MEDI-CAL
NOVEMBER 2024
LOCAL ASSISTANCE ESTIMATE
for
FISCAL YEARS
2024-25 *and* 2025-26

The Great Seal

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

MEDI-CAL
NOVEMBER 2024
LOCAL ASSISTANCE ESTIMATE
for
FISCAL YEARS
2024-25 and 2025-26

Fiscal Forecasting Division
State Department of Health Care Services
1501 Capitol Avenue, Suite 2001
Sacramento, CA 95814

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

GAVIN NEWSOM
Governor
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Kim Johnson
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Michelle Baass
Director
Department of Health Care Services

NOVEMBER 2024 MEDI-CAL ESTIMATE

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OTHER ADMINISTRATION

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

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GUIDE TO KEY FEATURES OF REGULAR POLICY CHANGES

This document in intended to aid in interpreting the information included in Regular Policy Changes.

PROP 56 - DEVELOPMENTAL SCREENINGS

Typically, this represents an accrual amount, before application of cash lags. (In some cases, complex policy changes require lags to be applied at this stage. In these cases, cash amounts are displayed.)

PC numbers are updated each November Estimate as items are re-sorted by category and dollar value.

Date of first fiscal impact, not the policy effective date.

Permanent reference number, does not change each November.

REGULAR POLICY CHANGE NUMBER: 154
IMPLEMENTATION DATE: 1/2020
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2171

		FY 2020-21	FY 2021-22
FULL YEAR COST	**- TOTAL FUNDS**	$53,308,000	$61,960,000
	- STATE FUNDS	$20,954,890	$25,877,550
PAYMENT LAG		0.9984	1.0000
% REFLECTED IN BASE		6.73 %	7.68 %
APPLIED TO BASE			
TOTAL FUNDS		$49,640,800	$57,201,500
STATE FUNDS		$19,513,350	$23, 890,150
FEDERAL FUNDS		$30,127,460	$33,311,320

If Full Year Cost is an accrual number, this adjusts an accrual estimate downward to account for payments that will fall outside of each fiscal year, resulting in a cash estimate. A lag of 1.0000 represents no adjustment.

To avoid double counting impacts of policy changes, this row identifies the portion of the cash impact that is estimated to be included in base data and in base trends. 0.00% represents no impact estimated in the base.

These are the amounts added to the Medi-Cal budget for this item after adjusting downward to remove costs estimated to already be reflected in the base data/trends.

Purpose:
This policy change estimates the cost for providing Proposition 56 funded payments for developmental screenings.

Authority:
AB 74 (Chapter 23, Statute of 2019)
Families First Coronavirus Response Act (FFCRA)
AB 80 (Chapter 12, Statutes of 2020)

Interdependent Policy Changes:
Proposition 56 Funds Transfer

Policy changes that may change if this policy change is revised.

Background:
On November 8, 2016, California voters passed the California Healthcare, Research and

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MANAGEMENT SUMMARY

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

NOTE: FOR THE NOVEMBER 2024 ESTIMATE:

- CURRENT YEAR = FY 2024-25
- BUDGET YEAR = FY 2025-26
- APPROPRIATION = MAY 2024 ESTIMATE + BUDGET ACT CHANGES, FY 2024-25

November 2024 Medi-Cal Estimate

Current Year (FY 2024-25) Projected Expenditures Compared to the Appropriation

(Dollars in Millions)

Medical Care Services	FY 2024-25 Appropriation	Nov 2024 Estimate	Change Amount	Change Percent
Total Funds	$153,686.1	$167,002.5	$13,316.4	8.7%
Federal Funds	$92,944.8	$101,365.4	$8,420.6	9.1%
General Fund	**$33,384.1**	**$36,184.8**	**$2,800.7**	**8.4%**
Other Non-Federal Funds	$27,357.2	$29,452.3	$2,095.1	7.7%

County and Other Local Assistance Administration	FY 2024-25 Appropriation	Nov 2024 Estimate	Change Amount	Change Percent
Total Funds	$7,275.9	$7,609.5	$333.6	4.6%
Federal Funds	$5,565.8	$6,101.9	$536.1	9.6%
General Fund	**$1,638.6**	**$1,452.0**	**($186.6)**	**-11.4%**
Other Non-Federal Funds	$71.5	$55.6	($15.9)	-22.2%

Total Expenditures	FY 2024-25 Appropriation	Nov 2024 Estimate	Change Amount	Change Percent
Total Funds	$160,962.1	$174,612.1	$13,650.0	8.5%
Federal Funds	$98,510.6	$107,467.3	$8,956.7	9.1%
General Fund	**$35,022.7**	**$37,636.8**	**$2,614.1**	**7.5%**
Other Non-Federal Funds	$27,428.7	$29,507.9	$2,079.2	7.6%

Note: Totals may not add due to rounding.

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Budget Year (FY 2025-26) Projected Expenditures Compared to Current Year (FY 2024-25)

(Dollars in Millions)

Medical Care Services	FY 2024-25 Estimate	FY 2025-26 Estimate	Change	
			Amount	Percent
Total Funds	$167,002.5	$180,461.7	$13,459.2	8.1%
Federal Funds	$101,365.4	$112,116.0	$10,750.6	10.6%
General Fund	**$36,184.8**	**$40,611.2**	**$4,426.4**	**12.2%**
Other Non-Federal Funds	$29,452.3	$27,734.5	($1,717.8)	-5.8%

County and Other Local Assistance Administration	FY 2024-25 Estimate	FY 2025-26 Estimate	Change	
			Amount	Percent
Total Funds	$7,609.5	$7,677.5	$68.0	0.9%
Federal Funds	$6,101.9	$5,937.2	($164.7)	-2.7%
General Fund	**$1,452.0**	**$1,477.7**	**$25.7**	**1.8%**
Other Non-Federal Funds	$55.6	$262.6	$207.0	372.3%

Total Expenditures	FY 2024-25 Estimate	FY 2025-26 Estimate	Change	
			Amount	Percent
Total Funds	$174,612.1	$188,139.2	$13,527.1	7.7%
Federal Funds	$107,467.3	$118,053.2	$10,585.9	9.9%
General Fund	**$37,636.8**	**$42,088.9**	**$4,452.1**	**11.8%**
Other Non-Federal Funds	$29,507.9	$27,997.1	($1,510.8)	-5.1%

Note: Totals may not add due to rounding.

Medi-Cal Local Assistance Estimate
Management Summary
November 2024

This summary is intended to provide a high-level overview of the November 2024 Medi-Cal Local Assistance Estimate (Estimate). The Department of Health Care Services (DHCS) 2025-26 Governor's Budget Highlights, available on the DHCS website at https://www.dhcs.ca.gov, serves as a companion document to the Medi-Cal Estimate.

DHCS estimates Medi-Cal spending to be $174.6 billion total funds ($37.6 billion General Fund) in Fiscal Year 2024-25 and $188.1 billion total funds ($42.1 billion General Fund) in Fiscal Year 2025-26. This does not include Certified Public Expenditures of local governments or General Fund expenditures in other state departments.

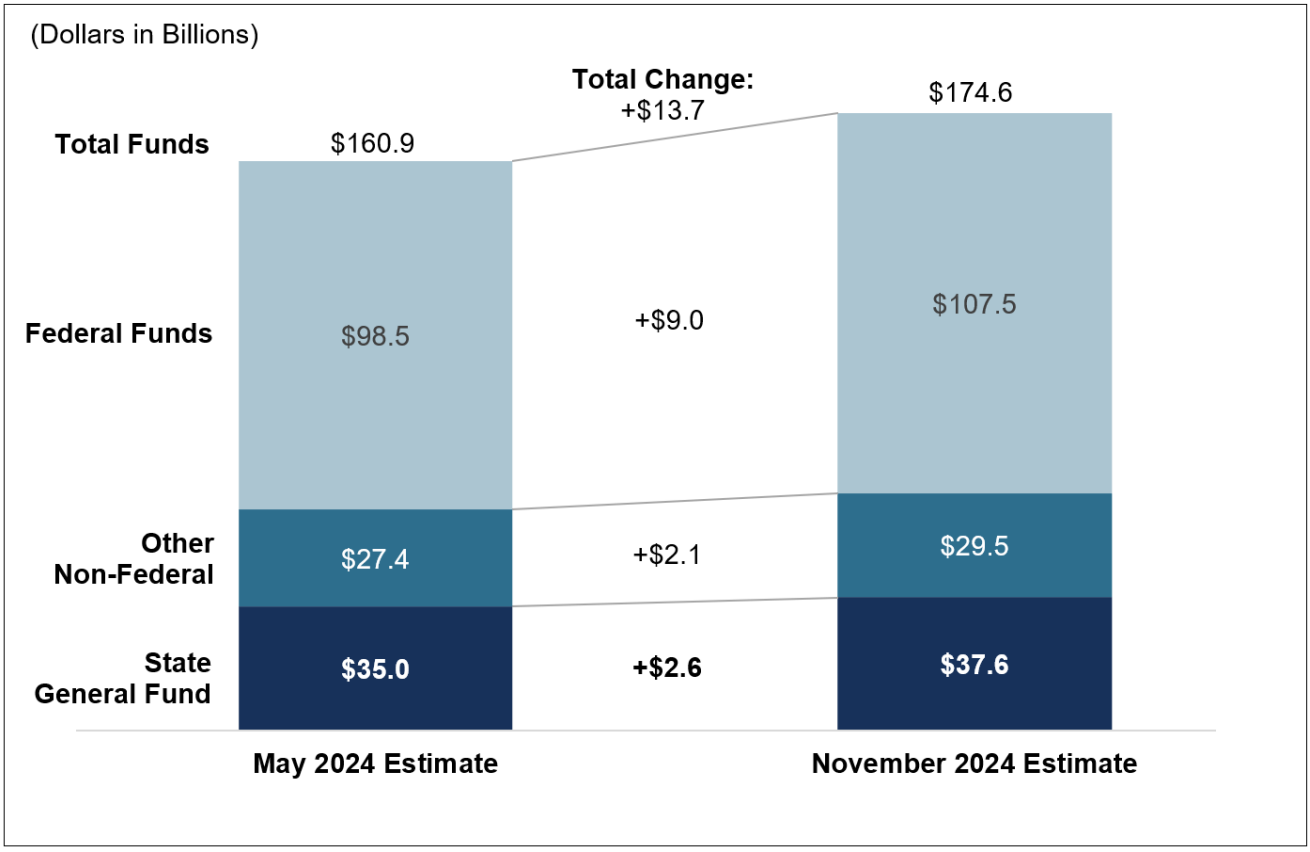
Document Organization. This document is divided into two sections that provide more detail on estimated funding amounts and the primary factors driving the estimates. These sections include:

- Summary of Estimate Totals
- Caseload Projections

Summary of Estimate Totals

This section provides a summary of total spending amounts in the Estimate highlighting several major factors that drive changes in projected spending.

