAL FI GO-FORWARD AND CLOSE OUT ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 63
IMPLEMENTATION DATE: 7/2015
ANALYST: Ila Zapanta
FISCAL REFERENCE NUMBER: 1924

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$5,000,000	$0
STATE FUNDS	$727,300	$0
FEDERAL FUNDS	$4,272,700	$0

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. Thus, the Department developed a Go-Forward Plan which includes the following Go-Forward Work Streams:

1. Procure IT System Maintenance and Operations Services and FI Business Operations Services
2. Transform CA-MMIS Enterprise
3. Transition the SRP
4. Plan and Implement the SRP

To achieve the Go-Forward Plan objectives, the vendor is required to complete SRP close-out activities and transition the SRP assets to the Department. These efforts support the Go-Forward Plan Work Streams. Additionally, as part of the Go-Forward Plan, the Department will complete varied activities to support Go-Forward Plan Work Streams.

Reason for Change:
There is no change in the Total Funds estimate from the prior estimate for FY 2016-17 and FY 2017-18. The funding splits in FY 2016-17, however, have been updated based on the approved Implementation Advance Planning Document Update (IAPDU).

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to no costs allocated in FY 2017-18.

MEDICAL FI GO-FORWARD AND CLOSE OUT ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 63

Methodology:

1. Costs are shared between Federal Funds (FF) and General Funds (GF).

FY 2016-17	TF	GF	FF
50% Title XIX / 50% GF	$332,000	$166,000	$166,000
90% Title XIX / 10% GF	$4,563,000	$456,000	$4,107,000
100% GF	$105,000	$105,000	$0
Total	**$5,000,000**	**$727,000**	**$4,273,000**

Funding:

FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 90% Title XIX / 10% GF (4260-101-0001/0890)
FI 100% GF (4260-101-0001)

MEDICAL FI MISCELLANEOUS EXPENSES

OTHER ADMIN. POLICY CHANGE NUMBER:	64
IMPLEMENTATION DATE:	7/2015
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	1922

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$2,100,000	$2,075,000
STATE FUNDS	$681,000	$674,750
FEDERAL FUNDS	$1,419,000	$1,400,250

DESCRIPTION

Purpose:
This policy change estimates the cost of miscellaneous expenses 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.

Pursuant to an Interagency Agreement (IA) with the Department, the California State Controller's Office (SCO) issues warrants to Medi-Cal providers and the California State Treasurer's Office (CSTO) provides funds for warrant redemption. SCO also provides the Department various administrative and project activities as they relate to the electronic claims process for the Health Enterprise (HE) system.

Pursuant to an 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 that 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.

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 also included.

Reason for Change:
The change from the prior estimate, for both FY 2016-17 and FY 2017-18, is a slight decrease due to less administrative costs needed for FPACT printing materials. The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to less HE claims administrative costs needed in FY 2017-18.

MEDICAL FI MISCELLANEOUS EXPENSES

OTHER ADMIN. POLICY CHANGE NUMBER: 64

Methodology:

1. Costs are shared between Federal Funds (FF) and General Funds (GF).

FY 2016-17	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)	$62,000	$15,000	$47,000
CSTO - Warrant Redemption (75% FF / 25% GF)	$81,000	$20,000	$61,000
CDCA - Provider Verification File (75% FF / 25% GF)	$2,000	$1,000	$1,000
FPACT (50% FF / 50% GF)	$180,000	$90,000	$90,000
Total	**$2,100,000**	**$681,000**	**$1,419,000**

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
FPACT (50% FF / 50% GF)	$180,000	$90,000	$90,000
Total	**$2,075,000**	**$675,000**	**$1,400,000**

Funding:

FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 75% Title XIX / 25% GF (4260-101-0001/0890)

MEDICAL FI CHANGE ORDERS

OTHER ADMIN. POLICY CHANGE NUMBER:	65
IMPLEMENTATION DATE:	7/2015
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	1919

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$486,000	$515,000
STATE FUNDS	$137,000	$128,750
FEDERAL FUNDS	$349,000	$386,250

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)
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 Change Orders, COs, are 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 sections below detail all active COs in progress.

- Diagnostic Related Groups (DRG) Change Order:

  SB 853 requires the Department to develop and implement a Medi-Cal payment methodology based on DRG. The DRG reflects the costs and staffing levels associated with quality of care for patients unless otherwise specified. As the implementation of SB 853 was not originally known or identifiable at the time the contract was procured, and requires an increased level of work and effort, the Department has agreed to reimburse the FI for all documentable expenses needed to implement the DRG requirement.

MEDICAL FI CHANGE ORDERS

OTHER ADMIN. POLICY CHANGE NUMBER: 65

- Operations Code Conversion Change Order:

  To comply with the Health Insurance Portability and Accountability Act (HIPAA), Welfare & Institutions 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 these COs were not originally known or knowable at the time the contract was procured, and requires 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 to implement the DRG requirement and the conversion of HCPCS codes.

Reason for Change:
The change from the prior estimate, for FY 2016-17 and FY 2017-18, is a decrease due to less operations code conversion costs. The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to the removal of DRG administration costs and increased operations code conversion costs in FY 2017-18.

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. Costs are shared between Federal Funds (FF) and General Funds (GF).

	FY 2016-17			FY 2017-18		
FI Change Orders	**TF**	**GF**	**FF**	**TF**	**GF**	**FF**
DRG Administration*	$62,000	$31,000	$31,000	$0	$0	$0
Operations Code Conversion	$424,000	$106,000	$318,000	$515,000	$129,000	$386,000
Total	**$486,000**	**$137,000**	**$349,000**	**$515,000**	**$129,000**	**$386,000**

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)*
FI 75% HIPAA FF/ 25% GF (4260-117-0001/0890)

MEDICAL FI OPTIONAL CONTRACTUAL SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 66
IMPLEMENTATION DATE: 7/2017
ANALYST: Ila Zapanta
FISCAL REFERENCE NUMBER: 1923

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$0	$804,000
STATE FUNDS	$0	$80,400
FEDERAL FUNDS	$0	$723,600

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. OCS can apply to the CA-MMIS Legacy System or to the CA-MMIS Replacement System. 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 in accordance with the Health Information Technology for Economic and Clinical Health Act.

Reason for Change:
The change for FY 2016-17 and FY 2017-18, from the prior estimate and in the current estimate, is due to a delay in the completion of work and shifting the final invoice to be paid in FY 2017-18.

Methodology:
1. Costs are shared between Federal Funds (FF) and General Funds (GF).

Fiscal Year	TF	GF	FF
FY 2017-18	$804,000	$80,400	$723,600

Funding:
FI 90% Title XIX / 10% GF (4260-101-0001/0890)

CA-MMIS XEROX SETTLEMENT AGREEMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	67
IMPLEMENTATION DATE:	7/2015
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	1978

	FY 2016-17	FY 2017-18
TOTAL FUNDS	-$41,320,000	$0
STATE FUNDS	-$41,320,000	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the settlement amounts expected to be received by the Department for the Xerox Settlement Agreement associated with the California Medicaid Management Information System (CA-MMIS) Medical Fiscal Intermediary (FI) contract.

Authority:
Not Applicable

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.

As part of the FI contract, the FI contractor was to take over, operate, and upgrade the CA-MMIS (Legacy System) and to design, develop, and implement (DD&I) a replacement Medicaid management information system (Replacement System). However, the Department and the FI now recognize that the pace of technological change for health enterprise data systems has significantly accelerated in the years since the Department began procurement work to replace the Legacy System. Accordingly, many other states as well as the federal Centers for Medicare and Medicaid Services (CMS) have adjusted their strategies on modernizing Medicaid management information systems.

In light of these technological changes and evolving approaches to enterprise data systems, the Department and the FI have agreed to discontinue the remaining Replacement System DD&I, enabling the Department to pursue a new procurement approach that would benefit from the most up-to-date technology and system design strategies available. The FI shall continue to operate and maintain the Legacy System, until September 30, 2019, or an earlier time when the Department has secured vendors to continue FI services.

Reason for Change:
There is no change from the prior estimate for FY 2016-17 and FY 2017-18. The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to the final settlement payments in FY 2016-17 and no additional settlement payments in FY 2017-18.

CA-MMIS XEROX SETTLEMENT AGREEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 67

Methodology:

1. The following settlement amounts were received in FY 2016-17:

(Dollars in Thousands)

FY 2016-17	TF	GF	FF
Total	($41,320)	($41,320)	$0

Funding:

100% GF (4260-101-0001)

HCO COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	68
IMPLEMENTATION DATE:	7/2014
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1858

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$41,644,000	$44,849,000
STATE FUNDS	$20,029,700	$21,571,400
FEDERAL FUNDS	$21,614,300	$23,277,600

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.

Cost reimbursements are direct costs incurred by the enrollment contractor while performing responsibilities under the contract that are in addition to fixed operations costs.

Reason for change:
There is no change from the prior estimate for FY 2016-17 and FY 2017-18. The increase of costs from FY 2016-17 to FY 2017-18 is due to increasing managed care enrollment and activity.

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: 68

(Dollars in Thousands)

	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced XXI	Enhanced XXI
FY 2016-17		(50%)	(50%)	(12%)	(88%)
Postage	$20,601	$9,785	$9,786	$124	$906
Printing	$6,062	$2,879	$2,880	$36	$267
Other HCO Informing Materials	$5,035	$2,392	$2,391	$30	$222
Customer Assistance Telephone	$1,596	$758	$758	$10	$70
Development of New Informing Mat.	$183	$87	$87	$1	$8
Translation Services	$524	$249	$248	$3	$24
Data Access	$435	$207	$206	$3	$19
Miscellaneous	$1,217	$578	$578	$7	$54
Special Training Sessions	$160	$76	$76	$1	$7
PCs, Printers, Copy Machines	$114	$54	$54	$1	$5
Additional Systems Group Staff	$4,337	$2,060	$2,060	$26	$191
Travel and Per Diem	$139	$66	$65	$1	$7
Temporary Staff	$641	$304	$305	$4	$28
Medi-Cal Publications Mailings	$600	$285	$285	$4	$26
Total	**$41,644**	**$19,780**	**$19,779**	**$251**	**$1,834**

(Dollars in Thousands)

	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced XXI	Enhanced XXI
FY 2017-18		(50%)	(50%)	(12%)	(88%)
Postage	$22,661	$10,764	$10,764	$136	$997
Printing	$6,668	$3,167	$3,168	$40	$293
Other HCO Informing Materials	$5,539	$2,631	$2,631	$33	$244
Customer Assistance Telephone	$1,756	$834	$834	$11	$77
Development of New Informing Mat.	$201	$95	$96	$1	$9
Translation Services	$576	$273	$273	$4	$26
Data Access	$479	$228	$227	$3	$21
Miscellaneous	$1,039	$494	$493	$6	$46
Special Training Sessions	$176	$84	$83	$1	$8
PCs, Printers, Copy Machines	$125	$59	$60	$1	$5
Additional Systems Group Staff	$4,771	$2,266	$2,266	$29	$210
Travel and Per Diem	$153	$72	$72	$1	$8
Temporary Staff	$705	$335	$335	$4	$31
Total	**$44,849**	**$21,302**	**$21,302**	**$270**	**$1,975**

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:	**69**
IMPLEMENTATION DATE:	**7/2014**
ANALYST:	**Candace Epstein**
FISCAL REFERENCE NUMBER:	**1856**

	FY 2016-17	FY 2017-18
TOTAL FUNDS	**$39,189,000**	**$40,650,000**
STATE FUNDS	**$18,851,600**	**$19,553,980**
FEDERAL FUNDS	**$20,337,400**	**$21,096,020**

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.

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: 69

- 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:
There is no change from the prior estimate for FY 2016-17 and FY 2017-18. FY 2017-18 costs are higher than FY 2016-17 due to bid price adjustments.

Methodology:
1. Operations costs are fixed price rates based on volumes within minimum and maximum ranges under the HCO contract.

(Dollars in Thousands)

FY 2016-17	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced XXI	Enhanced XXI
		50%	50%	12%	88%
Transactions	$10,763	$5,112	$5,113	$65	$473
Packet Mailings	$8,205	$3,897	$3,898	$49	$361
BDE Packet Mailings	$183	$87	$87	$1	$8
BDA/Call Center	$4,979	$2,365	$2,365	$30	$219
PPD	$669	$318	$318	$4	$29
SPD Inserts	$66	$33	$33	$0	$0
Medi-Cal Publications	$399	$190	$189	$2	$18
HIF	$176	$84	$83	$1	$8
Base Volume Increase	$13,749	$6,531	$6,531	$82	$605
Total	**$39,189**	**$18,617**	**$18,617**	**$234**	**$1,721**

HCO OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER: 69

(Dollars in Thousands)

FY 2017-18	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced XXI	Enhanced XXI
		50%	50%	12%	88%
Transactions	$11,131	$5,287	$5,287	$67	$490
Packet Mailings	$8,809	$4,184	$4,185	$53	$387
BDE Packet Mailings	$183	$87	$87	$1	$8
BDA/Call Center	$5,276	$2,506	$2,506	$32	$232
PPD	$840	$399	$399	$5	$37
SPD Inserts	$66	$33	$33	$0	$0
Medi-Cal Publications	$414	$197	$196	$3	$18
HIF	$182	$86	$87	$1	$8
Base Volume Increase	$13,749	$6,531	$6,531	$82	$605
Total	**$40,650**	**$19,310**	**$19,311**	**$244**	**$1,785**

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:	**70**
IMPLEMENTATION DATE:	**7/2015**
ANALYST:	**Candace Epstein**
FISCAL REFERENCE NUMBER:	**1864**

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$15,560,000	$16,518,000
STATE FUNDS	$7,484,740	$7,945,120
FEDERAL FUNDS	$8,075,260	$8,572,880

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 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.
- California enacted legislation to establish eligibility for full scope Medi-Cal benefits for undocumented children under 19 years of age (immigration reform project).

Reason for change:
There is no change from the prior estimate for FY 2016-17 and FY 2017-18. The net increase in costs from FY 2016-17 to FY 2017-18 is due to the continuation of the telephone call centers operations and staff through April 2018; however the immigration reform project is anticipated to end in FY 2016-17.

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: 70

	FY 2016-17	FY 2017-18
Telephone Call Center (TCC) Enrollment Operations	$1,214,000	$1,433,000
System Group Staff	$10,054,000	$15,085,000
TCC and Postage and Printing Cost for Undoc. Children	$4,292,000	$0
Total	**$15,560,000**	**$16,518,000**

(Dollars in Thousands)

FY 2016-17	TF	GF	FF
Title XIX (50% FF / 50% GF)	$14,783	$7,391	$7,392
Enhanced Title XXI (88% FF / 12% GF)	$777	$94	$683
Total	**$15,560**	**$7,485**	**$8,075**

(Dollars in Thousands)

FY 2017-18	TF	GF	FF
Title XIX (50% FF / 50% GF)	$15,692	$7,846	$7,846
Enhanced Title XXI (88% FF / 12% GF)	$826	$94	$732
Total	**$16,518**	**$7,940**	**$8,578**

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:	**71**
IMPLEMENTATION DATE:	**7/2014**
ANALYST:	**Candace Epstein**
FISCAL REFERENCE NUMBER:	**1857**

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$14,013,000	$14,318,000
STATE FUNDS	$6,740,120	$6,886,920
FEDERAL FUNDS	$7,272,880	$7,431,080

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.

An important goal of the HCO program is to provide every Medi-Cal applicant/ beneficiary, who shall be required or is eligible to enroll in a medical and/or dental plan under the Medi-Cal Managed Care program, with the opportunity to receive a face-to-face presentation describing that individual's rights and enrollment choices as well as a fundamental introduction to the managed health care delivery system. The primary objective of the HCO presentation is to educate applicants/beneficiaries to make an informed plan choice. An effective educational program ultimately increases the number of potential eligible enrollees who choose a plan prior to or during the informing process, thereby avoiding auto-assignment (default assignment) to a plan. This program is conducted by the enrollment contractor with the use of ESRs in county offices statewide.

Reason for change:
There is no change from the prior estimate for FY 2016-17 and FY 2017-18. FY 2017-18 costs are higher than FY 2016-17 due to bid price adjustments.

Methodology:
1. The hourly reimbursement costs are fixed price hourly rates for full-time equivalent ESR staff at county offices statewide.