2024-25 Comparison



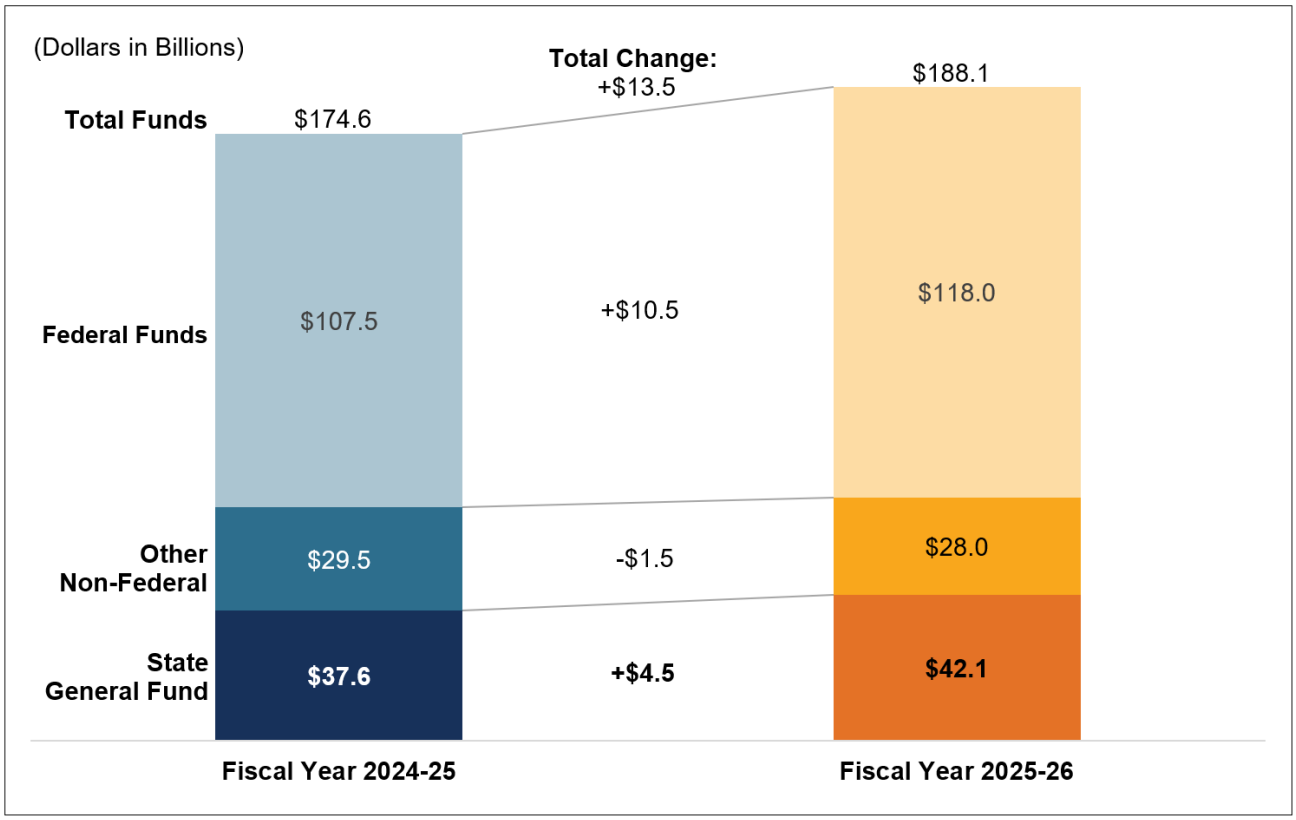
The November 2024 Medi-Cal Estimate for 2024-25 projects a $13.7 billion (8.5 percent) increase in total spending and a $2.6 billion (7.5 percent) increase in General Fund spending compared to the May 2024 Medi-Cal Estimate, including authority from all previous budget acts. Estimated spending from just the 2024 Budget Act is increased by $2.8 billion. Major factors driving the change in estimated General Fund spending include:

- An approximately $2.7 billion increase in costs for unsatisfactory immigration status (UIS) members. This increase is primarily driven by higher than anticipated enrollment and increased pharmacy costs.
- An estimated $540 million General Fund increase due to growth in Medi-Cal pharmacy expenditures beyond the UIS spending growth. Similar to other state Medicaid programs, California's Medi-Cal program has experienced a notable increase in overall pharmacy expenditures.
- An approximately $1.1 billion increase in costs from smaller than previously assumed impacts

related to redeterminations.

- A $1 billion reduction in General Fund costs related to the MCO tax. The Governor's Budget assumes an additional $453.7 million reduction in General Fund costs related to Proposition 35 passed by voters in November 2024. The 2025-26 Governor's Budget also assumes an additional $478.7 million reduction in General Fund costs related to approval of an amendment to the MCO tax related to consideration of Medicare revenue back to January 2024 instead of April 2024.

Year-over-Year Change from 2024-25 to 2025-26



After the adjustments described previously, the Medi-Cal Estimate projects that total spending will increase by $13.5 billion (7.7 percent) and General Fund spending will increase by $4.5 billion (11.8 percent) between 2024-25 and 2025-26. Major factors driving the changes in estimated General Fund spending from 2024-25 to 2025-26 include:

- An approximately $3.6 billion increase in costs due to changes in the use of available MCO tax revenues. Of this amount, $2.7 billion is related to implementation of Proposition 35 and another $478.7 million relates to a one-time adjustment in 2024-25 to reflect the full year of additional MCO revenues from consideration of Medicare revenue back to January 2024 instead of April 2024.

- An approximately $215.2 million increase due to the projected growth in Medi-Cal pharmacy expenditures. Similar to other state Medicaid programs, California's Medi-Cal program has experienced a notable increase in overall pharmacy expenditures.

- A net $268.5 million increase in other base costs, reflecting the net impact of growth in average managed care rates, changes in projected enrollment, growth in Medicare premium and Part D costs, and projected fee-for-service utilization other than pharmacy.

Caseload Projections

High Level Summary

This section provides an overview of caseload projections for Medi-Cal reflected in the Estimate. Projected caseload levels are summarized in the tables below:

Estimated Average Monthly Certified Eligibles
November 2024
Estimate

	Eligibles			Year over Year Change Percent	
	FY 2023-24	FY 2024-25	FY 2025-26	FY 2023-24 to FY 2024-25	FY 2024-25 to FY 2025-26
Seniors	1,277,700	1,444,200	1,590,200	13.03%	10.11%
Persons with Disabilities	1,064,100	1,041,100	1,022,800	-2.16%	-1.76%
Families and Children	7,709,100	7,348,000	6,919,900	-4.68%	-5.83%
Optional Expansion	5,119,800	5,051,300	4,884,000	-1.34%	-3.31%
Miscellaneous	70,700	67,800	72,800	-4.10%	7.37%
Total	**15,241,400**	**14,952,400**	**14,489,700**	**-1.90%**	**-3.09%**

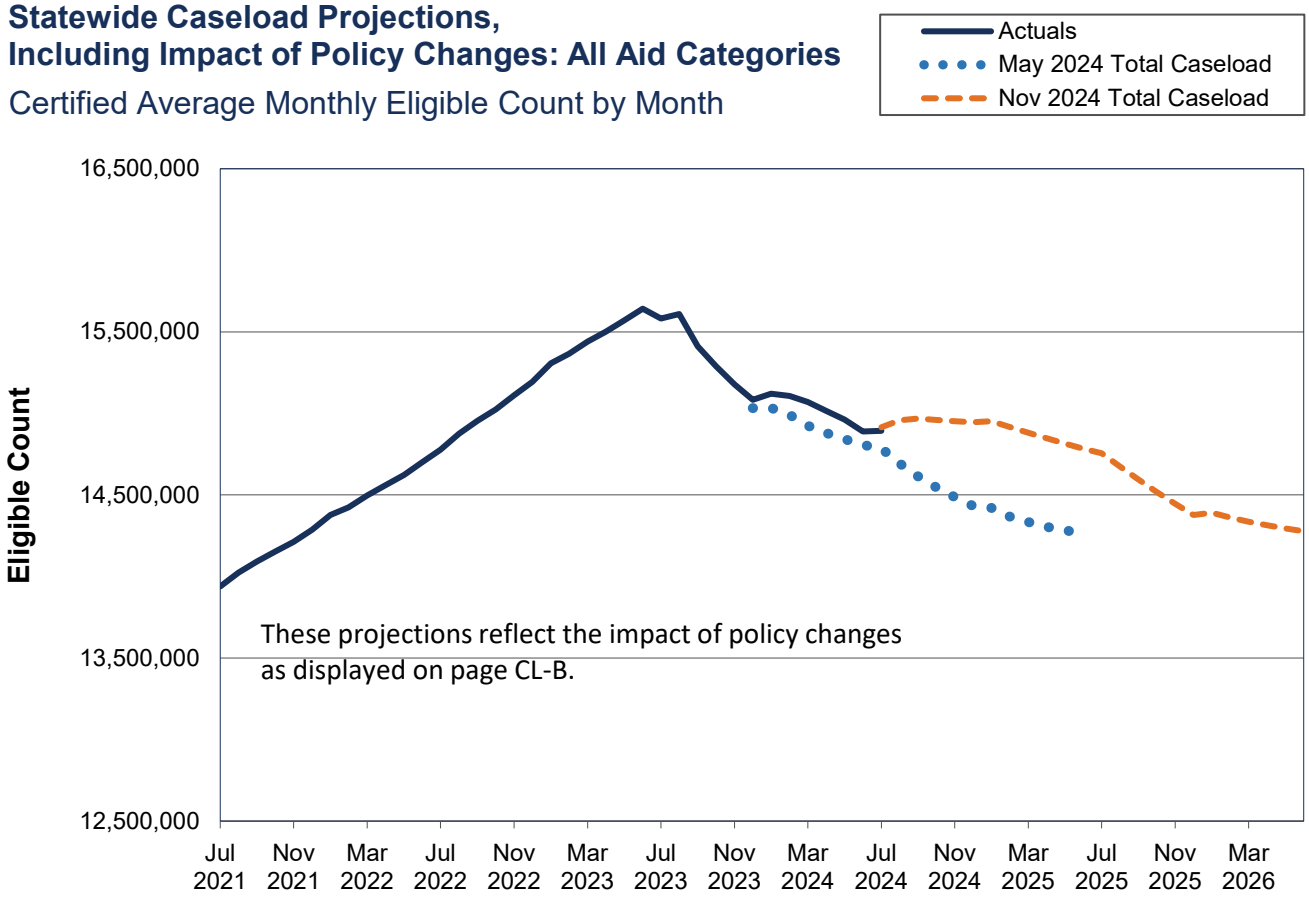
Change from May 2024 Estimate

	Eligibles		Percent	
	FY 2023-24	FY 2024-25	FY 2023-24	FY 2024-25
Seniors	17,600	182,400	1.40%	14.46%
Persons with Disabilities	12,700	11,900	1.21%	1.16%
Families and Children	10,300	(38,000)	0.13%	-0.51%
Optional Expansion	28,900	296,000	0.57%	6.22%
Miscellaneous	(700)	(8,100)	-0.98%	-10.67%
Total	**68,800**	**444,200**	**0.45%**	**3.06%**

The plot below displays the projected total Medi-Cal caseload over time.

Statewide Caseload Projections,
Including Impact of Policy Changes: All Aid Categories

Certified Average Monthly Eligible Count by Month



The Medi-Cal caseload declined most months from July 2023 through June 2024, the 12 months following the end of the COVID-19 pandemic continuous enrollment requirement. Recent data suggest that the downward caseload trend has stopped. The 2025-26 Governor's Budget assumes that caseload will be generally steady or only slightly decline through 2024-25. The Governor's Budget assumes the end of discretionary pandemic unwinding flexibilities that result in fewer discontinuances in June 2025. Consistent with this assumption, enrollment is expected to fall more steeply in 2025-26. Additionally, significant variability is possible in the near future due to potential changes in federal immigration policy.

Medi-Cal Funding Summary
November 2024 Estimate Compared to Appropriation
Fiscal Year 2024 - 2025

TOTAL FUNDS

Benefits:	**Total Appropriation**	**Nov 2024 Estimate**	**Difference Incr./(Decr.)**
4260-101-0001/0890 Medi-Cal General and Federal Funds	$125,815,241,000	$136,937,080,000	$11,121,839,000
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$72,949,000	$72,949,000	$0
4260-101-0233 Prop 99 Physician Srvc. Acct	$20,826,000	$20,826,000	$0
4260-101-0236 Prop 99 Unallocated Account	$31,392,000	$33,186,000	$1,794,000
4260-101-3085 Behavioral Health Service (100% SF)	$19,752,000	$13,059,000	($6,693,000)
4260-101-3305 Healthcare Treatment Fund	$802,947,000	$628,655,000	($174,292,000)
4260-101-3311 Healthcare Plan Fines Penalties Fund	$78,369,000	$69,930,000	($8,439,000)
4260-101-3428 MCO Tax 2023	$12,371,600,000	$11,590,417,000	($781,183,000)
4260-101-3431 Medi-Cal Provider Payment Reserve Fund	$442,000,000	$166,449,000	($275,551,000)
4260-101-8507 Home & Community Based Services (101)*	$52,745,000	$106,923,000	$54,178,000
4260-102-0001/0890 Capital Debt	$77,341,000	$75,393,000	($1,948,000)
4260-601-3375 Medi-Cal Loan Repayment Program 601	$63,259,000	$62,240,000	($1,019,000)
4260-104-0001 NDPH Hosp Supp	$1,900,000	$1,900,000	$0
4260-601-3096 NDPH Suppl	$7,209,000	$1,900,000	($5,309,000)
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	$195,154,000	$189,123,000	($6,031,000)
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	$52,056,000	$41,811,000	($10,245,000)
4260-112-0001 GF Support for Prop 56 Payments*	$64,000,000	$110,292,000	$46,292,000
4260-695-3305 Health Care Treatment Fund (Less GF)	($64,000,000)	$0	$64,000,000
4260-601-3420 Behavioral Health IGT Fund	$1,567,314,000	$2,336,193,000	$768,879,000
4260-162-8506 State Fiscal Recovery Fund of 2021	$0	$180,500,000	$180,500,000
4260-601-0942142 Local Trauma Centers	$81,670,000	$65,240,000	($16,430,000)
4260-601-0995 Reimbursements	$2,435,108,000	$2,501,284,000	$66,176,000
4260-601-3156 MCO Tax Fund	$0	$144,464,000	$144,464,000
4260-601-3213 LTC QA Fund	$571,142,000	$604,900,000	$33,758,000
4260-601-3323 Medi-Cal Emergency Transport Fund	$46,983,000	$71,661,000	$24,678,000
4260-601-3331 Medi-Cal Drug Rebates Fund	$2,258,631,000	$2,095,877,000	($162,754,000)
4260-601-7502 Demonstration DSH Fund	$84,339,000	$84,339,000	$0
4260-601-7503 Health Care Support Fund	$586,000	$534,000	($52,000)
4260-601-3443 Healthcare Oversight & Acct. Subfund	$0	$2,175,777,000	$2,175,777,000
4260-601-8108 Global Payment Program Fund	$1,027,153,000	$989,722,000	($37,431,000)
4260-601-8113 DPH GME Special Fund	$281,292,000	$371,065,000	$89,773,000
4260-603-0001 Children's Hospital Directed Payment	$115,000,000	$0	($115,000,000)
4260-605-3167 SNF Quality & Accountability	$501,000	$501,000	$0
4260-606-0834 SB 1100 DSH	$119,453,000	$124,461,000	$5,008,000
4260-611-3158/0890 Hospital Quality Assurance	$4,994,129,000	$5,135,798,000	$141,669,000
Total Benefits	**$153,686,141,000**	**$167,002,549,000**	**$13,316,408,000**
County and Other Local Assistance Administration:			
4260-101-0001/0890 Medi-Cal General and Federal Funds	$6,988,579,000	$7,204,006,000	$215,427,000
4260-101-3085 Behavioral Health Service (100% SF)	$25,097,000	$22,390,000	($2,707,000)
4260-101-8140 Vision Services CHIP HSI	$0	$1,378,000	$1,378,000
4260-101-8507 Home & Community Base Services	$740,000	$2,000	($738,000)
4260-106-0890 Money Follow Person Fed. Grant	$2,388,000	$2,113,000	($275,000)
4260-117-0001/0890 HIPPA	$23,570,000	$24,557,000	$987,000
4260-601-0995 Reimbursements	$45,317,000	$31,593,000	($13,724,000)
4260-601-3420 Behavioral Health IGT Fund	$134,000	$134,000	$0
4260-601-7503 Health Care Support Fund	$189,939,000	$323,213,000	$133,274,000
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	$150,000	$150,000	$0
Total County and Other Local Assistance Administration	**$7,275,914,000**	**$7,609,536,000**	**$333,622,000**
Grand Total - Total Funds	**$160,962,055,000**	**$174,612,085,000**	**$13,650,030,000**

Medi-Cal Funding Summary
November 2024 Estimate Compared to Appropriation
Fiscal Year 2024 - 2025