HCO ESR HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 71

2. The estimated costs for FY 2016-17 and FY 2017-18 are based on 155 ESRs per year.

FY 2016-17	TF	GF	FF
Title XIX (50% FF / 50% GF)	$13,312,000	$6,656,000	$6,656,000
Title XXI (88% FF / 12% GF)	$701,000	$84,000	$617,000
Total	**$14,013,000**	**$6,740,000**	**$7,273,000**

FY 2017-18	TF	GF	FF
Title XIX (50% FF / 50% GF)	$13,602,000	$6,801,000	$6,801,000
Title XXI (88% FF / 12% GF)	$716,000	$86,000	$630,000
Total	**$14,318,000**	**$6,887,000**	**$7,431,000**

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: 72
IMPLEMENTATION DATE: 7/2014
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1860

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$13,514,000	$14,200,000
STATE FUNDS	$6,757,000	$7,100,000
FEDERAL FUNDS	$6,757,000	$7,100,000

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 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: 72

Reason for change:
There is no change from the prior estimate for FY 2016-17 and FY 2017-18. The increase from FY 2016-17 to FY 2017-18 is due to an increase in postage and printing from additional mailings which includes catch up and ongoing mailings to MLTSS beneficiaries.

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 2016-17 and FY 2017-18 costs are below:

	FY 2016-17	FY 2017-18
Printing/Postage	$3,005,000	$4,850,000
Equipment/Non-Equipment	$1,409,000	$1,550,000
Staffing	$9,100,000	$7,800,000
Total	**$13,514,000**	**$14,200,000**

3. Costs are shared between federal funds (FF) and General Fund (GF).

	TF	GF	FF
FY 2016-17	**$13,514,000**	**$6,757,000**	**$6,757,000**

	TF	GF	FF
FY 2017-18	**$14,200,000**	**$7,100,000**	**$7,100,000**

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

HCO TAKEOVER

OTHER ADMIN. POLICY CHANGE NUMBER: 73
IMPLEMENTATION DATE: 8/2017
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1994

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$0	**$3,664,000**
STATE FUNDS	$0	**$1,832,000**
FEDERAL FUNDS	$0	**$1,832,000**

DESCRIPTION

Purpose:
This policy change estimates the takeover costs of the Health Care Options (HCO) program.

Authority:
New HCO contract

Interdependent Policy Changes:
Not Applicable

Background:
MAXIMUS, Inc. has been the enrollment contractor for the HCO program since October 1, 1996. MAXIMUS, Inc. is responsible for enrolling Medi-Cal beneficiaries into managed care health plans within three Medi-Cal managed care health plan models including Two-Plan, Regional, and Geographic Managed Care. MAXIMUS, Inc. also enrolls beneficiaries into two Dental Managed Care plan models; one in Sacramento County, where enrollment is mandatory, and one in Los Angeles County, where enrollment is voluntary.

Operations for the current HCO contract with MAXIMUS began on January 1, 2009, for three years and nine months, and six one-year optional extension years, with current operations ending September 30, 2018, with takeover extending through December 31, 2018, including a 12-month turnover period. Funds paid on the contract use a mixture of Federal Funds (FF) and General Funds (GF) 50/50 for Administration.

Reason for change:
There is no change from the prior estimate.

Methodology:
1. Costs are based on a fixed price bid.

2. Contract costs are shared between Federal Funds and General Funds.

	TF	GF	FF
FY 2017-18	$3,664,000	$1,832,000	$1,832,000

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 TURNOVER

OTHER ADMIN. POLICY CHANGE NUMBER: 74
IMPLEMENTATION DATE: 10/2017
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1993

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$0	$865,000
STATE FUNDS	$0	$432,500
FEDERAL FUNDS	$0	$432,500

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:
There is no material change from the prior estimate.

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	**$865,000**	$432,000	$433,000

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 OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER:	**75**
IMPLEMENTATION DATE:	**7/2014**
ANALYST:	**Nikaela Ratliff**
FISCAL REFERENCE NUMBER:	**1887**

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$98,000,000	$52,000,000
STATE FUNDS	$32,500,000	$17,250,000
FEDERAL FUNDS	$65,500,000	$34,750,000

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. Delta is responsible for all the FI services, including claims processing, provider enrollment, outreach, and the underwriting of the Medi-Cal Dental Program. The Department has 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 is currently seeking approval on an additional contract extension amendment to extend through Assumption of Operations of the new contractors.

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: 75

Reason for change:
The change from the prior estimate for FY 2016-17 is due to updated actual ACSL, TAR, and TSC minute volumes, the inclusion of FQHC ACSL costs, and the application of the California Consumer Price Index (CCPI) factor.

The change from FY 2016-17 to FY 2017-18 in the current estimate is due to only budgeting for a partial year due to contract operations end.

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.

(Dollars in Thousands)

FY 2016-17	TF	GF	FF
Administration/Operations (75% FF / 25% GF)	$63,000	$16,000	$47,000
Provider Enrollment (50% FF / 50% GF and 75% FF / 25% GF)	$11,000	$5,000	$6,000
Total ACSL/TAR	$74,000	$20,000	$54,000
TSC - Provider (50% FF / 50% GF)	$18,000	$9,000	$9,000
TSC - Beneficiary (50% FF / 50% GF)	$6,000	$3,000	$3,000
Total TSC	$24,000	$12,000	$12,000
Total Operations Costs	**$98,000**	**$32,000**	**$66,000**

(Dollars in Thousands)

FY 2017-18	TF	GF	FF
Administration/Operations (75% FF / 25% GF)	$33,000	$8,000	$25,000
Provider Enrollment (50% FF / 50% GF and 75% FF / 25% GF)	$6,000	$2,000	$3,000
Total ACSL/TAR	$39,000	$11,000	$28,000
TSC – Provider (50% FF / 50% GF)	$10,000	$5,000	$5,000
TSC – Beneficiary (50% FF / 50% GF)	$3,000	$2,000	$2,000
Total TSC	$13,000	$7,000	$7,000
Total Operations Costs	**$52,000**	**$17,000**	**$35,000**

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:	**76**
IMPLEMENTATION DATE:	**3/2017**
ANALYST:	**Nikaela Ratliff**
FISCAL REFERENCE NUMBER:	**2004**

	FY 2016-17	FY 2017-18
TOTAL FUNDS	**$7,808,000**	$15,616,000
STATE FUNDS	**$1,952,000**	**$3,904,000**
FEDERAL FUNDS	**$5,856,000**	$11,712,000

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 12 months following.

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 documents processed during Takeover will be paid at the bid rate for Phase One of Operations and will be counted in the Phase One Combined Claim and TAR Document volume. Takeover payment also includes costs for related expansion items and other work that may occur during Takeover, as outlined in the contract.

Reason for Change:
There is no change from the prior estimate. The change from FY 2016-17 to FY 2017-18 is due to the fact that a majority of the payments are anticipated to be made in FY 2017-18.

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 12 equal installments starting March 2017.

3. The Remaining 20% ($5,856,000 TF) will be made as a single payment 6 months after successful operations, assumed to be in FY 2018-19.

DENTAL NEW FI TAKEOVER

OTHER ADMIN. POLICY CHANGE NUMBER: 76

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2016-17	$7,808	$1,952	$5,856
FY 2017-18	$15,616	$3,904	$11,712

Funding:
FI 75% Title XIX / 25% GF (4260-101-0001/0890)

DENTAL FI HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	77
IMPLEMENTATION DATE:	7/2014
ANALYST:	Nikaela Ratliff
FISCAL REFERENCE NUMBER:	1888

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$12,765,000	$8,004,000
STATE FUNDS	$3,191,250	$2,001,000
FEDERAL FUNDS	$9,573,750	$6,003,000

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. Delta is responsible for all the FI services, including claims processing, provider enrollment, outreach, and the underwriting of the Medi-Cal Dental Program. The Department has 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 is currently seeking approval on an additional contract extension amendment to extend through Assumption of Operations of the new contractors.

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 increase from the prior estimate, for FY 2017-18 is due to a slight change in the number of months budgeted for in that fiscal year.

The change from FY 2016-17 to FY 2017-18 in the current estimate is due to only a partial year being costed in FY 2017-18.

DENTAL FI HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 77

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 2016-17	TF	GF	FF
Systems Group (SG)	$7,121,000	$1,780,000	$5,341,000
HIPAA SG	$859,000	$215,000	$644,000
SURS	$4,785,000	$1,196,000	$3,589,000
Total	**$12,765,000**	**$3,191,000**	**$9,574,000**

FY 2017-18	TF	GF	FF
Systems Group (SG)	$4,465,000	$1,116,000	$3,349,000
HIPAA SG	$539,000	$135,000	$404,000
SURS	$3,000,000	$750,000	$2,250,000
Total	**$8,004,000**	**$2,001,000**	**$6,003,000**

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:	78
IMPLEMENTATION DATE:	7/2014
ANALYST:	Nikaela Ratliff
FISCAL REFERENCE NUMBER:	1889

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$10,951,000	$5,638,000
STATE FUNDS	$5,118,000	$2,625,250
FEDERAL FUNDS	$5,833,000	$3,012,750

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. Delta is responsible for all the FI services, including claims processing, provider enrollment, outreach, and the underwriting of the Medi-Cal Dental Program. The Department has 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 is currently seeking approval on an additional contract extension amendment to extend through Assumption of Operations of the new contractors.

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.

DENTAL FI COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 78

Costs under these categories consist of direct costs, or a subset thereof, which can be specifically identifiable with the particular cost objective.

Reason for change:
The change from the prior estimate is due a revalidation of the expected expenditures as well as an increase to the costs associated with Knox-Keene.

The change from FY 2016-17 to FY 2017-18 in the current estimate is due to only costing for a partial year in FY 2017-18.

Methodology:
1. Costs are calculated by projecting with up to date actual invoices.

FY 2016-17	TF	GF	FF
Printing (50% FF / 50% GF)	$1,153,000	$576,500	$576,500
Data Center Access (75% FF / 25% GF)	$101,000	$25,000	$76,000
Postage/Parcel Service (50% FF / 50% GF)	$1,129,000	$564,000	$564,000
Special Training, Conf., Travel (50% FF / 50% GF)	$87,000	$44,000	$44,000
Audits (50% FF / 50% GF)	$174,000	$87,000	$87,000
Facilities Improvement (75% FF / 25% GF)	$713,000	$178,000	$535,000
Toll Free Phone Charges (75% FF / 25% GF)	$616,000	$154,000	$462,000
Knox-Keene Annual Assess. (50% FF / 50% GF)	$6,036,000	$3,018,000	$3,018,000
Misc. (50% FF / 50% GF)	$942,000	$471,000	$471,000
Total*	**$10,951,000**	**$5,117,500**	**$5,833,500**

FY 2017-18	TF	GF	FF
Printing (50% FF / 50% GF)	$500,000	$250,000	$250,000
Data Center Access (75% FF / 25% GF)	$55,000	$14,000	$41,000
Postage/Parcel Service (50% FF / 50% GF)	$611,000	$306,000	$306,000
Special Training, Conf., Travel (50% FF / 50% GF)	$47,000	$24,000	$24,000
Audits (50% FF / 50% GF)	$94,000	$47,000	$47,000
Facilities Improvement (75% FF / 25% GF)	$386,000	$97,000	$290,000
Toll Free Phone Charges (75% FF / 25% GF)	$333,000	$83,000	$250,000
Knox-Keene Annual Assess. (50% FF / 50% GF)	$3,100,000	$1,550,000	$1,550,000
Misc. (50% FF / 50% GF)	$510,000	$255,000	$255,000
Total*	**$5,638,000**	**$2,625,000**	**$3,012,000**

*Totals may differ due to rounding.

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 BENEFICIARY OUTREACH & ED PROGRAM - ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER:	79
IMPLEMENTATION DATE:	4/2016
ANALYST:	Nikaela Ratliff
FISCAL REFERENCE NUMBER:	1949

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$681,000	$4,133,000
STATE FUNDS	$340,500	$2,066,500
FEDERAL FUNDS	$340,500	$2,066,500

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 44 Beneficiary Outreach and Education Program

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,
- Telephone service center (TSC) calls and mailers to beneficiaries who have not utilized in the prior year,
- Direct outreach to State, County, and Community agencies,
- Website enhancements to the Denti-Cal website, and
- Development of a social media beneficiary mobile app.

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: 79

Reason for Change:
The decrease from the prior estimate for FY 2016-17 is due to a change in the implementation date of the program resulting in only a partial year costing. There is an insignificant change from the prior estimate for FY 2017-18.

The change from FY 2016-17 to FY 2017-18 in the current estimate is due to FY 2016-17 only including a partial year due to the implementation date.

Methodology:
1. The Beneficiary Outreach and Education program began on April 1, 2017 and invoicing in May 2017.

2. Assume for TSC costs are funded at 50% FF and 50% GF. TSC costs are $649,457 (TF) in FY 2016-17 and $3,939,532 (TF) in FY 2017-18.

3. Cost reimbursable items (brochures, banners, newspaper ads, etc.) are funded at 50% FF and 50% GF. These costs are $31,502 (TF) in FY 2016-17 and $194,000 (TF) in FY 2017-18.

4. The administrative costs for FY 2016-17 and FY 2017-18 will be:

Fiscal Year	TF	GF	FF
FY 2016-17	$681,000	$340,500	$340,500
FY 2017-18	$4,133,000	$2,066,000	$2,067,000

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 ASO TAKEOVER

OTHER ADMIN. POLICY CHANGE NUMBER:	**80**
IMPLEMENTATION DATE:	**2/2017**
ANALYST:	**Nikaela Ratliff**
FISCAL REFERENCE NUMBER:	**2003**

	FY 2016-17	FY 2017-18
TOTAL FUNDS	**$1,473,000**	**$2,947,000**
STATE FUNDS	**$368,250**	**$736,750**
FEDERAL FUNDS	**$1,104,750**	**$2,210,250**

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 12 months following.

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 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:
There is no change from the prior estimate.

The change from FY 2016-17 to FY 2017-18 is due to the fact that a majority of payments are anticipated to be made in FY 2016-17.

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 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 June 1, 2018.

DENTAL ASO TAKEOVER

OTHER ADMIN. POLICY CHANGE NUMBER: 80

Fiscal Year	TF	GF	FF
FY 2016-17	$1,473,000	$368,000	$1,105,000
FY 2017-18	$2,947,000	$737,000	$2,210,000

Funding:
FI 75% Title XIX / 25% GF (4260-101-0001/0890)

DENTAL TREATMENT AUTHORIZATION REQUEST PROCESSING

OTHER ADMIN. POLICY CHANGE NUMBER:	81
IMPLEMENTATION DATE:	4/2017
ANALYST:	Nikaela Ratliff
FISCAL REFERENCE NUMBER:	1969

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$744,000	$2,044,000
STATE FUNDS	$324,250	$874,500
FEDERAL FUNDS	$419,750	$1,169,500

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 decrease from the prior estimate for FY 2016-17 is due to an implementation shift from July 1, 2016 to April 1, 2017. The increase from the prior estimate for FY 2017-18 is due to increased Systems Group (SG) hours to needed to complete necessary system changes.

The change from FY 2016-17 to FY 2017-18 in the current estimate is due to only a partial year being costed for FY 2016-17.

Methodology:
1. Assume the implementation will begin April 1, 2017.

2. Assume the Dental FI SG has an hourly rate of $145 for FY 2016-17 and $149 for FY 2017-18.

3. Assume system changes will take 5,283 hours to complete.

   FY 2016-17: 1,321 hours x $145 = $191,000 TF for system changes
   FY 2017-18: 3,962 hours x $149 = $590,000 TF for system changes

DENTAL TREATMENT AUTHORIZATION REQUEST PROCESSING

OTHER ADMIN. POLICY CHANGE NUMBER: 81

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 $204,000 TF in FY 2016-17 and $408,000 TF in FY 2017-18.

5. Assume the change will require additional Dental FI staff, for the first 12 months, to initiate the process of reducing the TAR processing time from 15 days to 5 days at a cost of $1,394,000 TF.