STATE FUNDS

Benefits:	**State Funds Appropriation**	**Nov 2024 Estimate**	**Difference Incr./(Decr.)**
4260-101-0001 Medi-Cal General Fund*[1]	$33,057,453,000	$35,927,808,000	$2,870,355,000
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$72,949,000	$72,949,000	$0
4260-101-0233 Prop 99 Physician Srvc. Acct	$20,826,000	$20,826,000	$0
4260-101-0236 Prop 99 Unallocated Account	$31,392,000	$33,186,000	$1,794,000
4260-101-3085 Behavioral Health Service (100% SF)	$19,752,000	$13,059,000	($6,693,000)
4260-101-3305 Healthcare Treatment Fund	$802,947,000	$628,655,000	($174,292,000)
4260-101-3311 Healthcare Plan Fines Penalties Fund	$78,369,000	$69,930,000	($8,439,000)
4260-101-3428 MCO Tax 2023	$12,371,600,000	$11,590,417,000	($781,183,000)
4260-101-3431 Medi-Cal Provider Payment Reserve Fund	$442,000,000	$166,449,000	($275,551,000)
4260-101-8507 Home & Community Based Services (101)	$52,745,000	$106,923,000	$54,178,000
4260-102-0001 Capital Debt *	$27,332,000	$26,430,000	($902,000)
4260-601-3375 Medi-Cal Loan Repayment Program	$63,259,000	$62,240,000	($1,019,000)
4260-104-0001 NDPH Hosp Supp *	$1,900,000	$1,900,000	$0
4260-601-3096 NDPH Suppl	$7,209,000	$1,900,000	($5,309,000)
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	$195,154,000	$189,123,000	($6,031,000)
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($118,400,000)	($118,400,000)	$0
4260-112-0001 GF Support for Prop 56 Payments*	$64,000,000	$110,292,000	$46,292,000
4260-695-3305 Health Care Treatment Fund (Less GF)	($64,000,000)	$0	$64,000,000
4260-601-3420 Behavioral Health IGT Fund	$1,567,314,000	$2,336,193,000	$768,879,000
4260-601-0942142 Local Trauma Centers	$81,670,000	$65,240,000	($16,430,000)
4260-601-0995 Reimbursements	$2,435,108,000	$2,501,284,000	$66,176,000
4260-601-3156 MCO Tax Fund	$0	$144,464,000	$144,464,000
4260-601-3213 LTC QA Fund	$571,142,000	$604,900,000	$33,758,000
4260-601-3323 Medi-Cal Emergency Transport Fund	$46,983,000	$71,661,000	$24,678,000
4260-601-3331 Medi-Cal Drug Rebates Fund	$2,258,631,000	$2,095,877,000	($162,754,000)
4260-601-3443 Healthcare Oversight & Acct. Subfund	$0	$2,175,777,000	$2,175,777,000
4260-601-8108 Global Payment Program Fund	$1,027,153,000	$989,722,000	($37,431,000)
4260-601-8113 DPH GME Special Fund	$281,292,000	$371,065,000	$89,773,000
4260-603-0001 Children's Hospital Directed Payment*	$115,000,000	$0	($115,000,000)
4260-605-3167 SNF Quality & Accountability	$501,000	$501,000	$0
4260-606-0834 SB 1100 DSH	$119,453,000	$124,461,000	$5,008,000
4260-611-3158 Hospital Quality Assurance Revenue	$4,994,129,000	$5,135,798,000	$141,669,000
Total Benefits	**$60,741,363,000**	**$65,637,130,000**	**$4,895,767,000**
Total Benefits General Fund *	**$33,384,085,000**	**$36,184,830,000**	**$2,800,745,000**
County and Other Local Assistance Administration:			
4260-101-0001 Medi-Cal General Fund *	$1,633,496,000	$1,445,771,000	($187,725,000)
4260-101-3085 Behavioral Health Service (100% SF)	$25,097,000	$22,390,000	($2,707,000)
4260-101-8140 Vision Services CHIP HSI	$0	$1,378,000	$1,378,000
4260-101-8507 Home & Community Base Services	$740,000	$2,000	($738,000)
4260-117-0001 HIPAA *	$5,150,000	$6,238,000	$1,088,000
4260-601-0995 Reimbursements	$45,317,000	$31,593,000	($13,724,000)
4260-601-3420 Behavioral Health IGT Fund	$134,000	$134,000	$0
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	$150,000	$150,000	$0
Total County and Other Local Assistance Administration	**$1,710,084,000**	**$1,507,656,000**	**($202,428,000)**
Total County and Other Local Assistance Administration General Fund *	**$1,638,646,000**	**$1,452,009,000**	**($186,637,000)**
Grand Total - State Funds	**$62,451,447,000**	**$67,144,786,000**	**$4,693,339,000**
Grand Total - General Fund*	**$35,022,731,000**	**$37,636,839,000**	**$2,614,108,000**

Medi-Cal Funding Summary
November 2024 Estimate Compared to Appropriation
Fiscal Year 2024 - 2025

FEDERAL FUNDS

	Federal Funds Appropriation	Nov 2024 Estimate	Difference Incr./(Decr.)
Benefits:			
4260-101-0890 Federal Funds [1]	$92,757,788,000	$101,009,272,000	$8,251,484,000
4260-102-0890 Capital Debt	$50,009,000	$48,963,000	($1,046,000)
4260-106-0890 Money Follows Person Federal Grant	$52,056,000	$41,811,000	($10,245,000)
4260-162-8506 State Fiscal Recovery Fund of 2021	$0	$180,500,000	$180,500,000
4260-601-7502 Demonstration DSH Fund	$84,339,000	$84,339,000	$0
4260-601-7503 Health Care Support Fund	$586,000	$534,000	($52,000)
Total Benefits	**$92,944,778,000**	**$101,365,419,000**	**$8,420,641,000**
County and Other Local Assistance Administration:			
4260-101-0890 Federal Funds	$5,355,083,000	$5,758,235,000	$403,152,000
4260-106-0890 Money Follows Person Fed. Grant	$2,388,000	$2,113,000	($275,000)
4260-117-0890 HIPAA	$18,420,000	$18,319,000	($101,000)
4260-601-7503 Health Care Support Fund	$189,939,000	$323,213,000	$133,274,000
Total County and Other Local Assistance Administration	**$5,565,830,000**	**$6,101,880,000**	**$536,050,000**
Grand Total - Federal Funds	**$98,510,608,000**	**$107,467,299,000**	**$8,956,691,000**

[1] Reflects mid-year adjustments to the Appropriation

Medi-Cal Funding Summary

November 2024 Estimate Comparison of
FY 2024-25 to FY 2025-26

TOTAL FUNDS

Benefits:	**FY 2024-25 Estimate**	**FY 2025-26 Estimate**	**Difference Incr./(Decr.)**
4260-101-0001/0890 Medi-Cal General and Federal Funds	$136,937,080,000	$152,197,311,000	$15,260,231,000
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$72,949,000	$61,994,000	($10,955,000)
4260-101-0233 Prop 99 Physician Srvc. Acct	$20,826,000	$17,700,000	($3,126,000)
4260-101-0236 Prop 99 Unallocated Account	$33,186,000	$27,474,000	($5,712,000)
4260-101-3085 Behavioral Health Service (100% SF)	$13,059,000	$0	($13,059,000)
4260-101-3305 Healthcare Treatment Fund	$628,655,000	$604,685,000	($23,970,000)
4260-101-3311 Healthcare Plan Fines Penalties Fund	$69,930,000	$0	($69,930,000)
4260-101-3428 MCO Tax 2023	$11,590,417,000	$3,942,986,000	($7,647,431,000)
4260-101-3431 Medi-Cal Provider Payment Reserve Fund	$166,449,000	$0	($166,449,000)
4260-101-8507 Home & Community Based Services (101)	$106,923,000	$0	($106,923,000)
4260-102-0001/0890 Capital Debt	$75,393,000	$77,643,000	$2,250,000
4260-601-3375 Medi-Cal Loan Repayment Program 601	$62,240,000	$51,227,000	($11,013,000)
4260-104-0001 NDPH Hosp Supp	$1,900,000	$1,900,000	$0
4260-601-3096 NDPH Suppl	$1,900,000	$8,031,000	$6,131,000
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	$189,123,000	$228,132,000	$39,009,000
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	$41,811,000	$88,881,000	$47,070,000
4260-112-0001 GF Support for Prop 56 Payments*	$110,292,000	$132,225,000	$21,933,000
4260-695-3305 Health Care Treatment Fund (Less GF)	$0	($132,225,000)	($132,225,000)
4260-601-3420 Behavioral Health IGT Fund	$2,336,193,000	$1,918,398,000	($417,795,000)
4260-162-8506 State Fiscal Recovery Fund of 2021	$180,500,000	$0	($180,500,000)
4260-601-0942142 Local Trauma Centers	$65,240,000	$84,010,000	$18,770,000
4260-601-0995 Reimbursements	$2,501,284,000	$3,012,141,000	$510,857,000
4260-601-3156 MCO Tax Fund	$144,464,000	$0	($144,464,000)
4260-601-3213 LTC QA Fund	$604,900,000	$577,637,000	($27,263,000)
4260-601-3323 Medi-Cal Emergency Transport Fund	$71,661,000	$52,768,000	($18,893,000)
4260-601-3331 Medi-Cal Drug Rebates Fund	$2,095,877,000	$1,953,944,000	($141,933,000)
4260-601-7502 Demonstration DSH Fund	$84,339,000	$52,744,000	($31,595,000)
4260-601-7503 Health Care Support Fund	$534,000	$578,000	$44,000
4260-601-3443 Healthcare Oversight & Acct. Subfund	$2,175,777,000	$8,757,891,000	$6,582,114,000
4260-601-8108 Global Payment Program Fund	$989,722,000	$904,016,000	($85,706,000)
4260-601-8113 DPH GME Special Fund	$371,065,000	$423,511,000	$52,446,000
4260-603-0001 Children's Hospital Directed Payment	$0	$57,500,000	$57,500,000
4260-605-3167 SNF Quality & Accountability	$501,000	$0	($501,000)
4260-606-0834 SB 1100 DSH	$124,461,000	$123,088,000	($1,373,000)
4260-611-3158/0890 Hospital Quality Assurance	$5,135,798,000	$5,237,408,000	$101,610,000
Total Benefits	**$167,002,549,000**	**$180,461,698,000**	**$13,459,149,000**
County and Other Local Assistance Administration:			
4260-101-0001/0890 Medi-Cal General and Federal Funds	$7,204,006,000	$7,205,733,000	$1,727,000
4260-101-3085 Behavioral Health Service (100% SF)	$22,390,000	$15,208,000	($7,182,000)
4260-101-8140 Vision Services CHIP HSI	$1,378,000	$2,755,000	$1,377,000
4260-101-8507 Home & Community Base Services	$2,000	$0	($2,000)
4260-106-0890 Money Follow Person Fed. Grant	$2,113,000	$5,659,000	$3,546,000
4260-117-0001/0890 HIPPA	$24,557,000	$25,312,000	$755,000
4260-601-0995 Reimbursements	$31,593,000	$57,649,000	$26,056,000
4260-601-3420 Behavioral Health IGT Fund	$134,000	$186,744,000	$186,610,000
4260-601-7503 Health Care Support Fund	$323,213,000	$178,255,000	($144,958,000)
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	$150,000	$150,000	$0
Total County and Other Local Assistance Administration	**$7,609,536,000**	**$7,677,465,000**	**$67,929,000**
Grand Total - Total Funds	**$174,612,085,000**	**$188,139,163,000**	**$13,527,078,000**

Medi-Cal Funding Summary
November 2024 Estimate Comparison of
FY 2024-25 to FY 2025-26

STATE FUNDS

Benefits:	**FY 2024-25 Estimate**	**FY 2025-26 Estimate**	**Difference Incr./(Decr.)**
4260-101-0001 Medi-Cal General Fund*	$35,927,808,000	$40,274,798,000	$4,346,990,000
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$72,949,000	$61,994,000	($10,955,000)
4260-101-0233 Prop 99 Physician Srvc. Acct	$20,826,000	$17,700,000	($3,126,000)
4260-101-0236 Prop 99 Unallocated Account	$33,186,000	$27,474,000	($5,712,000)
4260-101-3085 Behavioral Health Service (100% SF)	$13,059,000	$0	($13,059,000)
4260-101-3305 Healthcare Treatment Fund	$628,655,000	$604,685,000	($23,970,000)
4260-101-3311 Healthcare Plan Fines Penalties Fund	$69,930,000	$0	($69,930,000)
4260-101-3428 MCO Tax 2023	$11,590,417,000	$3,942,986,000	($7,647,431,000)
4260-101-3431 Medi-Cal Provider Payment Reserve Fund	$166,449,000	$0	($166,449,000)
4260-101-8507 Home & Community Based Services (101)	$106,923,000	$0	($106,923,000)
4260-102-0001 Capital Debt *	$26,430,000	$26,353,000	($77,000)
4260-601-3375 Medi-Cal Loan Repayment Program	$62,240,000	$51,227,000	($11,013,000)
4260-104-0001 NDPH Hosp Supp *	$1,900,000	$1,900,000	$0
4260-601-3096 NDPH Suppl	$1,900,000	$8,031,000	$6,131,000
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	$189,123,000	$228,132,000	$39,009,000
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($118,400,000)	($118,400,000)	$0
4260-112-0001 GF Support for Prop 56 Payments*	$110,292,000	$132,225,000	$21,933,000
4260-695-3305 Health Care Treatment Fund (Less GF)	$0	($132,225,000)	($132,225,000)
4260-601-3420 Behavioral Health IGT Fund	$2,336,193,000	$1,918,398,000	($417,795,000)
4260-601-0942142 Local Trauma Centers	$65,240,000	$84,010,000	$18,770,000
4260-601-0995 Reimbursements	$2,501,284,000	$3,012,141,000	$510,857,000
4260-601-3156 MCO Tax Fund	$144,464,000	$0	($144,464,000)
4260-601-3213 LTC QA Fund	$604,900,000	$577,637,000	($27,263,000)
4260-601-3323 Medi-Cal Emergency Transport Fund	$71,661,000	$52,768,000	($18,893,000)
4260-601-3331 Medi-Cal Drug Rebates Fund	$2,095,877,000	$1,953,944,000	($141,933,000)
4260-601-3443 Healthcare Oversight & Acct. Subfund	$2,175,777,000	$8,757,891,000	$6,582,114,000
4260-601-8108 Global Payment Program Fund	$989,722,000	$904,016,000	($85,706,000)
4260-601-8113 DPH GME Special Fund	$371,065,000	$423,511,000	$52,446,000
4260-603-0001 Children's Hospital Directed Payment*	$0	$57,500,000	$57,500,000
4260-605-3167 SNF Quality & Accountability	$501,000	$0	($501,000)
4260-606-0834 SB 1100 DSH	$124,461,000	$123,088,000	($1,373,000)
4260-611-3158 Hospital Quality Assurance Revenue	$5,135,798,000	$5,237,408,000	$101,610,000
Total Benefits	**$65,637,130,000**	**$68,345,692,000**	**$2,708,562,000**
Total Benefits General Fund *	**$36,184,830,000**	**$40,611,176,000**	**$4,426,346,000**
County and Other Local Assistance Administration:			
4260-101-0001 Medi-Cal General Fund *	$1,445,771,000	$1,471,370,000	$25,599,000
4260-101-3085 Behavioral Health Service (100% SF)	$22,390,000	$15,208,000	($7,182,000)
4260-101-8140 Vision Services CHIP HSI	$1,378,000	$2,755,000	$1,377,000
4260-101-8507 Home & Community Base Services	$2,000	$0	($2,000)
4260-117-0001 HIPAA *	$6,238,000	$6,374,000	$136,000
4260-601-0995 Reimbursements	$31,593,000	$57,649,000	$26,056,000
4260-601-3420 Behavioral Health IGT Fund	$134,000	$186,744,000	$186,610,000
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	$150,000	$150,000	$0
Total County and Other Local Assistance Administration	**$1,507,656,000**	**$1,740,250,000**	**$232,594,000**
Total County and Other Local Assistance Administration General Fund *	**$1,452,009,000**	**$1,477,744,000**	**$25,735,000**
Grand Total - State Funds	**$67,144,786,000**	**$70,085,942,000**	**$2,941,156,000**
Grand Total - General Fund*	**$37,636,839,000**	**$42,088,920,000**	**$4,452,081,000**

Medi-Cal Funding Summary
November 2024 Estimate Comparison of
FY 2024-25 to FY 2025-26

FEDERAL FUNDS

Benefits:	**FY 2024-25 Estimate**	**FY 2025-26 Estimate**	**Difference Incr./(Decr.)**
4260-101-0890 Federal Funds	$101,009,272,000	$111,922,513,000	$10,913,241,000
4260-102-0890 Capital Debt	$48,963,000	$51,290,000	$2,327,000
4260-106-0890 Money Follows Person Federal Grant	$41,811,000	$88,881,000	$47,070,000
4260-162-8506 State Fiscal Recovery Fund of 2021	$180,500,000	$0	($180,500,000)
4260-601-7502 Demonstration DSH Fund	$84,339,000	$52,744,000	($31,595,000)
4260-601-7503 Health Care Support Fund	$534,000	$578,000	$44,000
Total Benefits	**$101,365,419,000**	**$112,116,006,000**	**$10,750,587,000**
County and Other Local Assistance Administration:			
4260-101-0890 Federal Funds	$5,758,235,000	$5,734,363,000	($23,872,000)
4260-106-0890 Money Follows Person Fed. Grant	$2,113,000	$5,659,000	$3,546,000
4260-117-0890 HIPAA	$18,319,000	$18,938,000	$619,000
4260-601-7503 Health Care Support Fund	$323,213,000	$178,255,000	($144,958,000)
Total County and Other Local Assistance Administration	**$6,101,880,000**	**$5,937,215,000**	**($164,665,000)**
Grand Total - Federal Funds	**$107,467,299,000**	**$118,053,221,000**	**$10,585,922,000**

Medi-Cal Funding Summary

November 2024 FY 2024-25 and FY 2025-26 Breakdown by Appropriation Year

Spending included in the Medi-Cal Estimate is authorized by the annual Budget Act and other statutory appropriations. This authority most often is available only for the duration of one fiscal year. However, in some cases, funding appropriated in one FY can be spent in a later FY. This means that authority for most spending in a given FY comes from the matching Appropriation Year, but authority for some spending may come from previous Appropriation Years. The following breakdown shows spending in each FY by Appropriation Year.