6. Costs are shared between federal funds (FF) and general funds (GF).

Fiscal Year	TF	GF	FF
FY 2016-17	$744,000	$324,500	$419,500
FY 2017-18	$2,044,000	$874,500	$1,169,500

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:	**82**
IMPLEMENTATION DATE:	**7/2014**
ANALYST:	**Nikaela Ratliff**
FISCAL REFERENCE NUMBER:	**1893**

	FY 2016-17	FY 2017-18
TOTAL FUNDS	**$400,000**	**$210,000**
STATE FUNDS	**$200,000**	**$105,000**
FEDERAL FUNDS	**$200,000**	**$105,000**

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. Delta is responsible for all the FI services, including claims processing, provider enrollment, outreach, and the underwriting of the Medi-Cal Dental Program. The Department has 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 is currently seeking approval on an additional contract extension amendment to extend through Assumption of Operations of the new contractors.

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 decrease from the prior estimate is due to updated actuals which reflected lower than anticipated average number or monthly revalidations.

The change from FY 2016-17 to FY 2017-18 in the current estimate is due to only budgeting for a partial year in FY 2017-18.

Methodology:

DENTAL FI FEDERAL RULE - REVALIDATION

OTHER ADMIN. POLICY CHANGE NUMBER: 82

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 $476 for FY 2016-17 and $489 for FY 2017-18.

3. Costs are shared between federal funds (FF) and General Fund (GF).

Fiscal Year	TF	GF	FF
FY 2016-17	$400,000	$200,000	$200,000
FY 2017-18	$210,000	$105,000	$105,000

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 CD-MMIS COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	83
IMPLEMENTATION DATE:	11/2015
ANALYST:	Nikaela Ratliff
FISCAL REFERENCE NUMBER:	1890

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$137,000	$2,196,000
STATE FUNDS	$34,250	$549,000
FEDERAL FUNDS	$102,750	$1,647,000

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. Delta is responsible for all the FI services, including claims processing, provider enrollment, outreach, and the underwriting of the Medi-Cal Dental Program. The Department has 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 is currently seeking approval on an additional contract extension amendment to extend through Assumption of Operations of the new contractors.

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: 83

The schedule of payments for turnover services to the current FI is contractually agreed upon. Fifty percent of the turnover bid price is paid in nine equal installments of which the first has been paid. The remaining eight installments are paid in the last eight months of the current FI operations. The remaining fifty percent is payable upon completion of all turnover and runout requirements.

Reason for change:
There is no change from the prior estimate.

The change in the current estimate from FY 2016-17 to FY 2017-18 is due to the final fifty percent of the turnover bid price becoming due upon completion of turnover and runout requirements.

Methodology:
1. Costs are based on takeover and turnover contract bid prices, adjusted for California Consumer Price Index as appropriate.

2. Costs are shared between federal funds (FF) and general funds (GF).

	TF	GF	FF
FY 2016-17	$137,000	$34,000	$103,000

	TF	GF	FF
FY 2017-18	$2,196,000	$549,000	$1,647,000

Funding:
FI 75% Title XIX FF / 25% GF (4260-101-0001/0890)
***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

DENTAL FI FEDERAL RULE - DATABASE CHECKS

OTHER ADMIN. POLICY CHANGE NUMBER:	**84**
IMPLEMENTATION DATE:	**7/2014**
ANALYST:	**Nikaela Ratliff**
FISCAL REFERENCE NUMBER:	**1894**

	FY 2016-17	FY 2017-18
TOTAL FUNDS	**$340,000**	**$175,000**
STATE FUNDS	**$170,000**	**$87,500**
FEDERAL FUNDS	**$170,000**	**$87,500**

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. Delta is responsible for all the FI services, including claims processing, provider enrollment, outreach, and the underwriting of the Medi-Cal Dental Program. The Department has 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 is currently seeking approval on an additional contract extension amendment to extend through Assumption of Operations of the new contractors.

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 decrease from the prior estimate is due to updated actuals that reflected a lower than expected number of database checks per month.

The change from FY 2016-17 to FY 2017-18 in the current estimate is due to calculating the cost for only a partial year in FY 2017-18.

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 $1.58 for FY 2016-17 and $1.62 for FY 2017-18.

3. Costs are shared between federal funds (FF) and General Fund (GF).

Fiscal Year	TF	GF	FF
FY 2016-17	$340,000	$170,000	$170,000
FY 2017-18	$175,000	$87,500	$87,500

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: 85
IMPLEMENTATION DATE: 7/2014
ANALYST: Nikaela Ratliff
FISCAL REFERENCE NUMBER: 1892

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$260,000	$137,000
STATE FUNDS	$65,000	$34,250
FEDERAL FUNDS	$195,000	$102,750

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. Delta is responsible for all the FI services, including claims processing, provider enrollment, outreach, and the underwriting of the Medi-Cal Dental Program. The Department has 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 is currently seeking approval on an additional contract extension amendment to extend through Assumption of Operations of the new contractors.

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:
There is no change from the prior estimate for FY 2016-17; however the increase to FY 2017-18 from the prior estimate is due to costing for additional time due to an updated assumption of operations date. The change from FY 2016-17 to FY 2017-18 in the current estimate is due to only a partial year's costing for FY 2017-18.

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: 85

2. The cost break down of billable hours for the security risk assessment process is projected at 93 hours per month billed at $234 per hour for a monthly estimated total of $21,762. The resulting estimated yearly cost is $260,000 TF ($65,000 GF).

3. Costs are shared between federal funds (FF) and General Fund (GF).

Fiscal Year	TF	GF	FF
FY 2016-17	$260,000	$65,000	$195,000
FY 2017-18	$137,000	$34,000	$103,000

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.

DENTAL FI CONLAN, SCHWARZMER, STEVENS V. BONTA

OTHER ADMIN. POLICY CHANGE NUMBER:	86
IMPLEMENTATION DATE:	7/2014
ANALYST:	Nikaela Ratliff
FISCAL REFERENCE NUMBER:	1891

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$255,000	$134,000
STATE FUNDS	$127,500	$67,000
FEDERAL FUNDS	$127,500	$67,000

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. Delta is responsible for all the FI services, including claims processing, provider enrollment, outreach, and the underwriting of the Medi-Cal Dental Program. The Department has 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 is currently seeking approval on an additional contract extension amendment to extend through Assumption of Operations of the new contractors.

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:
There is no change from the prior estimate for FY 2016-17; however the increase to FY 2017-18 from the prior estimate is due to costing for additional time due to an updated assumption of operations date.

The change from FY 2016-17 to FY 2017-18 in the current estimate is due to only a partial year's costing for FY 2017-18.

DENTAL FI CONLAN, SCHWARZMER, STEVENS V. BONTA

OTHER ADMIN. POLICY CHANGE NUMBER: 86

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.

2) The average monthly number of Correspondence Counts is 157 based on FY 2015-16 invoices and the rate per Correspondence Count is $135.14.

3) The annual cost impact based on the number of Correspondence Counts is estimated at $255,000 TF ($127,000 GF).

4) Costs are shared between federal funds (FF) and General Fund (GF).

Fiscal Year	TF	GF	FF
FY 2016-17	$255,000	$127,000	$128,000
FY 2017-18	$134,000	$67,000	$67,000

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 ASO ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER:	**87**
IMPLEMENTATION DATE:	**11/2017**
ANALYST:	**Nikaela Ratliff**
FISCAL REFERENCE NUMBER:	**2007**

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$0	$18,953,000
STATE FUNDS	$0	$6,827,500
FEDERAL FUNDS	$0	$12,125,500

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 Operations are expected to begin on the first day of the thirteenth month after the Contract Effective Date (CED), January 10, 2017. TAR processing will begin 10.5 months after CED. Delta is responsible for all ASO services of 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

DENTAL ASO ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER: 87

8. Independent Contractor Consideration
9. Annual Risk Assessments
10. Miscellaneous
11. Cost Reimbursement Invoices

Reason for Change:
There was a decrease from the prior estimate due to a revision of projected costs for FY 2017-18.

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 FY 2015-16 actual invoices with a growth factor. Provider Enrollment activities account for 15% of the total ACSL/TAR costs.

    a. Provider Enrollment
        i. 69% of costs are funded at 50% FF and 50% GF
        ii. 31% of costs are funded at 75% FF and 25% GF
    b. Remaining costs are funded at 75% FF and 25% GF

3. TSC minutes are based on FY 2015-16 actual invoices with a growth factor and funded at 50% FF and 50% GF.

(Dollars in Thousands)

FY 2017-18	TF	GF	FF
Administration/Operations (75% FF / 25% GF)	$9,683	$2,421	$7,262
Provider Enrollment (50% FF / 50% GF & 75% FF / 25% GF)	$1,709	$722	$987
Total ACSL/TAR	$11,392	$3,143	$8,249
TSC – Provider (50% FF / 50% GF)	$2,570	$1,285	$1,285
TSC – Beneficiary (50% FF / 50% GF)	$4,066	$2,033	$2,033
Total TSC	$6,636	$3,318	$3,318
Total Operations Costs	$18,028	$6,461	$11,567

DENTAL ASO ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER: 87

4. Cost reimbursements are based on FY 2015-16 actual invoices with a growth factor.

FY 2017-18	TF	GF	FF
Printing and Postage (50% FF / 50% GF)	$186,000	$93,000	$93,000
Parcel Service (50% FF / 50% GF)	$148,000	$74,000	$74,000
Data Center Access (75% FF / 25% GF)	$400	$100	$300
Toll Free Phone Charges (75% FF / 25% GF)	$367,000	$92,000	$275,000
Special Training, Conf., Travel (50% FF / 50% GF)	$28,000	$14,000	$14,000
Facilities Improvement (75% FF / 25% GF)	$15,000	$4,000	$11,000
Audits (50% FF / 50% GF)	$58,000	$29,000	$29,000
Independent Contractor Consideration (75% FF / 25% GF)	$200	$50	$150
Annual Risk Assessments (50% FF / 50% GF)	$100	$50	$50
Misc. (50% FF / 50% GF)	$122,000	$61,000	$61,000
Cost Reimbursement Invoice (50% FF / 50% GF)	$400	$200	$200
Total Cost Reimbursable	$925,100	$367,400	$557,700

5. Total Administration Cost

FY 2017-18	TF	GF	FF
Total Dental ASO Admin	**$18,953**	**$6,827**	**$12,125**

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 ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER:	**88**
IMPLEMENTATION DATE:	**11/2017**
ANALYST:	**Nikaela Ratliff**
FISCAL REFERENCE NUMBER:	**2006**

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$0	$10,598,000
STATE FUNDS	$0	$2,977,000
FEDERAL FUNDS	$0	$7,621,000

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. FI Operations are expected to begin on the first day of thirteen months after the Contract Effective Date (CED), January 10, 2017. HPE is responsible for all 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
10. Cost Reimbursement Invoice

DENTAL NEW FI ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER: 88

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:
There is a decrease from the prior estimate due to a revision of projected costs for FY 2017-18.

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	$5,901,000	$1,475,000	$4,426,000
Check Write	$115,000	$29,000	$87,000
Total	**$6,016,000**	**$1,504,000**	**$4,513,000**

4. Cost reimbursements are based on FY 2015-16 actual invoices with a growth factor.

FY 2017-18	TF	GF	FF
Printing and Postage (50% FF / 50% GF)	$432,000	$216,000	$216,000
Parcel Service (50% FF / 50% GF)	$590,000	$295,000	$295,000
Data Center Access (75% FF / 25% GF)	$0	$0	$0
Special Training, Conf., Travel (50% FF / 50% GF)	$46,000	$23,000	$23,000
Facilities Improvement (75% FF / 25% GF)	$60,000	$15,000	$45,000
Audits (50% FF / 50% GF)	$58,000	$29,000	$29,000
Ind. Contractor Consideration (75% FF / 25% GF)	$1,000	$250	$750
Annual Risk Assessments (50% FF / 50% GF)	$1,000	$500	$500
Misc. (50% FF / 50% GF)	$183,000	$91,500	$91,500
Cost Reimbursement Invoice (50% FF / 50% GF)	$0	$0	$0
Total	**$1,371,000**	**$670,000**	**$701,000**

5. Hourly Reimbursables:
   - Assume the annual System Group hours are 54,000 and the Billable Person Hourly Rate is $125.91

     54,000 × $125.91 = $6,799,140 (annual)

     $6,799,140 ÷ 12 (months) = $566,595 per month

DENTAL NEW FI ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER: 88

$566,595 x 5.667 months **= $3,211,000 TF ($803,000 GF)**

6. Total Administration Cost:

(Dollars in Thousands)

FY 2017-18	TF	GF	FF
Operations Cost	$6,016	$1,503	$4,513
Cost Reimbursement	$1,371	$670	$701
Hourly Reimbursements	$3,211	$803	$2,408
Total Dental FI Admin	**$10,598**	**$2,976**	**$7,622**

*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.

PERSONAL CARE SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER:	89
IMPLEMENTATION DATE:	4/1993
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	236

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$364,530,000	$371,080,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$364,530,000	$371,080,000

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: 89

(Dollars in Thousands)

FY 2016-17	TF	DHCS FFP	CDSS GF/ County Match
EW Time & Health Related	$640,060	$320,030	$320,030
CMIPS II	$89,000	$44,500	$44,500
Total	$729,060	**$364,530**	$364,530
FY 2017-18	**TF**	**DHCS FFP**	**CDSS GF/ County Match**
EW Time & Health Related	$646,460	$323,230	$323,230
CMIPS II	$95,700	$47,850	$47,850
Total	$742,160	**$371,080**	$371,080

Totals may differ due to rounding.

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

HEALTH-RELATED ACTIVITIES - CDSS

OTHER ADMIN. POLICY CHANGE NUMBER:	90
IMPLEMENTATION DATE:	7/1992
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	233

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$270,590,000	$277,756,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$270,590,000	$277,756,000

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 from Prior Estimate:
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: 90

(Dollars in Thousands)

FY 2016-17	TF	DHCS FFP	CDSS GF/ County Match
CWS	$318,080	$159,040	$159,040
CWS/CMS	$8,100	$4,050	$4,050
CSBG/APS	$215,000	$107,500	$107,500
TOTAL	$541,180	**$270,590**	$270,590

FY 2017-18	TF	DHCS FFP	CDSS GF/ County Match
CWS	$329,212	$164,606	$164,606
CWS/CMS	$8,300	$4,150	$4,150
CSBG/APS	$218,000	$109,000	$109,000
TOTAL	$555,512	**$277,756**	$277,756

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

CALHEERS DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	91
IMPLEMENTATION DATE:	6/2012
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	1679

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$131,661,000	$120,477,000
STATE FUNDS	$26,708,510	$23,413,020
FEDERAL FUNDS	$104,952,490	$97,063,980

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, by mail, by telephone, or with the Medicaid and Children's Health Insurance Program agency. 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 systems and MEDS.

CalHEERS was programmed to provide Modified Adjusted Gross Income 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: 91

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) and 12/88 FFP. CalHEERS ongoing Operations and Maintenance (O&M) cost is 25/75 FFP and 12/88 FFP. CalHEERS' costs are shared between Covered California and Medi-Cal.

Reason for Change:
The change from the prior estimate, for FY 2016-17, is due to project expenditures being revised based on the updated work plan. In addition, the funding splits for the Enterprise Innovation Technology Services (EITS) Division's costs were updated.

There is no change from the prior estimate for FY 2017-18.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to delays in processing invoices from FY 2015-16 to be paid in FY 2016-17 and increased system integration services costs in FY 2016-17.

Methodology:
1. Contractors began D&I work in July 2012 with payments beginning in August 2012. O&M started in January 2015.

2. In FY 2016-17 and FY 2017-18, costs are shared based on estimated enrollment for shared costs at a rate of 13.97% Covered California and 86.03% to the Department. Costs directly attributable to the Department will be 100% the responsibility of the Department.

3. In FY 2016-17 and FY 2017-18, costs incurred are for CalHEERS' D&I and O&M.
   The D&I period is eligible for:
   - 86.27% at 90% federal reimbursement
   - 13.73% at 88% federal reimbursement

   The O&M period is eligible for:
   - 86.27% at 75% federal reimbursement
   - 13.73% at 88% federal reimbursement

4. Effective FY 2016-17, the Department's EITS contractor costs are no longer included in the CalHEERS Implementation Advance Planning Document Update (IAPDU). The Department received approval from CMS in April 2016 on a separate IAPDU.