TOTAL FUNDS

Appropriation Year 2025-26

Benefits:	**FY 2024-25 Estimate**	**FY 2025-26 Estimate**
4260-101-0001 Medi-Cal General Funds	$0	$39,609,624,000
4260-101-0890 Medi-Cal Federal Funds	$0	$111,922,513,000
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$0	$61,994,000
4260-101-0233 Prop 99 Physician Srvc. Acct	$0	$17,700,000
4260-101-0236 Prop 99 Unallocated Account	$0	$27,474,000
4260-101-3305 Healthcare Treatment Fund	$0	$604,685,000
4260-101-3428 MCO Tax 2023	$0	$3,942,986,000
4260-102-0001 Capital Debt General Funds	$0	$26,353,000
4260-102-0890 Capital Debt Federal Funds	$0	$51,290,000
4260-104-0001 NDPH Hosp Supp	$0	$1,900,000
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	$0	($1,900,000)
4260-105-0001 Private Hosp Supp Fund	$0	$118,400,000
4260-698-3097 Private Hosp Supp (Less Funded by GF)	$0	($118,400,000)
4260-106-0890 Money Follows Person Federal Grant	$0	$88,881,000
4260-112-0001 GF Support for Prop 56 Payments*	$0	$132,225,000
4260-695-3305 Health Care Treatment Fund (Less GF)	$0	($132,225,000)
4260-601-0995 Reimbursements	$0	$3,012,141,000
Total Benefits	**$0**	**$159,365,641,000**
County and Other Local Assistance Administration:		
4260-101-0001 Medi-Cal General Funds	$0	$1,465,255,000
4260-101-0890 Medi-Cal Federal Funds	$0	$5,734,363,000
4260-101-3085 Mental Health Services	$0	$15,208,000
4260-101-8140 Vision Services CHIP HSI	$0	$2,755,000
4260-106-0890 Money Follow Person Fed. Grant	$0	$5,659,000
4260-117-0001 HIPAA General Funds	$0	$6,374,000
4260-117-0890 HIPAA Federal Funds	$0	$18,938,000
4260-601-0995 Reimbursements	$0	$57,649,000
Total County and Other Local Assistance Administration	**$0**	**$7,306,201,000**
Appropriation Year 2025-26 - Total Funds	**$0**	**$166,671,842,000**

Medi-Cal Funding Summary
November 2024 FY 2024-25 and FY 2025-26 Breakdown by Appropriation Year

TOTAL FUNDS

Appropriation Year 2024-25

Benefits:	**FY 2024-25 Estimate**	**FY 2025-26 Estimate**
4260-101-0001 Medi-Cal General Funds	$34,926,661,000	$0
4260-101-0890 Medi-Cal Federal Funds	$101,009,272,000	$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$72,949,000	$0
4260-101-0233 Prop 99 Physician Srvc. Acct	$20,826,000	$0
4260-101-0236 Prop 99 Unallocated Account	$33,186,000	$0
4260-101-3085 Mental Health Services	$12,962,000	$0
4260-101-3305 Healthcare Treatment Fund	$628,655,000	$0
4260-101-3311 Healthcare Plan Fines Penalties Fund	$69,930,000	$0
4260-101-3428 MCO Tax 2023	$11,590,417,000	$0
4260-101-3431 Medi-Cal Provider Payment Reserve Fund	$166,449,000	$0
4260-102-0001 Capital Debt General Funds	$26,430,000	$0
4260-102-0890 Capital Debt Federal Funds	$48,963,000	$0
4260-104-0001 NDPH Hosp Supp	$1,900,000	$0
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	($1,900,000)	$0
4260-105-0001 Private Hosp Supp Fund	$118,400,000	$0
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($118,400,000)	$0
4260-106-0890 Money Follows Person Federal Grant	$41,811,000	$0
4260-112-0001 GF Support for Prop 56 Payments*	$110,292,000	$0
4260-601-0995 Reimbursements	$2,501,284,000	$0
4260-601-3156 MCO Tax Fund	$144,464,000	$0
4260-601-3443 Healthcare Oversight & Acct. Subfund	$2,175,777,000	$8,757,891,000
4260-603-0001 Children's Hospital Directed Payment*	$0	$57,500,000
Total Benefits	**$153,580,328,000**	**$8,815,391,000**
County and Other Local Assistance Administration:		
4260-101-0001 Medi-Cal General Funds	$1,306,504,000	$0
4260-101-0890 Medi-Cal Federal Funds	$5,758,235,000	$0
4260-101-3085 Mental Health Services	$22,390,000	$0
4260-101-8140 Vision Services CHIP HSI	$1,378,000	$0
4260-106-0890 Money Follow Person Fed. Grant	$2,113,000	$0
4260-117-0001 HIPAA General Funds	$6,238,000	$0
4260-117-0890 HIPAA Federal Funds	$18,319,000	$0
4260-601-0995 Reimbursements	$31,593,000	$0
Total County and Other Local Assistance Administration	**$7,146,770,000**	**$0**
Appropriation Year 2024-25 - Total Funds	**$160,727,098,000**	**$8,815,391,000**

Medi-Cal Funding Summary
November 2024 FY 2024-25 and FY 2025-26 Breakdown by Appropriation Year

TOTAL FUNDS

Appropriation Year 2023-24

Benefits:	FY 2024-25 Estimate	FY 2025-26 Estimate
4260-101-0001 Medi-Cal General Funds	$57,215,000	$0
Total Benefits	**$57,215,000**	**$0**
Appropriation Year 2023-24 - Total Funds	**$57,215,000**	**$0**

Appropriation Year 2022-23

Benefits:	FY 2024-25 Estimate	FY 2025-26 Estimate
4260-101-0001 Medi-Cal General Funds	$641,736,000	$594,304,000
4260-101-3085 Mental Health Services	$97,000	$0
Total Benefits	**$641,833,000**	**$594,304,000**
County and Other Local Assistance Administration:		
4260-101-0001 Medi-Cal General Funds	$131,484,000	$0
Total County and Other Local Assistance Administration	**$131,484,000**	**$0**
Appropriation Year 2022-23 - Total Funds	**$773,317,000**	**$594,304,000**

Appropriation Year 2021-22

Benefits:	FY 2024-25 Estimate	FY 2025-26 Estimate
4260-101-0001 Medi-Cal General Funds	$302,196,000	$70,870,000
4260-101-8507 Home & Community Based Services (101)	$106,923,000	$0
4260-162-8506 State Fiscal Recovery Fund of 2021	$180,500,000	$0
Total Benefits	**$589,619,000**	**$70,870,000**
County and Other Local Assistance Administration:		
4260-101-0001 Medi-Cal General Funds	$7,783,000	$6,115,000
4260-101-8507 Home & Community Base Services	$2,000	$0
Total County and Other Local Assistance Administration	**$7,785,000**	**$6,115,000**
Appropriation Year 2021-22 - Total Funds	**$597,404,000**	**$76,985,000**

Non-Budget Act Items

Benefits:	FY 2024-25 Estimate	FY 2025-26 Estimate
4260-601-3375 Medi-Cal Loan Repayment Program 601	$62,240,000	$51,227,000
4260-601-3096 NDPH Suppl	$1,900,000	$8,031,000
4260-601-3097 Private Hosp Suppl	$189,123,000	$228,132,000
4260-601-3420 Behavioral Health IGT Fund	$2,336,193,000	$1,918,398,000
4260-601-0942142 Local Trauma Centers	$65,240,000	$84,010,000
4260-601-3213 LTC QA Fund	$604,900,000	$577,637,000
4260-601-3323 Medi-Cal Emergency Transport Fund	$71,661,000	$52,768,000
4260-601-3331 Medi-Cal Drug Rebates Fund	$2,095,877,000	$1,953,944,000
4260-601-7502 Demonstration DSH Fund	$84,339,000	$52,744,000
4260-601-7503 Health Care Support Fund	$534,000	$578,000
4260-601-8108 Global Payment Program Fund	$989,722,000	$904,016,000
4260-601-8113 DPH GME Special Fund	$371,065,000	$423,511,000
4260-605-3167 SNF Quality & Accountability	$501,000	$0
4260-606-0834 SB 1100 DSH	$124,461,000	$123,088,000
4260-611-3158 Hospital Quality Assurance Revenue	$5,135,798,000	$5,237,408,000
Total Benefits	**$12,133,554,000**	**$11,615,492,000**
County and Other Local Assistance Administration:		
4260-601-3420 Behavioral Health IGT Fund	$134,000	$186,744,000
4260-601-7503 Health Care Support Fund	$323,213,000	$178,255,000
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	$150,000	$150,000
Total County and Other Local Assistance Administration	**$323,497,000**	**$365,149,000**
Non-Budget Act Items - Total Funds	**$12,457,051,000**	**$11,980,641,000**
Grand Total - Total Funds	**$174,612,085,000**	**$188,139,163,000**

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CURRENT YEAR

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

MEDI-CAL PROGRAM ESTIMATE SUMMARY
FISCAL YEAR 2024-25

	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
I. BASE ESTIMATES				
A. C/Y FFS BASE	$33,695,870,570	$16,847,935,280	$16,847,935,280	$0
B. C/Y BASE POLICY CHANGES	$86,747,495,980	$51,497,036,490	$32,946,811,490	$2,303,648,000
C. BASE ADJUSTMENTS	($688,027,000)	($352,150,510)	($335,876,490)	$0
D. ADJUSTED BASE	**$119,755,339,550**	**$67,992,821,260**	**$49,458,870,280**	**$2,303,648,000**
II. REGULAR POLICY CHANGES				
A. ELIGIBILITY	$35,019,000	($2,772,700,000)	$2,805,670,000	$2,049,000
B. AFFORDABLE CARE ACT	$7,675,629,000	$8,391,556,400	($237,400,400)	($478,527,000)
C. BENEFITS	$1,294,687,890	$1,170,533,000	$124,154,890	$0
D. PHARMACY	($4,799,310,850)	($4,830,202,420)	($2,064,985,430)	$2,095,877,000
E. DRUG MEDI-CAL	$50,403,700	$40,310,330	$1,168,720	$8,924,640
F. MENTAL HEALTH	$37,102,000	($357,893,350)	$371,048,350	$23,947,000
G. WAIVER--MH/UCD & BTR	$4,450,512,000	$2,333,027,500	$649,235,500	$1,468,249,000
H. MANAGED CARE	$19,931,428,000	$12,688,493,550	($8,779,732,550)	$16,022,667,000
I. PROVIDER RATES	$1,473,365,900	$1,361,911,240	($1,024,602,390)	$1,136,057,050
J. SUPPLEMENTAL PMNTS.	$13,352,350,680	$8,013,019,150	$175,703,490	$5,163,628,050
K. COVID-19	$806,931,000	$578,688,900	$228,242,100	$0
L. STATE-ONLY CLAIMING	$0	($439,360,000)	$439,360,000	$0
M. OTHER DEPARTMENTS	$791,808,000	$791,808,000	$0	$0
N. OTHER	$2,147,281,060	$6,403,405,490	($5,961,903,430)	$1,705,779,000
O. TOTAL CHANGES	**$47,247,207,380**	**$33,372,597,790**	**($13,274,041,150)**	**$27,148,650,750**
III. TOTAL MEDI-CAL ESTIMATE	**$167,002,546,930**	**$101,365,419,050**	**$36,184,829,140**	**$29,452,298,750**