CALHEERS DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 91

FY 2016-17	TF	GF	FF
75% Title XIX FF / 25% GF	$82,759,000	$20,690,000	$62,069,000
88% Title XXI FF / 12% GF	$17,573,000	$2,109,000	$15,464,000
90% Title XIX FF / 10% GF	$27,654,000	$2,765,000	$24,889,000
CalHEERS Subtotal	$127,986,000	$25,564,000	$102,422,000
50% Title XIX FF / 50% GF	$1,088,000	$544,000	$544,000
75% Title XIX FF / 25% GF	$2,232,000	$558,000	$1,674,000
88% Title XXI FF / 12% GF	$355,000	$42,000	$313,000
DHCS EITS Subtotal	$3,675,000	$1,144,000	$2,531,000
Total	**$131,661,000**	**$26,708,000**	**$104,953,000**

FY 2017-18	TF	GF	FF
75% Title XIX FF / 25% GF	$70,404,000	$17,601,000	$52,803,000
88% Title XXI FF / 12% GF	$17,494,000	$2,099,000	$15,395,000
90% Title XIX FF / 10% GF	$29,129,000	$2,913,000	$26,216,000
CalHEERS Subtotal	$117,027,000	$22,613,000	$94,414,000
75% Title XIX FF / 25% GF	$2,968,000	$742,000	$2,226,000
88% Title XXI FF / 12% GF	$482,000	$58,000	$424,000
DHCS EITS Subtotal	$3,450,000	$800,000	$2,650,000
Total	**$120,477,000**	**$23,413,000**	**$97,064,000**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
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:	**92**
IMPLEMENTATION DATE:	**7/1997**
ANALYST:	**Jedidiah Warren**
FISCAL REFERENCE NUMBER:	**243**

	FY 2016-17	FY 2017-18
TOTAL FUNDS	**$54,966,000**	**$57,301,000**
STATE FUNDS	**$0**	**$0**
FEDERAL FUNDS	**$54,966,000**	**$57,301,000**

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 2016-17, is an increase due to updated expenditures. The change from the prior estimate, for FY 2017-18, is a decrease due to updated expenditures. The change from FY 2016-17 to FY 2017-18, in the current estimate is an increase due to higher HCBS Waiver Admin costs in FY 2017-18.

Methodology:
1. CDDS provides the following cash estimates of its administrative cost components:

CDDS ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 92

	FY 2016-17	DHCS FFP	CDDS GF	IA #
1	DC/SOCF Medi-Cal Admin.	$6,967,000	$6,967,000	03-75282/83
	DC/SOCF HIPAA*	$163,000	$0	03-75282/83
2	DC/SOCF Medi-Cal Elig	$550,000	$550,000	01-15378
3	HCBS Waiver Admin.	$21,307,000	$21,307,000	01-15834
4	RC Medicaid Admin.	$18,012,000	$6,004,000	03-75734
5	NHR Admin.	$433,000	$433,000	03-75285
6	TCM Headquarters Admin.	$409,000	$409,000	03-75284
	TCM RC Admin.	$6,487,000	$6,487,000	03-75284
	TCM HIPAA*	$638,000	$0	03-75284
	Total	**$54,966,000**	$42,157,000	

	FY 2017-18	DHCS FFP	CDDS GF	IA #
1	DC/SOCF Medi-Cal Admin.	$6,389,000	$6,389,000	03-75282/83
	DC/SOCF HIPAA*	$163,000	$0	03-75282/83
2	DC/SOCF Medi-Cal Elig	$550,000	$550,000	01-15378
3	HCBS Waiver Admin.	$26,769,000	$26,769,000	01-15834
4	RC Medicaid Admin.	$15,952,000	$5,317,333	03-75734
5	NHR Admin.	$596,000	$596,000	03-75285
6	TCM Headquarters Admin.	$351,000	$351,000	03-75284
	TCM RC Admin.	$5,893,000	$5,893,000	03-75284
	TCM HIPAA*	$638,000	$0	03-75284
	Total	**$57,301,000**	$45,865,000	

Funding:
100% Title XIX (4260-101-0890)
100% HIPAA FFP (4260-117-0890)*

DEPARTMENT OF SOCIAL SERVICES ADMIN COST

OTHER ADMIN. POLICY CHANGE NUMBER:	**93**
IMPLEMENTATION DATE:	**7/2002**
ANALYST:	**Randolph Alarcio**
FISCAL REFERENCE NUMBER:	**256**

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$27,676,000	$28,553,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$27,676,000	$28,553,000

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:
There is no change from the prior estimate for FY 2016-17 and FY 2017-18. The change from FY 2016-17 to FY 2017-18, 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 2016-17	TF	DHCS FFP	CDSS GF
IHSS PCSP	$14,030,000	$7,015,000	$7,015,000
IHSS Health Related	$136,000	$68,000	$68,000
CWS/CMS for Medi-Cal	$1,170,000	$585,000	$585,000
IHSS Plus Option Sec. 1915(j)	$4,560,000	$2,280,000	$2,280,000
SAWS	$784,000	$392,000	$392,000
Medi-Cal State Hearings	$19,600,000	$9,800,000	$9,800,000
Public Inquiry and Response	$571,000	$286,000	$285,000
Medicaid Disability Evaluation Services	$14,500,000	$7,250,000	$7,250,000
TOTAL	$55,351,000	**$27,676,000**	$27,675,000
FY 2017-18	**TF**	**DHCS FFP**	**CDSS GF**
IHSS PCSP	$14,310,000	$7,155,000	$7,155,000
IHSS Health Related	$136,000	$68,000	$68,000
CWS/CMS for Medi-Cal	$1,194,000	$597,000	$597,000
IHSS Plus Option Sec. 1915(j)	$4,560,000	$2,280,000	$2,280,000
SAWS	$784,000	$392,000	$392,000
Medi-Cal State Hearings	$19,600,000	$9,800,000	$9,800,000
Public Inquiry and Response	$571,000	$286,000	$285,000
Medicaid Disability Evaluation Services	$15,950,000	$7,975,000	$7,975,000
TOTAL	$57,105,000	**$28,553,000**	$28,552,000

*Totals may differ due to rounding.

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

MATERNAL AND CHILD HEALTH

OTHER ADMIN. POLICY CHANGE NUMBER:	94
IMPLEMENTATION DATE:	7/1992
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	234

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$29,049,000	$35,201,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$29,049,000	$35,201,000

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:

1. Conducts outreach to pregnant and parenting adolescents who are potentially eligible for Medi-Cal;
2. Assists Medi-Cal eligibles in accessing services;
3. Recruits providers for Medi-Cal's Comprehensive Perinatal Services Program (CPSP) and provides technical assistance regarding CPSP enhanced services to Medi-Cal beneficiaries;
4. 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;
5. Administers program for preventive and primary care services for children and youth; and
6. 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 (Chapter 25, Statutes of 2014) 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: 94

- 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 for FY 2016-17 from the prior estimate.

The change from the prior estimate, for FY 2017-18, is due to updated expenditures showing a projected increase in Title XIX federal funding for CPSP and PCG. CDPH anticipates an increase in county funds match for program expansion and outreach at the county level.

The change in the current estimate, from FY 2016-17 to FY 2017-18 is due to a higher projection for FY 2017-18 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. Annual expenditures for FY 2016-17 is estimated at $29.049 million FFP.

3. Annual expenditures for FY 2017-18 is estimated at $35.201 million FFP.

4. The following estimates have been provided on a cash basis by CDPH.

(Dollars in Thousands)

FY 2016-17	DHCS FFP	CDPH GF	County Match
BIH	$5,109	$2,854	$1,641
CPSP & PCG	$22,697	$0	$15,925
AFLP	$1,243	$0	$1,094
Total	**$29,049**	$2,854	$18,660

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

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

HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN

OTHER ADMIN. POLICY CHANGE NUMBER: 95
IMPLEMENTATION DATE: 7/1999
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 246

	FY 2016-17	FY 2017-18
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) 16-93191

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 service required by legislation, above the level for which funding has been provided. Therefore, funding

HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN

OTHER ADMIN. POLICY CHANGE NUMBER: 95

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 2016-17.
There is no change from the prior estimate for FY 2017-18.
There is no change from FY 2016-17 to FY 2017-18 in the current estimate.

Methodology:
1. CDSS provides the annual Local Revenue Fund of $9,943,000 for FY 2016-17 and FY 2017-18.

(Dollars in Thousands)

Fiscal Year	TF	CDSS GF	DHCS FFP
FY 2016-17	$39,772	$9,943	**$29,829**
FY 2017-18	$39,772	$9,943	**$29,829**

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

FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	96
IMPLEMENTATION DATE:	7/2007
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1192

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$14,641,000	$14,645,000
STATE FUNDS	$3,930,000	$3,907,000
FEDERAL FUNDS	$10,711,000	$10,738,000

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
IA 10-10494 A01
IA 13-20463 A01
AB 1559 (Chapter 565, Statutes of 2014)
SB 853 (Chapter 717, Statutes of 2010)

Interdependent Policy Changes:
PC 129 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: 96

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 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.

The CHCQ is currently negotiating an amendment of the contract with the Department to include the reimbursement for the NAR/NATCEP, the Centralized Applications Unit, and the Provider Certification Unit.

Skilled Nursing Facility: SB 853 (Chapter 717, Statutes of 2010) 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 2016-17 and FY 2017-18, is due to the following:

- The May 2017 Estimate corrects a technical funding error in order to include all federal fund reimbursements to CDPH.
- CLPP – Increased cost projections based on actual billings.
- Skilled Nursing Facilities – Increased cost projections due to revised staffing needs and operating expenses.

The change in the current estimate, from FY 2016-17 to FY 2017-18, is due to a higher cost projection for the Office of AIDS in FY 2017-18.

FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 96

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 2016-17 (Cash Basis)	DHCS FFP*	DHCS SF**	CDPH GF	Other Match
MCAH	$1,900,000	$0	$1,900,000	$0
Office of AIDS	$687,000	$0	$687,000	$0
CLPP	$1,807,000	$0	$0	$1,807,000***
CHCQ	$2,387,000	$0	$0	$2,387,000
Skilled Nursing Facilities	$3,930,000	$3,930,000	$0	$0
Total	**$10,711,000**	**$3,930,000**	$2,587,000	$4,194,000

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	$1,807,000	$0	$0	$1,807,000***
CHCQ	$2,387,000	$0	$0	$2,387,000
Skilled Nursing Facilities	$3,907,000	$3,907,000	$0	$0
Total	**$10,738,000**	**$3,907,000**	$2,637,000	$4,194,000

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:	97
IMPLEMENTATION DATE:	7/2014
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1820

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$14,032,000	$11,711,000
STATE FUNDS	$7,016,000	$5,855,500
FEDERAL FUNDS	$7,016,000	$5,855,500

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 (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.

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: 97

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 increase from the prior estimate, for FY 2016-17, is due to invoices repaid to the Department by Covered California for overpayment corrections as well as residual grant funds which allows for increased spending in the current year. The decrease from the prior estimate, for FY 2017-18, is due to repayments the Department will make to CMS for overpayment corrections. The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to updated actual invoices in FY 2016-17.

Methodology:
1. The Department estimates $26,743,000 (before support adjustment) will be spent on these activities in FY 2016-17 and 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 funds will be spent as follows:

(Dollars in Thousands)

FY 2016-17	TF	Special Fund	FF
Enrollment Counselors	$ (636)	$ (318)	$ (318)
Outreach and Enrollment	$ 9,281	$ 4,641	$ 4,641
Renewal Assistance	$ 5,887	$ 2,944	$ 2,944
Support Adjustment	$ (500)	$ (250)	$ (250)
Total	**$ 14,032**	**$ 7,016**	**$ 7,016**

FY 2017-18	TF	Special Fund	FF
Enrollment Counselors	$ -	$ -	$ -
Outreach and Enrollment	$ 8,292	$ 4,146	$ 4,146
Renewal Assistance	$ 3,919	$ 1,960	$ 1,960
Support Adjustment	$ (500)	$ (250)	$ (250)
Total	**$ 11,711**	**$ 5,856**	**$ 5,856**

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:	98
IMPLEMENTATION DATE:	7/1997
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	239

	FY 2016-17	FY 2017-18
TOTAL FUNDS	**$4,818,000**	**$4,200,000**
STATE FUNDS	$0	$0
FEDERAL FUNDS	**$4,818,000**	**$4,200,000**

DESCRIPTION

Purpose:
This policy change estimates the federal match provided to the California Department of Public Health (CDPH) for administrative costs associated with Childhood Lead Poisoning Prevention (CLPP) Program case management services.

Authority:
Interagency Agreement 07-65689

Interdependent Policy Changes:
Not Applicable

Background:
The CLPP Program provides services to the community for the purpose of increasing awareness regarding the hazards of lead exposure, reducing lead exposure, and increasing the number of children assessed and appropriately blood tested for lead poisoning as defined by the Medi-Cal State Plan and CDPH. Specifically, the program services include the following:

- Offers home visitation, environmental home inspections, and nutritional assessments to families of children found to be severely lead-poisoned.
- Provides telephone contacts and educational materials to families of lead-poisoned and lead exposed children.
- Provides information and education to the general public, medical providers, and community-based organizations.
- Provides public health nurse case management and environmental investigation services with associated administrative activities to lead burdened children who are Medi-Cal beneficiaries and meet the case definition of lead poisoning.

Reason for Change:
There is no change from the prior estimate. The change from FY 2016-17 to FY 2017-18, in the current estimate, results from delayed invoices being paid in FY 2016-17 and not continuing to FY 2017-18.

Methodology:
1. Annual expenditures on the accrual basis are $8,400,000. Cash basis expenditures vary from year-to-year based on when claims are actually paid.

CLPP CASE MANAGEMENT SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 98

2. The estimates are provided by CDPH on a cash basis.

(Dollars in Thousands)

FY 2016-17	DHCS FFP	CDPH CLPP Fee Funds
FY 2015-16 Admin. Costs	$1,668	$1,668
FY 2016-17 Admin. Costs	$3,150	$3,150
Total	**$4,818**	$4,818

FY 2017-18	DHCS FFP	CDPH CLPP Fee Funds
FY 2016-17 Admin. Costs	$1,050	$1,050
FY 2017-18 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:	99
IMPLEMENTATION DATE:	7/1984
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	253

	FY 2016-17	FY 2017-18
TOTAL FUNDS	**$3,910,000**	**$4,116,000**
STATE FUNDS	$0	$0
FEDERAL FUNDS	**$3,910,000**	**$4,116,000**

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:
Estimated projections were updated by CDA.

DEPARTMENT OF AGING ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 99

Methodology:
The estimates below, on a cash basis, were provided by CDA.

(Dollars in Thousands)

	FY 2016-17		FY 2017-18	
CBAS Support	**CDA GF**	**FFP**	**CDA GF**	**FFP**
FY 2015-16 DOS	$31	$32		
FY 2016-17 DOS	$1,824	$2,138	$119	$129
FY 2017-18 DOS			$1,824	$2,138
Total CBAS	$1,855	$2,170	$1,943	$2,267
MSSP Support				
FY 2014-15 DOS	$1	$1		
FY 2015-16 DOS	$14	$14		
FY 2016-17 DOS	$1,219	$1,389	$89	$120
FY 2017-18 DOS			$1,219	$1,389
Total MSSP	$1,234	$1,404	$1,308	$1,509
ADRC Support*				
FY 2015-16 DOS		$1		
FY 2016-17 DOS		$335		$22
FY 2017-18 DOS				$318
Total ADRC		$336		$340
Grand Total	$3,089	**$3,910**	$3,251	**$4,116**

Funding:
100% Title XIX (4260-101-0890)
100% MFP Federal Grant (4260-106-0890)*

CALIFORNIA SMOKERS' HELPLINE

OTHER ADMIN. POLICY CHANGE NUMBER:	100
IMPLEMENTATION DATE:	1/2014
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1680

	FY 2016-17	FY 2017-18
TOTAL FUNDS	**$1,287,000**	**$1,000,000**
STATE FUNDS	$0	$0
FEDERAL FUNDS	**$1,287,000**	**$1,000,000**

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. This policy change has been renamed and was previously titled "Tobacco Quitline Administrative Services."

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 California Smokers' Helpline (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. The maximum amount reimbursable for the IA is $1 million FFP annually.

Reason for Change:
There is no change from the prior estimate. The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to FY 2015-16 Quarters 3 and 4 claims being included in FY 2016-17 as a result of a delay in claims processing.

Methodology:
1. The Helpline services administrative costs are based on expenditure data for services provided to Medi-Cal beneficiaries. CDPH submits invoices for 50% reimbursement of actual and allowable administrative costs.

2. On an accrual basis, the maximum reimbursable amount for Helpline services is $1,000,000 FFP annually.

CALIFORNIA SMOKERS' HELPLINE

OTHER ADMIN. POLICY CHANGE NUMBER: 100

3. The estimated administrative costs reimbursements, for FY 2016-17 and FY 2017-18, on a cash basis are:

FY 2016-17	TF	FF
FY 2015-16 Claims, Q3-Q4	$287,000	$287,000
FY 2016-17 Claims, Q1-Q4	$1,000,000	$1,000,000
Total	**$1,287,000**	**$1,287,000**

FY 2017-18	TF	FF
FY 2017-18 Claims, Q1-Q4	$1,000,000	$1,000,000
Total	**$1,000,000**	**$1,000,000**

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

VITAL RECORDS DATA

OTHER ADMIN. POLICY CHANGE NUMBER:	**101**
IMPLEMENTATION DATE:	**5/2016**
ANALYST:	**Candace Epstein**
FISCAL REFERENCE NUMBER:	**1774**

	FY 2016-17	FY 2017-18
TOTAL FUNDS	**$856,000**	**$961,000**
STATE FUNDS	**$0**	**$0**
FEDERAL FUNDS	**$856,000**	**$961,000**

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 2013.

Reason for Change:
FY 2016-17 is lower than the prior estimate due to delays in invoicing. Costs for FY 2017-18 are higher than the prior estimate due to costs from FY 2016-17 occurring in FY 2017-18. Costs for FY 2017-18 are higher than FY 2016-17 due to delays in invoicing.

Methodology:
1. The Department and CDPH will receive MITA 90% FFP for Design, Development, and Installation activities and 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. Establishing an automated data interchange cost $100,000 with 90% FFP.

4. Assume a data flow based on a monthly average of 20,000 death records and 45,000 birth records.

VITAL RECORDS DATA

OTHER ADMIN. POLICY CHANGE NUMBER: 101

5. The ongoing cost for each record will be $1.54 to reimburse the cost associated with preparing the record for transfer and transferring the record to the Department.

6. Costs for FY 2016-17 include records for May and June 2016.

   FY 2016-17
   $1.54 per record x (20,000 death records + 45,000 birth records) x 14 months = $1,401,400 TF ($1,051,000 FFP)

   Due to delays in invoicing, 75% will be paid in FY 2016-17, and the remaining 25% will be paid in FY 2017-18.

   FY 2017-18
   $1.54 per record x (20,000 death records + 45,000 birth records) x 12 months = $1,201,000 TF ($901,000 FFP)
   Due to delays in invoicing, 25% of the prior year will be paid in FY 2017-18, and 75% of FY 2017-18 payments will be paid in FY 2017-18.

FY 2016-17	TF	HSSF	FFP
Data Interchange Development	$75,000	$7,000	$68,000
Data Provision	$1,051,000	$263,000	$788,000
Total	**$1,126,000**	**$270,000**	**$856,000**

FY 2017-18	TF	HSSF	FFP
Data Interchange Development	$25,000	$2,000	$23,000
Data Provision	$1,251,000	$312,000	$939,000
Total	**$1,276,000**	**$315,000**	**$961,000**

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

KIT FOR NEW PARENTS

OTHER ADMIN. POLICY CHANGE NUMBER:	102
IMPLEMENTATION DATE:	7/2001
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	249

	FY 2016-17	FY 2017-18
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.

Methodology:
1. CCFC will distribute an estimated 370,000 kits in FY 2016-17 and FY 2017-18, 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: 102

Fiscal Year	Accrual	FY 2016-17	FY 2017-18
FY 2015-16	$2,237,000	$559,000	$0
FY 2016-17	$2,237,000	$1,678,000	$559,000
FY 2017-18	$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: 103
IMPLEMENTATION DATE: 12/1988
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 232

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$956,000	$956,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$956,000	$956,000

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 16-93008

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, 2016 and was renewed effective July 1, 2016.

Reason for Change:
There is no change from the prior estimate for FY 2016-17 and FY 2017-18. There is no change from FY 2016-17 to FY 2017-18 in the current estimate.

Methodology:
1. The contract amount is estimated to be $956,000 for FY 2016-17 and FY 2017-18. The non-federal match is budgeted by CDVA.

FY	FY 2016-17			FY 2017-18		
Cash Basis	TF	CDVA GF	DHCS FF	TF	CDVA GF	DHCS FF
Administrative	$436,000	$218,000	$218,000	$436,000	$218,000	$218,000
Workload Units	$1,476,000	$738,000	$738,000	$1,476,000	$738,000	$738,000
Total	$1,912,000	$956,000	**$956,000**	$1,912,000	$956,000	**$956,000**

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 2016-17	FY 2017-18
TOTAL FUNDS	$686,000	$558,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$686,000	$558,000

DESCRIPTION

Purpose:
This policy change estimates the federal financial participation (FFP) provided to the California Department of Public Health (CDPH) for the Information and Education (I&E) program to establish and implement clinical linkages to the Family Planning, Access, Care and Treatment (Family PACT) program.

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 Division. I&E projects have been a major component of Maternal, Child and Adolescent Health (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:
There is no change from the prior estimate. The change from FY 2016-17 to FY 2017-18 is due to fewer agencies choosing to match funds for the program.

Methodology:
1. CDPH budgets the non-federal matching funds.

2. CDPH provides the estimated costs on a cash basis.

CDPH I&E PROGRAM AND EVALUATION

OTHER ADMIN. POLICY CHANGE NUMBER: 104

(Dollars in Thousands)

FY 2016-17	TF	CDPH GF	DHCS FF
FY 2015-16	$590	$295	$295
FY 2016-17	$781	$390	$391
Total	$1,371	$685	**$686**

FY 2017-18	TF	CDPH GF	DHCS FF
FY 2016-17	$334	$167	$167
FY 2017-18	$781	$390	$391
Total	$1,115	$557	**$558**

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

CHHS AGENCY HIPAA FUNDING

OTHER ADMIN. POLICY CHANGE NUMBER: 105
IMPLEMENTATION DATE: 7/2001
ANALYST: Sharisse DeLeon
FISCAL REFERENCE NUMBER: 257

	FY 2016-17	FY 2017-18
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

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.

Reason for Change:
There is no change from the prior estimate for both FY 2016-17 and FY 2017-18. There is no change from FY 2016-17 to FY 2017-18 in the current estimate.

Methodology:
1. The CHHS Agency prioritizes HIPAA projects so that the most critical projects are implemented first.

2. The Department expects to renew the IA prior to the June 30, 2017 expiration date. The new three-year IA is assumed to be effective July 1, 2017.

Cash Basis	DHCS FF	CHHS GF
FY 2016-17	$849,000	$849,000
FY 2017-18	$849,000	$849,000

Funding:
100% HIPAA (4260-117-0890)

MEDI-CAL INPATIENT SERVICES FOR INMATES

OTHER ADMIN. POLICY CHANGE NUMBER: 106
IMPLEMENTATION DATE: 3/2011
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 1665

	FY 2016-17	FY 2017-18
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 for county inmates.

MEDI-CAL INPATIENT SERVICES FOR INMATES

OTHER ADMIN. POLICY CHANGE NUMBER: 106

Reason for Change:
There is no change from the prior estimate for FY 2016-17 and FY 2017-18. There is no change from FY 2016-17 to FY 2017-18 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 2016-17 and FY 2017-18.

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

MERIT SYSTEM SERVICES FOR COUNTIES

OTHER ADMIN. POLICY CHANGE NUMBER: 107
IMPLEMENTATION DATE: 7/2003
ANALYST: Jason Moody
FISCAL REFERENCE NUMBER: 263

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$198,000	$194,000
STATE FUNDS	$99,000	$97,000
FEDERAL FUNDS	$99,000	$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 meet 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. The change from FY 2016-17 to FY 2017-18 in the current estimate is due to the decrease in the amount of the agreement with Cooperative Personnel Services.

Methodology:
1. CalHR provided the estimates on a cash basis.

2. The estimated reimbursement is $198,000 TF ($99,000 GF) in FY 2016-17 and $194,000 TF ($97,000 GF) in FY 2017-18.

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

CDDS DENTAL SERVICES - ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER:	108
IMPLEMENTATION DATE:	11/2011
ANALYST:	Nikaela Ratliff
FISCAL REFERENCE NUMBER:	1631

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$120,000	$120,000
STATE FUNDS	$120,000	$120,000
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. Select adult optional dental services were reinstated May 1, 2014.

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:
There is no change from the prior estimate for FY 2016-17. There is also no change from FY 2016-17 to FY 2017-18 in the current estimate.

Methodology:
1. Assume the cost of processing claims is $120,000 annually, based on actual invoices.
2. All costs are reimbursed by CDDS.

Funding:
Reimbursement GF (4260-610-0995)

PIA EYEWEAR COURIER SERVICE

OTHER ADMIN. POLICY CHANGE NUMBER: 109
IMPLEMENTATION DATE: 7/2003
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 1114

	FY 2016-17	FY 2017-18
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:
The change from the prior estimate for, FY 2016-17 and FY 2017-18, is a decrease to align budgeted amounts with actual payment history.

In the current estimate, there is no change estimated from FY 2016-17 to FY 2017-18.

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 2016-17. FY 2017-18 payments are estimated to remain stable at 195,000 packages.

   $1.75 x 195,000 = $341,250 TF ($170,625 GF)

(Rounded)

Fiscal Year	TF	GF	FF
FY 2016-17	$341,000	$170,500	$170,500
FY 2017-18	$341,000	$170,500	$170,500

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

MANAGED CARE REGULATIONS - MENTAL HEALTH

OTHER ADMIN. POLICY CHANGE NUMBER:	112
IMPLEMENTATION DATE:	7/2017
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	2019

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$0	$27,792,000
STATE FUNDS	$0	$9,264,000
FEDERAL FUNDS	$0	$18,528,000

DESCRIPTION

Purpose:
This policy change estimates the cost to reimburse County Mental Health Plans (MHPs) for administrative activities arising from the implementation of new federal regulations. 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.

Authority:
Title 42, Code of Federal Regulations Part 438

Interdependent Policy Changes:
Not Applicable

Background:
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 final 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). The Department is working with county partners to identify the extent and magnitude of both fiscal and administrative impacts to MHPs.

MANAGED CARE REGULATIONS - MENTAL HEALTH

OTHER ADMIN. POLICY CHANGE NUMBER: 112

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.

Reason for Change:
There is no change, for FY 2016-17, from the prior estimate. The change for FY 2017-18, from the prior estimate, is a decrease due to updating the estimated costs per position for the administrative activities. In addition, the categories have changed to align with the Federal Regulations.

Methodology:
The estimated costs of Managed Care and Parity Regulations for FY 2017-18 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).

1. State Monitoring:
   Compile data and information from various other areas for required reporting to the State.

   - Assume 1.0 analyst is needed per county at a cost of $90,299 per analyst. The total estimated costs are $5,056,000 TF.

2. Network Adequacy:
   Collect and submit detailed provider data to the State for required reporting of provider networks and provider capacity.

   - Assume 2.0 analysts are needed per county at a cost of $90,299 per analyst. The total estimated costs are $10,112,000 TF.

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 1 analyst is needed per county at a cost of $90,299 per analyst. The total estimated costs are $5,056,000 TF.

4. Grievances and Appeals System:
   Ongoing staffing impact to comply with 72-hour authorization upon notice of reversal of adverse benefit determination.

   - Assume 1.0 analyst is needed per county at a cost of $90,299 per analyst. The total estimated costs are $5,056,000 TF.

5. Program Integrity:
   MHPs will need to conduct monitoring for contractor compliance, prepare and submit data, documentation, and information to the State.

   - Assume 1.0 analyst is needed per county at a cost of $90,299 per analyst. The total estimated costs are $5,056,000 TF.

MANAGED CARE REGULATIONS - MENTAL HEALTH

OTHER ADMIN. POLICY CHANGE NUMBER: 112

6. One-Time County IT Costs:
   MHPs will need to begin collecting and reporting additional data to the State.

   - Assume 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 costs are $5,880,000 TF.

7. One-Time County Translation Costs:
   MHPs will need to translate at a minimum five beneficiary documents.

   - Assume 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 costs are:

(Dollars in Thousands)

Managed Care Regulations-MH Costs	**TF**	**GF**	**FF**	**CF**
State Monitoring	$5,056	$1,264	$2,528	$1,264
Network Adequacy	$10,112	$2,528	$5,056	$2,528
Quality Measurement & Improvement; External Quality Review	$5,056	$1,264	$2,528	$1,264
Grievances and Appeals System	$5,056	$1,264	$2,528	$1,264
Program Integrity	$5,056	$1,264	$2,528	$1,264
County IT Costs	$5,880	$1,470	$2,940	$1,470
County Translation Costs	$840	$210	$420	$210
Total FY 2017-18	$37,056	**$9,264**	**$18,528**	$9,264

Funding:
100% Title XIX FF (4260-101-0890)
100% Title XIX GF (4260-101-0001)

TITLE XXI FEDERAL MATCH REDUCTION OTHER ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 115
IMPLEMENTATION DATE: 10/2017
ANALYST: Katy Clay
FISCAL REFERENCE NUMBER: 2030

	FY 2016-17	FY 2017-18
TOTAL FUNDS	$0	-$1,927,000
STATE FUNDS	$0	$9,793,000
FEDERAL FUNDS	$0	-$11,720,000

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 002 CCS Case Management
PC 007 OTLICP, MCAP, Special Populations Admin Costs
PC 068 HCO Cost Reimbursement
PC 069 HCO Operations
PC 070 HCO - Enrollment Contractor Costs
PC 071 HCO ESR Hourly Reimbursement
PC 091 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, the ACA enhanced federal matching rate for the CHIP program will be reduced by 23 percent to 65%, unless Congress takes action to both reauthorize the program and extend the funding at the enhanced amount. 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:
This is a new policy change.

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 in FY 2017-18 is estimated as $1,927,000.

Funding:

TITLE XXI FEDERAL MATCH REDUCTION OTHER ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 115

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)

MEDI-CAL INFORMATION ONLY
May 2017
FISCAL YEARS 2016-17& 2017-18

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 a be 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 a SPA reflecting the rate changes, retroactive to July 1, 2016.

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 (ALW), In-Home Operations (IHO), 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.

HOME AND COMMUNITY BASED SERVICES

Assisted Living Waiver (ALW)

The ALW pays for assisted services and supports, care coordination, and community transition in 14 counties (Sacramento, San Joaquin, Los Angeles, Riverside, Sonoma, Fresno, San Bernardino, Alameda, Contra Costa, San Diego, Kern, San Mateo, Santa Clara and Orange.) Waiver participants can elect to receive services in either 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 3,700. CMS approved a renewal of the ALW on August 28, 2014 effective from March 1, 2014 through February 28, 2019. On July 1, 2017, the Department will expand into San Francisco County and transition all San Francisco Community Living Support Benefit (SF CLSB) Waiver participants 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 ~~on~~ **in** this waiver will receive all medically necessary services as outlined in ~~their~~ **his/her** care ~~plans~~ **plan** and approved by the CMA. 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 ~~anticipates the waiver to be implemented by~~ **is in the process of renewing the NF/AH Waiver which expired on December 31, 2016. 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 for the participant's assessed LOC. CMS approved the IHO waiver renewal from January 1, 2015 through December 31, 2019. The Department will integrate and close the IHO waiver into the new HCB Waiver as of January 1, 2017.

Nursing Facility/Acute Hospital – Transition and Diversion Waiver

The NF/AH – Transition and Diversion Waiver provides Medi-Cal beneficiaries with long-term medical conditions, who meet the acute hospital, adult or pediatric subacute, nursing facility, **or** distinct-part nursing facility (NF) Level of Care, with the option of returning to and/or remaining in his/her home or home-like setting in the community in lieu of hospitalization.