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2024-25

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	ELIGIBILITY				
1	CALAIM - INMATE PRE-RELEASE PROGRAM	$48,758,000	$32,180,000	$16,578,000	$0
2	MEDI-CAL STATE INMATE PROGRAMS	$38,066,000	$38,066,000	$0	$0
3	BREAST AND CERVICAL CANCER TREATMENT	$19,736,000	$10,244,600	$9,491,400	$0
4	HEALTH ENROLLMENT NAVIGATORS FOR CLINICS	$7,490,000	$3,745,000	$3,745,000	$0
6	NON-OTLICP CHIP	$0	$106,656,300	($106,656,300)	$0
7	NON-EMERGENCY FUNDING ADJUSTMENT	$0	($3,054,378,750)	$3,054,378,750	$0
8	SCHIP FUNDING FOR PRENATAL CARE	$0	$70,822,050	($70,822,050)	$0
9	MEDI-CAL COUNTY INMATE REIMBURSEMENT	$0	$0	($1,703,000)	$1,703,000
10	CS3 PROXY ADJUSTMENT	$0	$67,383,500	($67,383,500)	$0
11	REFUGEE MEDICAL ASSISTANCE	$0	$0	($346,000)	$346,000
201	SB 525 MINIMUM WAGE - CASELOAD IMPACT	($79,031,000)	($47,418,700)	($31,612,300)	$0
	ELIGIBILITY SUBTOTAL	**$35,019,000**	**($2,772,700,000)**	**$2,805,670,000**	**$2,049,000**
	AFFORDABLE CARE ACT				
12	COMMUNITY FIRST CHOICE OPTION	$9,133,032,000	$9,133,032,000	$0	$0
13	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	$18,208,000	$18,208,000	$0	$0
14	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	$5,393,000	($5,393,000)	$0
15	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	$0	$33,933,400	($33,933,400)	$0
16	ACA DSH REDUCTION	($1,475,611,000)	($799,010,000)	($198,074,000)	($478,527,000)
	AFFORDABLE CARE ACT SUBTOTAL	**$7,675,629,000**	**$8,391,556,400**	**($237,400,400)**	**($478,527,000)**
	BENEFITS				
17	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$954,239,000	$954,239,000	$0	$0
18	FAMILY PACT PROGRAM	$141,858,000	$107,142,500	$34,715,500	$0
19	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$101,991,000	$60,229,500	$41,761,500	$0
20	MULTIPURPOSE SENIOR SERVICES PROGRAM	$63,951,000	$31,975,500	$31,975,500	$0
21	BEHAVIORAL HEALTH TREATMENT	$19,392,000	$9,696,000	$9,696,000	$0
22	CYBHI WELLNESS COACH BENEFIT	$12,687,000	$7,185,500	$5,501,500	$0
23	MEDICAL INTERPRETER PILOT PROJECT	$0	$0	$0	$0
24	HEARING AID COVERAGE FOR CHILDREN PROGRAM	$504,890	$0	$504,890	$0
25	CCT FUND TRANSFER TO CDSS	$65,000	$65,000	$0	$0
	BENEFITS SUBTOTAL	**$1,294,687,890**	**$1,170,533,000**	**$124,154,890**	**$0**

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2024-25

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	PHARMACY				
26	RESPIRATORY SYNCYTIAL VIRUS VACCINES	$183,927,150	$102,122,780	$81,804,370	$0
27	PHARMACY RETROACTIVE ADJUSTMENTS	$11,000,000	($32,763,200)	$43,763,200	$0
28	MEDICATION THERAPY MANAGEMENT PROGRAM	$0	$0	$0	$0
29	MEDI-CAL DRUG REBATE FUND	$0	$0	($2,095,877,000)	$2,095,877,000
30	LITIGATION SETTLEMENTS	($276,000)	$0	($276,000)	$0
31	BCCTP DRUG REBATES	($2,251,000)	($2,251,000)	$0	$0
32	FAMILY PACT DRUG REBATES	($2,284,000)	($2,284,000)	$0	$0
33	MEDICAL SUPPLY REBATES	($188,800,000)	($94,400,000)	($94,400,000)	$0
34	STATE SUPPLEMENTAL DRUG REBATES	($403,519,000)	($403,519,000)	$0	$0
35	FEDERAL DRUG REBATES	($4,397,108,000)	($4,397,108,000)	$0	$0
	PHARMACY SUBTOTAL	**($4,799,310,850)**	**($4,830,202,420)**	**($2,064,985,430)**	**$2,095,877,000**
	DRUG MEDI-CAL				
37	HCBS SP - CONTINGENCY MANAGEMENT	$35,085,000	$28,284,000	$0	$6,801,000
39	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	$14,391,700	$11,207,330	$1,060,720	$2,123,640
40	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	$927,000	$819,000	$108,000	$0
	DRUG MEDI-CAL SUBTOTAL	**$50,403,700**	**$40,310,330**	**$1,168,720**	**$8,924,640**
	MENTAL HEALTH				
43	BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE	$530,635,000	$180,500,000	$350,135,000	$0
44	MHP COSTS FOR FFPSA	$60,616,000	$30,701,000	$14,983,000	$14,932,000
45	CALAIM - BH - CONNECT DEMONSTRATION	$29,593,000	$20,123,000	$655,000	$8,815,000
46	MHP COSTS FOR CONTINUUM OF CARE REFORM	$3,970,000	$1,102,650	$2,867,350	$0
47	OUT OF STATE YOUTH - SMHS	$1,070,000	$535,000	$535,000	$0
49	SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS	$0	($141,000)	$141,000	$0
50	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	$0	$0	($200,000)	$200,000
51	INTERIM AND FINAL COST SETTLEMENTS - SMHS	($588,782,000)	($590,714,000)	$1,932,000	$0
	MENTAL HEALTH SUBTOTAL	**$37,102,000**	**($357,893,350)**	**$371,048,350**	**$23,947,000**
	WAIVER--MH/UCD & BTR				
52	GLOBAL PAYMENT PROGRAM	$2,936,500,000	$1,468,251,000	$0	$1,468,249,000
53	CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES	$1,709,080,000	$980,031,200	$729,048,800	$0
54	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	$534,000	$534,000	$0	$0
55	ENHANCED CARE MANAGEMENT RISK CORRIDOR	($195,602,000)	($115,788,700)	($79,813,300)	$0
	WAIVER--MH/UCD & BTR SUBTOTAL	**$4,450,512,000**	**$2,333,027,500**	**$649,235,500**	**$1,468,249,000**

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2024-25

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	MANAGED CARE				
58	2023 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	$14,095,818,000	$8,457,490,850	$5,638,327,150	$0
60	MANAGED CARE HEALTH CARE FINANCING PROGRAM	$2,622,195,000	$1,735,580,950	$886,614,050	$0
61	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	$2,232,379,000	$1,622,164,500	$610,214,500	$0
62	MANAGED CARE PUBLIC HOSPITAL EPP	$1,944,701,000	$1,386,785,300	$557,915,700	$0
64	WORKFORCE & QUALITY INCENTIVE PROGRAM	$297,468,000	$148,690,750	$148,777,250	$0
65	MANAGED CARE PUBLIC DP-NF PASS-THROUGH PYMT PROG	$281,681,000	$148,117,700	$133,563,300	$0
68	MANAGED CARE DISTRICT HOSPITAL DIRECTED PAYMENTS	$100,000,000	$70,759,000	$0	$29,241,000
70	CYBHI - STUDENT BH INCENTIVE PROGRAM	$94,202,000	$47,101,000	$47,101,000	$0
71	NON-HOSPITAL 340B CLINIC DIRECTED PAYMENTS	$43,750,000	$21,875,000	$21,875,000	$0
73	CCI-QUALITY WITHHOLD REPAYMENTS	$13,886,000	$6,943,000	$6,943,000	$0
81	2023 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	$0	$0	($5,638,327,000)	$5,638,327,000
82	2023 MCO ENROLLMENT TAX MANAGED CARE PLANS	$0	$0	($7,941,724,000)	$7,941,724,000
83	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	$0	$0	($2,268,062,000)	$2,268,062,000
84	COORDINATED CARE INITIATIVE RISK MITIGATION	($27,380,000)	($13,690,000)	($13,690,000)	$0
85	PROP 56 - DIRECTED PAYMENT RISK MITIGATION	($600,000,000)	($418,398,600)	($181,601,400)	$0
86	RETRO MC RATE ADJUSTMENTS	($1,169,110,000)	($525,914,900)	($787,659,100)	$144,464,000
202	HCBS SP - HOUSING AND HOMELESSNESS INCENTIVE PROG	$1,838,000	$989,000	$0	$849,000
	MANAGED CARE SUBTOTAL	**$19,931,428,000**	**$12,688,493,550**	**($8,779,732,550)**	**$16,022,667,000**
	PROVIDER RATES				
87	RATE INCREASE FOR FQHCS/RHCS/CBRCS	$419,494,270	$268,308,860	$151,185,400	$0
88	PP-GEMT IGT PROGRAM	$310,902,190	$203,998,490	$0	$106,903,700
89	MEDI-CAL PROVIDER PAYMENT INCREASES 2025 & LATER	$153,980,000	$92,388,000	$61,592,000	$0
90	DPH INTERIM & FINAL RECONS	$208,277,000	$208,277,000	$0	$0
91	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	$152,445,850	$105,370,100	($24,585,600)	$71,661,350
92	FQHC/RHC/CBRC RECONCILIATION PROCESS	$121,734,430	$77,861,410	$43,873,030	$0
93	NURSING FACILITY RATE ADJUSTMENTS	$62,208,140	$32,721,480	$29,486,650	$0
94	LTC RATE ADJUSTMENT	$24,692,940	$12,850,220	$11,842,720	$0
95	HOSPICE RATE INCREASES	$13,006,400	$7,834,140	$5,172,250	$0
96	MEDI-CAL PROVIDER PAYMENT INCREASE	$11,995,500	$7,194,000	$4,801,500	$0
97	GDSP NBS & PNS FEE ADJUSTMENTS	$5,543,000	$3,364,100	$2,178,900	$0
100	DPH INTERIM RATE	$0	$347,999,700	($347,999,700)	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2024-25