The waiver is approved from January 1, 2012 through December 31, 2016. The Department has submitted an amendment for the current waiver year beginning February 1, 2016 through December 31, 2016 to account for recent changes in the Fair Labor Standards Act (FLSA) requiring compensation for personal care services overtime. The Department is in the process of renewing the NF/AH Waiver which ~~is proposed to be~~ **expired on December 31, 2016. To ensure a sufficient review period, CMS approved the extension of the current waiver through March 30, 2017. The renewed waiver will be** renamed the HCB Alternatives Waiver ~~that is currently set to end December 31, 2016~~. The waiver renewal ~~will be~~ was submitted to CMS ~~no sooner than September 2016~~ with a proposed effective date of January 1, 2017.

NF/AH Waiver Amendment

The NF/AH waiver offers services in the home or community to Medi-Cal beneficiaries who would likely otherwise receive care in a skilled nursing facility. Eligibility for the NF/AH is based on skilled nursing levels of care. The level of care per waiver participant is determined by the Medi-Cal beneficiary's medical. The FLSA regulations requiring compensation for overtime worked by personal care workers was implemented in California February 1, 2016. Full implementation of FLSA, under Senate Bill 855, will begin May 1, 2016 for all providers in IHSS and the NF/AH waiver for Waiver Personal Care Services (WPCS) programs. This will result in some participants needing to exceed their individual cost limit with no change in authorized hours. The waiver is held to the principle of federal cost neutrality thus services are arranged based on an annual cost limitation per participant. In order to maintain cost neutrality, the overall total costs for the Waiver and Medi-Cal State Plan services cannot exceed the costs of facilities offering equivalent levels of care. Currently, the cost neutrality limit requirements are

applied individually to each NF/AH Waiver participant therefore limiting access to critically needed services and risking unnecessary institutionalization on a case by case basis. The additional overtime costs under the new FLSA overtime requirements may cause some participants to exceed their individual cost limit. Safeguards established within the waiver require the Department to dis-enroll participants who exceed their individual cost limits. The waiver also is currently capped at 3,952 slots per year, thus, a wait list has been created.

The waiver amendment will shift from an individual cost limit to a weighted average level of care while maintaining aggregate cost neutrality and ensure that participants are able to get all needed services despite the individual cost limit and new federal rules on overtime. The waiver amendment proposes a retroactive effective date of February 1, 2016.

San Francisco Community Living Support Benefit (CLSB) Waiver

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

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

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

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

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 approved from July 1, 2012, through June 30, 2017. ~~On~~ **Effective** July 1, 2017, the Department will integrate the SF CLSB waiver **population** into the ALW. **As a result of this integration, the Department will not renew the SF CLSB waiver upon completion of its' current term on June 30, 2017.**

HOME AND COMMUNITY BASED SERVICES

Acquired Immune Deficiency Syndrome (AIDS) Medi-Cal Waiver

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

Services provided include:

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

Clients eligible for the program must be Medi-Cal recipients whose health status qualifies them for nursing facility care or hospitalization, in an ~~"Aid Code"~~ **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**,** ~~adults who are~~ 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 ~~who~~ are **eligible if they have been** certified by the nurse case manager as HIV/AIDS symptomatic~~;~~**.** ~~and individuals with a health status that is consistent with in-home services and who~~ **All waiver participants must** have a home setting that is safe for both the client and service providers.

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 ~~will be~~ **was** submitted to CMS for renewal with a proposed effective date of January 1, 2017.

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
- Waiver Year 3: 12,000
- Waiver Year 4: 5,624
- Waiver Year 5: 5,624

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 reduced based on the integration of this population into managed care no later than January 1, 2018 in the seven CCI counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

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 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.

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 is expected to begin July 1, 2016 as a five year waiver, ending June 30, 2021.

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.

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, following the member in the nursing facility. The eligibility criteria for SCAN specifies that a member be at least 65 years of age, have Medicare A and B, have full scope Medi-Cal with no share of cost and live in SCAN's approved service areas of Los Angeles, Riverside, or San Bernardino counties. SCAN does not enroll individuals with End Stage Renal Disease.

HOME AND COMMUNITY BASED SERVICES

Special Grant

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

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

1115 WAIVER-MH/UCD, BTR, & MEDI-CAL 2020

The Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD) ended on October 31, 2010, and the California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) ended on December 31, 2015. The Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020) was approved effective January 1, 2016, for five years.

Medi-Cal 2020 builds on the successes of the state's Bridge to Reform waiver in 2010, a critical piece of the state's implementation of the Affordable Care Act. The Medi-Cal 2020 waiver opens the door to innovative changes in the way Medi-Cal provides services to its members, all with the goals of improving efficiency, access, and quality of care.

This final Medi-Cal 2020 renewal reflects the overall construct announced at the end of October. It includes initial federal funding over the five years of $6.2 billion, with the potential for additional federal funding in the Global Payment Program (GPP) after the initial year of the waiver.

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

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

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

- Dental Transformation Initiative (DTI) – For the first time, California's Waiver also includes opportunities for improvements in the Medi-Cal Dental Program. The DTI

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

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

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

MANAGED CARE

Medi-Cal Managed Care Rates

Base Rates are developed 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/Family 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/Family 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

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.

SBX2-2 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 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 discontinue in FY 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 supports, except In-Home Supportive Services (IHSS), into managed care. IHSS would be removed from capitation rate payments effective January 1, 2018.

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

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

In addition to managed care carve-outs, the Department is required to provide additional reimbursement through the FFS Medi-Cal program to Federally Qualified Health Center/Rural Health Clinic providers who have rendered care to beneficiaries enrolled in managed care

plans. These providers are reimbursed for the difference between their prospective payment system rate and the amount they receive from managed care health plans. These FFS expenditures are referred to as “wrap-around” payments.

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

2016-17 and 2017-18 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 ~~2.41%~~ **3.69%** increase in classic rates over the 2016-17 fiscal year rates **and assume the Optional Expansion rates are held constant**.

PROVIDER RATES

Reimbursement Methodology and the Quality Assurance Fee for AB 1629 Facilities

AB 1629 requires the Department to develop a cost-based, facility-specific reimbursement rate methodology for freestanding skilled (level B) nursing facilities, including subacute units which are part of a freestanding skilled nursing facility. Rates are updated annually and are established based on the most recent audited cost report data. AB 1629 also imposed a Quality Assurance Fee (QAF) on these facilities and added requirements for discharge planning and assistance with community transitions.

The rate methodology developed by the Department computes facility-specific, cost-based per diem payments for SNFs based on five cost categories, which are subject to limits. Limits are set based on expenditures within geographic peer groups. Also, costs specific to one category may not be shifted to another cost category.

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

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

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

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

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

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

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

PROVIDER RATES

Quality and Accountability Supplemental Payment Program

SB 853 (Chapter 717, Statutes of 2010) requires the Department to implement a Quality and Accountability Supplemental Payment (QASP) Program for SNFs by August 1, 2010. The QASP Program will enable SNF reimbursement to be tied to demonstrated quality of care improvements for SNF residents. AB 1489 (Chapter 631, Statutes of 2012) delayed the payments and required the Department to make the payments by April 30, 2014.

AB 119 (Chapter 17, Statutes of 2015) extends the AB 1629 facility-specific rate methodology, QAF, and QASP program through July 31, 2020. Further, beginning rate year 2015-16, the annual weighted average rate increase is 3.62%, and the QASP will continue at FY 2014-15 levels, rather than setting aside a portion of the annual rate increase. Additionally, beginning FY 2015-16, the legislation requires the Department to incorporate direct care staff retention as a performance measure into the QASP Program.

Reimbursement Methodology for Other Long-Term Care Facilities (non-AB 1629)

The reimbursement methodology is based on a prospective flat-rate system, with facilities divided into peer groups by licensure, level of care, bed size and geographic area in some cases. Rates for each category are determined based on data obtained from each facility's annual or fiscal period closing cost report. Audits conducted by the Department result in adjustments to the cost reports on an individual or peer-group basis. Adjusted costs are segregated into four categories:

Fixed Costs (Typically 10.5 percent of total costs). Fixed costs are relatively constant from year to year, and therefore are not updated. Fixed costs include interest on loans, depreciation, leasehold improvements and rent.

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

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

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

Methodology by Type of LTC Facility

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

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

PROVIDER RATES

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

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

Effective August 1, 2016, ABX2 1 (Chapter 3, Statutes of 2016) requires the Department to reimburse ICF/DD, ICF/DD-H, and ICF/DD-N providers the rate in effect in the 2008-09 rate year, increased by 3.7%.

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

Revenues

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

FY 2015-16:	$ ~~26,854,000~~ **26,466,000**	ICF-DD Quality Assurance Fee
	$ ~~540,994,000~~ **529,686,000**	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	$ 9,393,000	ICF-DD Transportation/Day Care Quality Assurance Fee
	$ ~~1,862,000~~ **1,293,000**	Freestanding Pediatric Subacute Quality Assurance Fee
	$ ~~1,609,742,000~~ **1,656,378,000**	MCO ~~Enrollment~~ Tax
	$ 4,600,535,000	Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)
	$ 8,000,000	Emergency Medical Air Transportation (EMATA) Fund
	$ ~~6,797,380,000~~ **6,831,751,000**	Total
FY 2016-17:	$ ~~27,256,000~~ **27,208,000**	ICF-DD Quality Assurance Fee
	$ ~~560,578,000~~ **520,740,000**	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	$ ~~9,324,000~~ **9,874,000**	ICF-DD Transportation/Day Care Quality Assurance Fee
	$ ~~1,862,000~~ **1,267,000**	Freestanding Pediatric Subacute Quality Assurance Fee
	$ 2,283,263,000	MCO Enrollment Tax
	$ ~~5,150,578,000~~ **4,330,242,000**	Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)
	$ 8,000,000	Emergency Medical Air Transportation (EMATA) Fund
	$ ~~8,040,861,000~~ **7,180,594,000**	Total
FY 2017-18:	$ ~~27,836,000~~ **27,644,000**	ICF-DD Quality Assurance Fee
	$ ~~580,871,000~~ **539,591,000**	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	$ ~~9,324,000~~ **9,874,000**	ICF-DD Transportation/Day Care Quality Assurance Fee
	$ ~~1,862,000~~ **1,267,000**	Freestanding Pediatric Subacute Quality Assurance Fee
	$ 2,428,921,000	MCO Enrollment Tax
	$ ~~5,150,578,000~~ **3,790,120,000**	Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)
	$ 6,000,000	Emergency Medical Air Transportation (EMATA) Fund
	$ ~~8,205,392,000~~ **6,803,417,000**	Total

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Effective August 1, 2009, the Department expanded the amount of revenue upon which the quality assurance fee for AB 1629 facilities is assessed, to include Medicare.

The FY 2011-12 ICF/DD Transportation/Day Care QA fee includes a one-time retroactive collection of $22.5 million in QA fees for FY 2007-08 through FY 2010-11. In addition to the retroactive QA fees, the QA fee includes an estimated $6.1 million for FY 2011-12. The ICF/DD Transportation/Day Care QA fee is expected to remain consistent in future years.

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 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,

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grants to designated public hospitals and non-designated public hospitals, and increased capitation payments to managed health care plans. The fund is also used to pay for health care coverage for children and for staff and related administrative expenses required to implement the QAF program.

AB 1607 (Chapter 27, Statutes of 2016) extended the inoperative date of the Hospital QAF program to January 1, 2018, creating a one-year extension of the program.

Proposition 52, approved by California voters on November 8, 2016, permanently extends the Hospital QAF program.

The California Department of Public Health (CDPH) lowered Licensing and Certification (L&C) fees for long-term care providers for FY 2010-11. The aggregate amount of the reductions allowed the QA fee amounts collected from the freestanding NF-Bs and ICF/DDs (including Habilitative and Nursing) to increase by an equal amount. Currently, the QA fee amounts are calculated to be net of the L&C fees in order to be within the federally designated cap, which provides for the maximum amount of QA fees that can be collected. For FY 2011-12, CDPH increased L&C fees which resulted in a reduction in the collection of the QA fee by an equal amount to the L&C fee increase for free-standing NF-Bs, Freestanding Pediatric Subacute Facilities and ICF/DDs (including Habilitative and Nursing).

Effective January 1, 2011, AB 2173 (Chapter 547, Statutes of 2010) imposes an additional penalty of $4 for convictions involving vehicle violations.

AB 119 (Chapter 17, Statutes of 2015) extends the AB 1629 facility-specific rate methodology, QAF, and QASP program through July 31, 2020. Further, beginning rate year 2015-16, the annual weighted average rate increase is 3.62%, and the QASP will continue at FY 2014-15 levels, rather than setting aside a portion of the annual rate increase. Additionally, beginning FY 2015-16, the legislation requires the Department to incorporate direct care staff retention as a performance measure into the QASP Program.

ELIGIBILITY

County Administration Base

The Department is in the process of finalizing a Request for ~~Offer~~ **Proposal** (~~RFO~~ **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 ~~2016-17~~ **FY 2017-18**.

Qualifying Individual Program

The Balanced Budget Act of 1997 provided 100% federal funding, effective January 1, 1998, to pay for Medicare premiums for two new groups of Qualifying Individuals (QI). QI-1s have their Part B premiums paid and QI-2s receive an annual reimbursement for a portion of the premium. The QI programs were scheduled to sunset December 31, 2002, but only the QI-2 program did sunset December 31, 2002. HR 3971, enacted as Public Law 109-91, extended the program through September 30, 2007. The sunset date was extended to March 31,

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2015, by HR 4302, the Protecting Access to Medicare Act of 2014. The Medicare Access and CHIP Reauthorization Act of 2015 provides a permanent allotment of the QI-1 program.

Transitional Medi-Cal Program

As part of Welfare Reform in 1996 (PRWORA of 1996, P.L. 104-193), the Transitional Medi-Cal Program (TMC) became a one-year federal mandatory program for parents and children who are terminated from the Section 1931(b) program due to increased earnings and/or hours from employment. Prior to this current twelve-month program, TMC was limited to four months for those discontinued from the Aid to Families with Dependent Children program due to earnings. Since 1996, it has had sunset dates that Congress has continually extended. With the passage of HR2, The Medicare Access and CHIP Reauthorization Act of 2015, the TMC sunset date was removed, and TMC became a permanent program.

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.

Lanterman Developmental Center Closure

On April 1, 2010, the California Department of Developmental Services (CDDS) submitted a plan to the Legislature for the closure of Lanterman Developmental Center. CDDS is working with consumers, families, and the regional centers to transition residents to community living arrangements. If eligible for Medi-Cal, residents moving into the community will be enrolled in a Medi-Cal managed care health plan or will receive services through the fee-for-service (FFS) system. All residents were transitioned out of Lanterman Development Center by December 31, 2014.

Medi-Cal Inpatient Services for **Adult and Juvenile** Inmates

This assumption has been deleted as this is included in the Medi-Cal State Inmate Programs and Medi-Cal County Inmate Programs policy changes.

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

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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.

Proposal for Glendale Adventist Medical Center

The Department of State Hospitals (DSH) is pursuing a contract with Glendale Adventist Medical Center, for up to a 40-bed program in a secure facility located in a non-DSH hospital at a daily rate of $300 per bed. This equates to an estimated cost of $109,500 per bed, per year. The program will be licensed as a Skilled Nursing Facility (SNF) and will serve SNF patients transferred primarily from DSH-Metropolitan. The patients eligible for this transfer would be committed as either: Not Guilty by Reason of Insanity (NGI), Mentally Disordered Offenders (MDO), or Lanterman-Petris-Short (LPS) patients in need of treatment on a SNF unit. DSH-Metropolitan is currently able to transfer up to 40 patients to Glendale and backfill those beds with low-security forensic patients who are able to receive treatment outside of the Secure Treatment Area (STA) and who are in need of SNF care. This will, in turn, free additional beds in the STA and allow DSH to admit additional forensic patients.

AFFORDABLE CARE ACT

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 for FY 2014-15, $585.9 million for FY 2016-17**,** and **$546.2 million for** FY 2017-18. Final reconciliation for FY 2013-14 is estimated to cost ~~$179.5~~ **$164.6** million to be paid in FY 2016-17.

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Optional Expansion Medical Loss Ratio (MLR) Audit Requirement

The Department will audit Optional Expansion MLR calculations of managed care plans for two periods. The first period covers 18 months from January 1, 2014 to June 30, 2015. The second period covers 12 months from July 1, 2015 to June 30, 2016. The MLR used for the Optional Expansion population requires managed care plans to return excess capitation payments up to 85 percent of allowed costs. No action is taken if the MLR is between 85 to 95 percent. If the managed care plan's allowed costs exceed 95 percent of net capitation payments, the Department must pay the plan the difference to bring the MLR down to 95 percent.

These audits are expected to result in a recoupment of Optional Expansion capitation payments over multiple years after FY 2016-17. Managed care plans must pay recoupment amounts back to the Department 90 days after the issuance of the audit report. The Department will pay back 100 percent of the recouped funds to the federal government, as the Optional Expansion rates were 100 percent federal funds. Audits will be initiated no sooner than ~~June 30, 2016~~ **July 1, 2017**.

BENEFITS

State-Only Anti-Rejection Medicine Benefit Extension

Assembly Bill 2352 (Chapter 676, Statutes of 2010) requires Medi-Cal beneficiaries to remain eligible for State-Only Medi-Cal coverage for anti-rejection medication for up to two years following an organ transplant unless, during that time, the beneficiary becomes eligible for Medicare or private health insurance that would cover the medication. Currently, some patients qualify for Medi-Cal under a federal rule allowing coverage for anti-rejection medication for one year post organ transplant. After this eligibility ends, the Department will no longer receive FFP. Therefore, the costs for extending this benefit will be 100% General Fund. The fiscal impact is indeterminate.

Medi-Cal Nonmedical Transportation

This assumption has been deleted and is now a new policy change.

3. **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

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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.

4. **California Children's Services (CCS)-Medical Therapy Program (MTP) – Potential Impact of Special Education Litigation**

The Department has been engaged in litigation (Toby Douglas V. CA Office of Adm. Hearings, L.M. vs Tuolumne CCS) in State and Federal court with the Department of General Services' Office of Administrative Hearings (OAH) and with plaintiffs who have prevailed in OAH due process hearings to address a fundamental difference in the interpretation of the mandates of Part B of the Individuals with Disabilities Education Act (IDEA) and Government Code 7570 et. seq. relating to Special Education. This litigation follows from three county (Tuolumne, Santa Clara and Calaveras) level IDEA due process-complaint decisions by OAH Administrative Law Judges in which the CCS- MTP was made responsible for the provision of educationally necessary occupational therapy (OT) and physical therapy (PT) without regard to medical necessity. The Department appealed the decisions. OAH and the plaintiffs prevailed, including in state and federal appellate court, which established a legal precedent that has the potential to obligate the CCS-MTP to provide ongoing educationally necessary OT and PT services without regard to medical necessity statewide. The Department is currently accessing the potential financial impact.

HOME & COMMUNITY BASED-SERVICES

AB 398—Traumatic Brain Injury

The Traumatic Brain Injury Pilot Project was authorized by AB 1410 (Chapter 676, Statutes of 2007). AB 1410 was updated and replaced by AB 398 (Chapter 439, Statutes of 2009) which directed the Department to work in conjunction with the Department of Rehabilitation to develop a waiver or SPA that would allow the Department to provide HCBS to at least 100 persons with Traumatic Brain Injury. The legislation contained language stating the project would only be operable upon appropriation of funds. There is currently no appropriation to initiate and sustain this pilot project. In conjunction with DOR, the Department has explored serving this population through other HCBS waivers.

BREAST AND CERVICAL CANCER TREATMENT

PHARMACY

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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.

Outpatient Prescription Drug Rule

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** ~~must complete~~ 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 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**. ~~The Department anticipates a fiscal impact from this change however, the net impact is currently unknown~~.

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.

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.

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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.

DRUG MEDI-CAL

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.

SUD Services Modification for Narcotic Treatment Program

Effective January 1, 2014, SPA #13-038 modified SUD services by removing the 200 minute per month cap on individual counseling services for Narcotic Treatment Programs. This policy allows medical necessity to be the basis for the amount of counseling needed by the patient. Individuals are evaluated and assessed prior to receiving treatment, hence the clinician would make the assessment of how many minutes of therapy a client needs.

SUD Services Modification for DMC Treatment Programs

Effective January 1, 2015, SPA #15-012 modified SUD services by expanding the group counseling size limits for DMC. This policy allows flexibility to ensure patients have access to groups.

This change affects the following programs:

- Narcotic Treatment Program (NTP)
- Intensive Outpatient Treatment Services (IOT)
- Outpatient Drug Free Treatment Services (ODF)

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MENTAL HEALTH

Certified Community Behavioral Health Clinics (CCBHC)

This assumption has been deleted as the Department was not chosen to participate in the CCBHC demonstration project.

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.

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 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.

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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 (2020 Waiver) requires California's resolution of all existing negative federal fund grant account balances and deferred claims.

   - **Negative federal fund grant balances: Negative balances for federal fiscal year (FFY) 2013 and prior must be resolved, by the end of the 2020 Waiver period (December 31, 2020). California and CMS are actively working toward the resolution of these negative grant account balances for any negative grant account balances remaining after June 30, 2017, CMS will issue a disallowance and require California to return sufficient funding to bring the grant account 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. If the appeal is unsuccessful, California will need to repay CMS, in even quarterly installments, with interest, during the life of the 2020 Waiver.**

   - **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 is not be subject to interest. Some deferred claims contribute to the negative account balances, mentioned above, and will be liquidated through the negative grant account balance resolution. DHCS is actively working to resolve these deferrals and the total federal funding reimbursement is unknown at this time. DHCS is proposing to begin the federal fiscal year quarterly payments in Fiscal Year 2018-19 when the amounts are finalized.**

   Ongoing deferred claims repayment: In the past, California has not returned federal funding on CMS deferred claims until after the deferred claim was officially disallowed. Pursuant to the Special Terms and Conditions of the 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

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funding. CMS disallowances fluctuate quarter to quarter, resulting in an unpredictable federal fund repayment amount.

MANAGED CARE

FQHC Alternative Payment Methodology (APM) Pilot

California State Senate Bill (SB) 147 (Chapter 760, Statutes of 2015) authorized a three-year APM pilot program for county and community-based FQHCs willing to participate in the pilot program. SB 147's purpose is to incentivize delivery system and practice transformation at FQHCs through flexibilities available under a capitated model which would move the clinics away from the traditional volume-based, PPS, to a payment methodology that better aligns the evolving financing and delivery of health services. The proposed APM structure provides participating FQHCs the flexibility to deliver care in the most effective manner, without having to worry about the more restrictive traditional billing structure that is in place today. With the flexibility of payment reform, FQHCs will begin to provide and/or expand upon the innovative forms of care which are not reimbursed under traditional volume-based PPS.

Under the proposed APM pilot, for beneficiaries who are assigned to a FQHC as their primary care provider, the direct payor for full FQHC payment would transition from the state to Medi-Cal managed care plans. The clinic-specific capitated payment methodology would ensure participating clinics are reimbursed at no less than the PPS rate, as prescribed under federal law, while incentivizing delivery system reform and practice transformation at FQHCs through funding flexibilities available under a full capitation payment structure. By virtue of implementing a capitated model, the pilot is also structured to allow for more administrative flexibility for the clinics. For those assigned members, clinics will no longer need to submit claims for wrap-around payments to the state and wait years for a reconciliation to PPS to occur.

DHCS has an implementation target date of ~~October 1, 2017~~ **no sooner than January 1, 2018**, for the proposed pilot; however, the pilot is still pending CMS approval.

2. Whole Child Model Implementation

Building on existing successful models and delivery systems, the Whole Child Model (formally known as the CCS Redesign project) 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 Whole Child Model 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 Whole Child Model 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

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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 three of the fifteen 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.

3. Health Homes For Patients With Complex Needs

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 health, behavioral health services, community-based long term services and supports, and other community-based services needed by beneficiaries with chronic conditions.

AB 361 authorizes the Department to create a Health Home Program (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 Health Home Program Fund. The HHP Fund will be used to pay for the non-federal share of HHP costs.

The Department expects an implementation date of July 1, 2018.

PROVIDER RATES

Newborn Screening Program Fee Increase

SB 1095 (Chapter 393, Statutes of 2016) requires the California Department of Public Health (CDPH) Genetic Disease Screening Program (GDSP) to expand statewide newborn screenings to include any disease that is detectable in blood samples as soon as practicable, but no later than two years after the disease is adopted by the Federal Recommended Uniform Screening Panel (RUSP).

Pompe Disease and Hurler's syndrome (mucopolysaccharidosis type I) were conditions previously adopted by the RUSP when SB 1095 was enrolled. As such, GDSP will be required to add them to the Newborn Screening panel and begin screening for both diseases by August 2018. It is assumed the screening for these two conditions will cost an additional estimated $11 per patient.

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Revised Federal Regulations for Long-Term Care Facilities

Effective November 2016, the Federal Register revised 42 CFR part 483, subpart B requiring Long-Term Care facilities to meet updated health and safety standards in order to participate as nursing facilities under the Medicaid program. This rule directly affects all skilled nursing facilities and nursing facilities. The final rule reflects requirements aligned with current clinical practice standards to improve resident safety along with the quality and effectiveness of care and services delivered to residents, as well as implementing sections of the ACA.

CMS will use a phased approach to spread out the implementation of the various requirements over the next three years, beginning November 2016. These regulations are currently in suspense due to a federal injunction.

If the federal regulations are implemented, it will result in new federally mandated costs for the Long Term Care facilities which will be reimbursed to Medi-Cal providers as an add-on to the facilities' rates. The fiscal impact is expected to be significant.

SUPPLEMENTAL PAYMENTS

Hospital Inpatient Rate Freeze

The hospital inpatient rate freeze imposed by SB 853, the Health Trailer Bill of 2010, was annulled by SB 90. Any payment reductions because of the rate freeze will be refunded to hospitals.

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.

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, effective July 1, 2015. Once approved, the Department assumes that LEAs would choose to bill retroactively for new services, 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). On March 29, 2016, SPA 16-001 was submitted to CMS which proposes to amend the population receiving TCM services in the LEA Program to include all Medicaid eligibles, regardless of whether they have an IEP/IFSP under the Individuals with Disabilities Education Act. Approval of SPA 16-001 will align California with the provisions in Welfare and Institutions Code 14132.06.

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

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

OTHER: AUDITS AND LAWSUITS

SB 1103 Litigation

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

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

  OAHA has been holding these administrative appeals in abeyance during the *Mission Hospital Regional Medical Center v. Douglas* litigation, which finally terminated in early 2014. OAHA dismissed at least 24 of the SB 1103 administrative appeals on the grounds that these appeals are precluded by *res judicata*, that is, by the *Mission* litigation's challenge to SB 1103. In approximately 16 cases, the dismissed hospitals have filed petitions for writ of mandate with the Los Angeles County Superior Court seeking to compel OAHA to order the Department to recalculate their reimbursement rate and pay the increased rate. In three such cases, the superior court denied the writ petition and the hospitals have appealed.

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(*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 not participated 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, 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~~**, all** of which involve hospitals that did not participate in the Mission litigation. Given the Court of Appeal's opinion in Ridgecrest, the Department ~~is currently in the process of~~ **began** negotiating settlements with these providers. ~~To date, a~~ **A** settlement of $220,000 ~~has been~~ **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. **OAHA issued final decisions incorporating the Children's Hospital at Mission and Community Hospital of Monterey Peninsula settlement agreements on November 3, 2016, and November 7, 2016, respectively. The Department continues to negotiate settlements in the two administrative appeals that remain before OAHA.** It is estimated that the total value of ~~the remaining two~~ **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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Santa Rosa Memorial Hospital, et al. v. Sandra Shewry, Director of the Department of Health Care Services (Federal Court Litigation).

Plaintiffs are 17 hospitals that 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 ABX4 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 1396a(a)(8), 1396a(a)(13), and 1396a(a)(30). The status of the case is as follows:

- On November 18, 2009, the district court issued a preliminary injunction with respect to the 10% payment reduction for non-contract hospital inpatient services rendered on or after that date with respect to only the 17 plaintiff hospitals,
- On May 27, 2010, the Ninth Circuit issued a decision affirming the preliminary injunction,
- On February 22, 2012, the United States Supreme Court issued a ruling that vacates the Ninth Circuit decision and remanded the case back to the Ninth Circuit to reconsider the Department's appeal of the preliminary injunction, and
- On January 9, 2014, the Ninth Circuit issued a decision reversing and vacating the November 2009 injunction and remanded to the district court for further proceedings.
- On October 10, 2014, the district court stayed further proceedings, pending a decision by the United States Supreme Court in the case of *Armstrong, et al.* v. *Exceptional Child Center, et al.*
- On March 31, 2015, the Supreme Court held in the *Armstrong* case that the Supremacy Clause of the United States Constitution did not confer a right of action for providers to sue states for violation of section 1396a(a)(30)(A). In June 2015 the parties in the *Santa Rosa* case completed supplemental briefing on the impact of that case and are waiting on the federal district court to issue a decision on the parties pending cross-motions for summary judgment.
- On July 20, 2015, the district court denied the Department's motion for summary judgment based on mootness, and dismissed the Plaintiffs' lawsuit without prejudice to pursuing their state court lawsuit challenging the AB 5 and AB 1183 payment reductions.
- The Department appealed the district court's ruling denying its motion for summary judgment and dismissing the Plaintiffs' lawsuit without prejudice. Appellate briefing has been completed and the parties are waiting for the Court of Appeals to schedule a hearing.

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~~ **The** parties await the court's final statement of decision.

LA Care v. Department of Health Care Services

The Plaintiff in this case is a managed care plan that contracts with the Department to provide Medi-Cal covered services to Medi-Cal eligible persons enrolled in the plan. In 2013, Lancaster Hospital sued the Plaintiff complaining that the rates the Plaintiff paid for emergency and post-stabilization services rendered to plan enrollees were invalid on various grounds. Lancaster Hospital was an out-of-network hospital (i.e., not part of the Plaintiff's network of contracting hospitals). The rates that the Plaintiff paid Lancaster Hospital for emergency and post stabilization services were the specific rates that the Department told managed care plans to pay out-of-network hospitals for such services. The Plaintiff ultimately reached a settlement with Lancaster Hospital, agreeing to pay some portion of the amount that the hospital alleged it was underpaid. The Plaintiff then sued the Department seeking indemnification for what it agreed to pay Lancaster hospital. On March 10, 2016, the parties participated in non-binding mediation. Since then, settlement negotiations are continuing.

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

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May 24, 2013, the Ninth Circuit denied the Plaintiffs' request for rehearing and on June 25, 2013, issued an order formally vacating the four court injunctions. On January 13, 2014, the United States Supreme Court denied the Plaintiffs' petition for certiorari asking it to review the Ninth Circuit decision. Now that the injunction is vacated, the Department will implement the AB 97 payment reductions (also rate freeze with respect to the *California Hospital Association* case), as described in the 10% Payment Reduction for LTC Facilities and Non-AB 1629 LTC Rate Freeze policy changes. The lawsuit has been remanded to the federal district court where Plaintiffs have indicated they intend to seek a new court order prohibiting the Department from implementing the AB 97 reduced payments for DP/NFs. On March 1, 2016, the Governor signed into law Assembly Bill X2 1, adopting Welfare and Institutions Code section 14105.195, which prohibits the Department from retroactively implementing the AB 97 payment reductions for DP/NFs. Based on this legislation, California Hospital Association ~~has indicated that it will dismiss this lawsuit.~~ **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.

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

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

  On January 31, 2012, the court issued an injunction prohibiting implementation of the payment reductions for physicians, dentists, clinics, non-drug pharmacy services, emergency medical transportation, medical supplies, and durable medical equipment, except for services rendered prior to January 31, 2012, that are not reimbursed at the unreduced rates prior to that date. The Department and Plaintiffs appealed that portion of the district court's order excluding some services from the injunction. On March 22, 2012, the Ninth Circuit denied the Department's request for a stay of the injunction pending appeal. On December 13, 2012, the Ninth Circuit issued a decision reversing the preliminary injunction with respect to the AB 97 rate freeze and reduction for DP/NFs. On May 24, 2013, the Ninth Circuit denied the Plaintiffs' request for rehearing and on June 25, 2013 issued an order formally vacating the four court injunctions. On January 13, 2014, the United States Supreme Court denied the Plaintiffs' petition for certiorari asking it to review the Ninth Circuit decision. Now that the injunction is vacated, the Department will implement the AB 97 payment reductions, as described in the 10% Provider Payment Reduction policy changes. This case has been remanded to the federal district court where the Plaintiffs have indicated they intend to seek a new court order prohibiting the Department from implementing the AB 97 reduced payments.