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	PROVIDER RATES				
101	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	$0	$0	($604,900,000)	$604,900,000
102	MEDI-CAL PROVIDER PAYMENT RESERVE FUND	$0	$0	($166,449,000)	$166,449,000
103	REDUCTION TO RADIOLOGY RATES	($1,678,000)	($938,100)	($739,900)	$0
104	LABORATORY RATE METHODOLOGY CHANGE	($9,235,810)	($5,318,170)	($3,917,650)	$0
203	PROP 35 - PROVIDER PAYMENT INCREASE FUNDING	$0	$0	($186,143,000)	$186,143,000
	PROVIDER RATES SUBTOTAL	**$1,473,365,900**	**$1,361,911,240**	**($1,024,602,390)**	**$1,136,057,050**
	SUPPLEMENTAL PMNTS.				
105	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	$4,550,530,000	$3,037,633,850	$0	$1,512,896,150
106	HOSPITAL QAF - FFS PAYMENTS	$3,530,277,000	$1,604,908,000	$0	$1,925,369,000
107	HOSPITAL QAF - MANAGED CARE PAYMENTS	$1,297,400,000	$883,341,600	$0	$414,058,400
108	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	$850,473,000	$494,768,000	$0	$355,705,000
109	PRIVATE HOSPITAL DSH REPLACEMENT	$746,417,000	$373,377,500	$373,039,500	$0
110	PROP 56 - MEDI-CAL FAMILY PLANNING	$512,553,080	$306,675,280	$205,877,790	$0
111	DSH PAYMENT	$475,352,000	$341,052,000	$37,825,000	$96,475,000
112	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	$446,253,000	$257,130,000	$118,400,000	$70,723,000
113	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$233,064,000	$233,064,000	$0	$0
114	FFP FOR LOCAL TRAUMA CENTERS	$144,174,000	$78,934,500	$0	$65,239,500
115	DPH PHYSICIAN & NON-PHYS. COST	$120,572,000	$120,572,000	$0	$0
116	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	$116,334,000	$66,241,000	($567,000)	$50,660,000
117	CAPITAL PROJECT DEBT REIMBURSEMENT	$87,354,000	$60,924,500	$26,429,500	$0
118	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	$61,315,000	$61,315,000	$0	$0
119	NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS	$52,500,000	$26,250,000	$26,250,000	$0
120	NDPH IGT SUPPLEMENTAL PAYMENTS	$52,164,000	$25,773,000	($1,595,000)	$27,986,000
121	PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS	$45,840,840	$27,247,060	$18,593,780	$0
122	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	$16,326,000	$16,326,000	$0	$0
123	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	$10,000,000	$5,000,000	$5,000,000	$0
124	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	$8,000,000	$4,000,000	$4,000,000	$0
125	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	$5,950,770	$3,385,860	$2,564,910	$0
126	NDPH SUPPLEMENTAL PAYMENT	$4,207,000	$2,307,000	$1,900,000	$0
127	FREE CLINICS AUGMENTATION	$2,000,000	$0	$2,000,000	$0
128	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	$1,002,000	$501,000	$0	$501,000

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2024-25

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	SUPPLEMENTAL PMNTS.				
129	IGT ADMIN. & PROCESSING FEE	$0	$0	($15,360,000)	$15,360,000
130	PROPOSITION 56 FUNDING	$0	$0	($628,655,000)	$628,655,000
131	GEMT SUPPLEMENTAL PAYMENT PROGRAM	($17,708,000)	($17,708,000)	$0	$0
	SUPPLEMENTAL PMNTS. SUBTOTAL	**$13,352,350,690**	**$8,013,019,150**	**$175,703,490**	**$5,163,628,050**
	COVID-19				
132	COVID-19 REDETERMINATIONS IMPACT	$798,398,000	$518,926,950	$279,471,050	$0
133	PHARMACY-BASED COVID-19 TESTS	$6,657,000	$4,495,050	$2,161,950	$0
134	COVID-19 BEHAVIORAL HEALTH	$1,876,000	$1,727,900	$148,100	$0
135	COVID-19 VACCINE FUNDING ADJUSTMENT	$0	$53,539,000	($53,539,000)	$0
137	COVID-19 VACCINES	$0	$0	$0	$0
	COVID-19 SUBTOTAL	**$806,931,000**	**$578,688,900**	**$228,242,100**	**$0**
	STATE-ONLY CLAIMING				
138	STATE-ONLY CLAIMING ADJUSTMENTS - RETRO ADJ.	$0	($439,360,000)	$439,360,000	$0
	STATE-ONLY CLAIMING SUBTOTAL	**$0**	**($439,360,000)**	**$439,360,000**	**$0**
	OTHER DEPARTMENTS				
139	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$791,808,000	$791,808,000	$0	$0
	OTHER DEPARTMENTS SUBTOTAL	**$791,808,000**	**$791,808,000**	**$0**	**$0**
	OTHER				
146	BEHAVIORAL HEALTH BRIDGE HOUSING	$272,087,000	$0	$272,087,000	$0
148	CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY	$70,000,000	$0	$70,000,000	$0
149	MEDICAL PROVIDER INTERIM PAYMENT LOAN REPAYMENT	$310,922,000	$0	$310,922,000	$0
150	QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES	$245,666,000	$208,816,000	$36,850,000	$0
151	CYBHI - EVIDENCE-BASED BH PRACTICES	$219,285,000	$0	$219,285,000	$0
152	SELF-DETERMINATION PROGRAM - CDDS	$202,734,000	$202,734,000	$0	$0
153	HCBS SP CDDS	$431,814,000	$431,814,000	$0	$0
154	CALAIM - PATH WPC	$91,898,000	$48,730,000	$0	$43,168,000
155	CYBHI - URGENT NEEDS AND EMERGENT ISSUES	$44,500,000	$0	$44,500,000	$0
156	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	$98,775,000	$98,775,000	$0	$0
157	MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG	$62,240,000	$0	$0	$62,240,000
158	QAF WITHHOLD TRANSFER	$59,276,000	$29,638,000	$29,638,000	$0
159	CALAIM - PATH FOR CLINICS	$40,000,000	$0	$40,000,000	$0
160	CARE ACT	$36,621,000	$0	$36,621,000	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2024-25

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER				
161	MISC. ONE-TIME PAYMENTS	$31,500,000	$0	$31,500,000	$0
162	INFANT DEVELOPMENT PROGRAM	$23,567,000	$23,567,000	$0	$0
164	CYBHI - CALHOPE STUDENT SUPPORT	$10,475,000	$0	$10,475,000	$0
166	EQUITY & PRACTICE TRANSFORMATION PAYMENTS	$22,592,000	$11,296,000	$11,296,000	$0
167	INDIAN HEALTH SERVICES	$16,984,480	$11,322,990	$5,661,490	$0
168	CALHOPE	$23,602,000	$0	$20,543,000	$3,059,000
169	ABORTION SUPPLEMENTAL PAYMENT PROGRAM	$14,858,000	$0	$14,858,000	$0
170	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	$16,992,000	$9,219,000	$7,773,000	$0
171	CYBHI - FEE SCHEDULE THIRD PARTY ADMINISTRATOR	$10,000,000	$0	$0	$10,000,000
173	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	$7,522,000	$3,385,000	$4,137,000	$0
174	ASSET LIMIT INCREASE & ELIM. - CNTY BH FUNDING	$6,084,000	$0	$6,084,000	$0
175	FOSTER YOUTH SUBSTANCE USE DISORDER GRANT PROGRAM	$0	$0	$0	$0
176	SECTION 19.56 LEGISLATIVE PRIORITIES	$2,357,000	$0	$2,357,000	$0
177	ADVISORY COUNCIL ON PHYS. FIT. & MENTAL WELL-BEING	$1,000,000	$0	$0	$1,000,000
178	WPCS WORKERS' COMPENSATION	$620,000	$310,000	$310,000	$0
180	HCBS SP - CALBRIDGE BH NAVIGATOR PROGRAM	$75,000	$0	$0	$75,000
181	HCBS SP - NON-IHSS CARE ECONOMY PMTS	$70,000	$35,000	$0	$35,000
182	HCBS SP - ETSB FOR LAGUNA HONDA HOSPITAL RESIDENTS	$49,000	$0	$0	$49,000
183	HCBS SP - ALW FUNDING SHIFT	$0	$0	($105,788,000)	$105,788,000
184	HEALTH CARE SVCS. FINES AND PENALTIES	$0	$0	($69,930,000)	$69,930,000
185	IMD ANCILLARY SERVICES	$0	($68,429,000)	$68,429,000	$0
186	HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	$