- *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.

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

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September 26, 2013, pursuant to 42 U.S.C. sections 1396a(a)(10)(A), 1396d(l)(1) and (20), 1395x(aa)(1)(A) and 1395x(r), and the Ninth Circuit decision in *California Association of Rural Health Clinics, et al v. Douglas* (9th Cir. 2013) 738 F.3d 1007. On December 8, 2015, the court granted the Petition for Writ of Mandate. The court further directed Counsel for Petitioners to prepare a formal judgment and writ, submit it to the Department's counsel for approval as to form, and thereafter submit it to the court for signature and entry of judgment. On January 11, 2016, the Court issued the final formal judgment and writ. On February 19, 2016, Counsel for Petitioners sent a letter to Counsel for Respondents; this letter set forth an informal settlement proposal. Counsel for Respondents responded in April 2016, via letter, reflecting the Department's disinterest in pursuing the proposal. **The Department appealed the final judgment and as of December 2016, no briefing schedule has been set.**

Managed Care Potential Legal Damages

~~Four~~ **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:

- ~~*Santa Clara County Health Authority dba Santa Clara Family Health Plan v. DHCS*~~
- *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 April 20, 2011, the trial court issued a judgment in favor of Plaintiff Santa Clara County Health Authority and on~~ **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 Department and Santa Clara have also entered into a settlement agreement. In November 2014, the Department fully paid Santa Clara in accordance with the terms of the settlement.~~ **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).**

AIDS Healthcare dba Positive Healthcare

Plaintiff seeks declaratory and injunctive relief to prohibit the Department from complying with W&I Code section 14105.46. The complaint alleges that section 14105.46 violates State and federal law, because that State statute illegally compels AIDS Healthcare Foundation (AHF) to accept payment under the methodology set forth in the federal 340B program for the drugs it provides to persons with HIV and AIDS.

As a result of a Motion to Dismiss filed by the Department, on March 15, 2010, the court dismissed this case in its entirety, with prejudice. Plaintiff appealed. On November 3, 2011,

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the Ninth Circuit Court of Appeals issued an unpublished decision affirming in part and reversing in part the lower court's dismissal of the case. Plaintiff's claims for violations of equal protection, 42 U.S.C. section 1396a(a)(30)(A), and failure to obtain federal approval of a SPA proceeded. In October 2012, the U.S. District Court stayed this case pending a ruling in the AB 97 consolidated appeal. On December 13, 2012, the Ninth Circuit Court of Appeal issued a decision in the AB 97 consolidated cases. The Department filed a motion to continue the stay, but on February 25, 2013, the court lifted the stay.

After the stay was lifted, the parties filed cross-motions for summary judgment. On March 18, 2013, the court found in favor of the Department on the Equal Protection claims, but ruled in favor of Plaintiff on their cross-motion for summary judgment on the (a)(30)(A) and SPA approval causes of action. The court held that:

- The Department was required to obtain SPA approval prior to implementation and did not do so, and
- Neither the legislature nor the Department considered the relevant factors under (a)(30)(A). The court enjoined the Department from implementing the 340B drug program, effective May 3, 2013.

The Department submitted the SPA on November 1, 2013. CMS approved the SPA on January 30, 2014. Following the Department's motion, the Ninth Circuit vacated the judgment and remanded to the district court to consider the impact of CMS' approval. At the June 18, 2014, hearing on the order of the Ninth Circuit Vacating and Remanding, the district court changed the findings of fact to reflect the SPA approval, but re-issued the permanent injunction.

The Ninth Circuit granted the Director's motion for a stay until June 22, 2015, at which time the Department filed in the Ninth Circuit a Motion for Summary Reversal and Remand with Direction to Dismiss, and for a Stay of the Briefing Schedule. AHF's opposition was filed on July 16, 2015. The Director filed the opening brief with the Ninth Circuit on January 5, 2016. ~~The court approved AHF's request for an extension of time to file its response to the Director's first brief on cross-appeal. The Director's (third brief on cross-appeal) has been filed and oral arguments have yet to be set.~~

After an extension requested by AHF, the appeal was heard before the Ninth Circuit on October 4, 2016. On November 8, 2016, the Ninth Circuit ruled in favor of the Department and remanded this matter for entry of judgment in favor of the Department. On December 1, 2016, the Ninth Circuit issued its mandate in this matter, which requires the district court to execute the terms of the Ninth Circuit's ruling, which is to enter judgment in favor of the Director.

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 in attorneys' fees and costs~~. ~~On July 10, 2015, the court ordered both Petitioners and the Department to file a supplemental brief as to the timeliness of the motion.~~ On February 5, 2016, the court denied the plaintiff's motion for attorneys**' fees**. Plaintiff filed a notice of appeal on February 24, 2016**, and filed their opening brief on December 27, 2016. The Department response brief is due March 27, 2017**. ~~We are awaiting plaintiff's opening brief.~~ Oral arguments have not been set.

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 April 12, 2016, the district court denied the plaintiffs' claim for retroactive relief for admissions during July 1, 2013 through December 20, 2015. The Department is currently seeking reconsideration of the court's December 21, 2015 decision, while Plaintiffs are seeking to amend their complaint. Both motions are scheduled to be heard on September 22, 2016.~~ **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**

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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.

Riverside Recovery Resources v. Riverside County Department of Mental Health, et al.

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

Plaintiff filed their opening brief in support of the writ of administrative mandamus on May 1, 2015. Plaintiff argues the Department should be equitably estopped from disallowing the claims because of a lack of clarity in the certification standards. The Department filed its opposition on June 30, 2015. Plaintiff filed its reply brief on July 31, 2015. On August 20, 2015 the court issued a tentative ruling holding the Department violated Welfare & Institutions code section 14171 by failing to provide Plaintiff with an administrative appeal pursuant to the Administrative Procedures Act. The tentative ruling remanded the case back to the Department for a formal evidentiary hearing before an administrative law judge. On November 19, 2015, pursuant to a stipulation, the court remanded the case back to the Department to provide Plaintiff with a formal evidentiary hearing. The Department has filed a return in superior court showing that the Department has complied with the writ of mandate by vacating its decision on the second level appeal and setting the date for a formal hearing on Riverside Recovery's appeal. Although the hearing was originally set for March 15, 2016, at plaintiff's request, it ~~has been~~ **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.**

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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.

Korean Community Center of the East Bay, et al. v. Toby Douglas, et al.

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

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

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

Currently, the parties ~~have agreed to~~ **continue to operate under** a temporary stay to provide time for settlement discussions. Discovery will close on ~~August 24, 2016~~ **March 24, 2017**. Petitioners' opening brief is due on ~~September 14, 2016~~ **April 14, 2017**, with Respondents' opposition brief due on ~~November 10, 2016~~ **May 22, 2017**, and Petitioners' reply due on ~~December 6, 2016~~ **June 14, 2017**. This matter will be heard on ~~December 21, 2016~~ **June 30, 2017**, if settlement is not reached.

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 Services Nursing Facility/Acute Hospital 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.)

~~Parties are currently conducting discovery. Trial was s set for October 11, 2016.~~ **The court denied Plaintiffs' first two Motions for Summary Judgment (MSJs) without 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 negotiation.**

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.

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

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that they have a right to hearing on the delay, and (2) grant all pending applicants that appear eligible conditional eligibility for Medi-Cal benefits.

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

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

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

Petitioners filed a motion to enforce the Writ claiming that the filing of the appeal did not automatically stay enforcement. This motion was heard by the court March 9, 2016 and was denied on May 9, 2016. **The Department's opening brief in the appeal was filed on October 11, 2016, and Petitioners' response brief was filed on December 8, 2016. The Department's reply brief is currently due on February 1, 2017.**

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.

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Educationally Necessary Statewide Occupational Therapy and Physical Therapy Services

The Department is engaged in litigation in State and Federal court with the Department of General Services' Office of Administrative Hearings (OAH) to address a fundamental difference in the interpretation of the mandates of Part B of the Individuals with Disabilities Education Act (IDEA) and Government Code 7570 et. seq. relating to Special Education. This litigation follows from three 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 ~~is appealing~~ **appealed** the Tuolumne **decision**. ~~Oral argument is scheduled for August 17, 2016.~~ **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 ~~tentatively~~ ruled against the Department ~~on June 2, 2016~~. ~~At the June 3, 2016 hearing, however, the court took the matter under submission and has not yet issued a final decision. If the~~ OAH ~~prevails~~ **prevailed**, ~~this will establish~~ **which 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.**

MALDEF, et al. Title VI Administrative Complaints

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 DHHC 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 ~~will conduct~~ **conducts** its own investigation of the Department pursuant to the administrative complaint, and will contact the Department for any additional information.

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~~DHHS OCR is reviewing the cover letter and administrative complaint.~~ **There has been no subsequent activity known to the Department since the complaint was filed.**

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 DHCS 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 DHCS 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.

~~This case was filed in the Sacramento County Superior Court on June 29, 2016.~~ **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.**

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 ~~requested an extension to submit a response to the petition/complaint, and the response is now due on or before September 6, 2016.~~ **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 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**

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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.

Dental Managed Care Plans Notifications of Dispute with the Department

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

On August 1, 2016, the Department issued All Plan Letter 16-009, waiving the Department's contractual right to withhold 10% of the monthly capitation payment from July 1, 2014, through July 31, 2016. For the service periods that remain at issue, the ~~Department seeks to resolve these matters without the expense of further litigation. Under the terms of the proposed settlement, the Department would reimburse the Plans the remaining withheld amounts~~ **parties are engaged in settlement discussions**.

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.

Federal Compliance Audit Report for Fiscal Year Ended June 30, 2015

Macias, Ginni, and O'Connell (MGO) sampled 40 cash draws for CHIP amount to $1,086,034,397. Of the sample selection, MGO noted 10 cash draws included a total of $3,685,271 in Local Education Agency (LEA) expenditures not allowed under CHIP.

Although this was only a questioned cost, CMS is requesting a repayment. The Department is working on this item to determine how best to pay and when.

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, ~~2014~~ **2015**. Although the State made Medicaid EHR incentive payments to eligible hospitals, it did not always make them in accordance with Federal

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Requirements. The OIG is requesting the Department refund **CMS** $22,043,234 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.

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 manufacturers rebates of $69,109,297 ($42,564,416 Federal share).

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.

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Audit of California's Medicaid Inpatient Disproportionate Share Hospital (DSH) Payments to Kern Medical Center, Bakersfield, California, State Fiscal Year 1998

The OIG worked to verify that State Fiscal SFY 1998 DSH Payments to Kern Medical Center (KMC) did not exceed the hospital specific limit as mandated by OBRA of 1993.

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

The overstatement of the KMC limit consisted of the following items:

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

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

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

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 released until September 2017.

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OTHER: REIMBURSEMENTS

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.

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

Freestanding Clinic – Former Agnews State Hospital

The 2003-04 Governor's Budget directed the California Department of Developmental Services (CDDS) to develop a plan to close Agnews Developmental Center (Agnews) by July 2005. The facility is now officially closed and all of the former residents have been placed in community settings or other alternate locations.

As part of the closure plan, Agnews agreed to continue to operate a freestanding clinic at the former Agnews location in order to continue to cover services that were previously provided as part of the general acute care hospital. The clinic services include health, dental and behavioral services which are offered to former Agnews residents as well as referrals from the various developmental centers in the area. The freestanding clinic became operational on April 1, 2009, and will remain open until CDDS is no longer responsible for the Agnews property.

The Department has obtained approval from CMS to amend the State Plan to establish a cost-based reimbursement methodology for the freestanding clinic beginning April 1, 2009.

The Department will enter into an Interagency Agreement with CDDS to reimburse the FFP for Medi-Cal clients served at the clinic.

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.

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.

Enterprise Cost Reporting and Settlement (ECRS) System Project

The Department proposes to implement the Enterprise Cost Reporting and Settlement (ECRS) system to establish a Department-wide, enterprise approach to the collection of cost reports, the calculation of the financial amounts owed or due, and the accounting transactions (e.g., accounts receivable) involved in final settlements. Currently, the Department collects cost information reported by various Medi-Cal providers and counties to settle financial amounts owed or due. These cost reports are compared against payment information from various sources and are used by various divisions. These processes vary and are predominantly manual, resource intensive, and dated. The ECRS system would replace these manual processes and support various divisions across the Department.

The Stage 1 Business Analysis (S1BA) was approved on December 22, 2016. The design, development and implementation (DD&I) phase of the ECRS is in progress and is expected to be completed by March 2018. The maintenance and operations costs are expected to begin July 2018 and are needed to support and maintain the new system going forward.

OTHER: RECOVERIES

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.

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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 increase savings for the Department.

FISCAL INTERMEDIARY: MEDICAL

1. Advance Payment Authority

The Department proposes to seek legislative authority which authorizes the State Controller's Office to make advance payments pursuant to the California Medicaid Management Information Systems 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.

2. 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 new FI contracts 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.**
- **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.**

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.

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

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FISCAL INTERMEDIARY: DENTAL

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 ~~other~~ administrative requirements to ~~make the program more provider friendly~~ **improve and streamline the provider experience** while maintaining program integrity. The ~~results of this effort are anticipated to be increased~~ **objective of these efforts is to increase** provider participation and ~~potentially increased~~ **increase** beneficiary utilization.

Teledentistry

~~The Department considers~~ Teledentistry **is recognized as** a cost-effective alternative to dental services provided in-person, predominantly in underserved areas. Teledentistry is a ~~way~~ **service modality** for dentists to deliver services to their patients that is similar to in-person care. The standard of care is the same whether the patient is seen in person or through the ~~Teledentistry~~ **teledentistry** environment. ~~This method of providing services~~ **Teledentistry** allows for improved access to care options for beneficiaries who typically experience access to care issues.

DISCONTINUED POLICY CHANGES

Fully Incorporated into Base Data/Ongoing

ELIGIBILITY
PC 2 Undocumented Children Full Scope Expansion

AFFORDABLE CARE ACT
PC 18 ACA Optional Expansion
PC 21 ACA Mandatory Expansion

BENEFITS
PC 37 Acupuncture Services Restoration
PC 47 CHDP Program Dental Referral

HOME & COMMUNITY-BASED SERVICES

BREAST AND CERVICAL CANCER

PHARMACY

DRUG MEDI-CAL

MENTAL HEALTH

1115 WAIVER—MH/UCD & BTR

MANAGED CARE

PROVIDER RATES

SUPPLEMENTAL PAYMENTS

OTHER: AUDITS AND LAWSUITS

OTHER: REIMBURSEMENTS

OTHER: RECOVERIES
PC 201 Medi-Cal Buy-In Quality Review Project Recoveries

FISCAL INTERMEDIARY: MEDICAL

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL

DISCONTINUED POLICY CHANGES

Time Limited/No Longer Available

ELIGIBILITY

AFFORDABLE CARE ACT

BENEFITS

HOME & COMMUNITY-BASED SERVICES

BREAST AND CERVICAL CANCER

PHARMACY

DRUG MEDI-CAL

MENTAL HEALTH

1115 WAIVER—MH/UCD & BTR

MANAGED CARE
PC 113 Health Homes for Patients With Complex Needs

PROVIDER RATES

SUPPLEMENTAL PAYMENTS

OTHER: AUDITS AND LAWSUITS

OTHER: REIMBURSEMENTS

OTHER: RECOVERIES

FISCAL INTERMEDIARY: MEDICAL

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL

DISCONTINUED POLICY CHANGES

Withdrawn

ELIGIBILITY

AFFORDABLE CARE ACT

BENEFITS

HOME & COMMUNITY-BASED SERVICES

BREAST AND CERVICAL CANCER

PHARMACY

DRUG MEDI-CAL

MENTAL HEALTH

1115 WAIVER—MH/UCD & BTR
PC 50 Whole Child Model Implementation

MANAGED CARE
PC 109 Notices of Dispute/Administrative Appeals

PROVIDER RATES

SUPPLEMENTAL PAYMENTS

OTHER: AUDITS AND LAWSUITS

OTHER: REIMBURSEMENTS
OA 49 Universal Assessment Tool

OTHER: RECOVERIES

FISCAL INTERMEDIARY: MEDICAL

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL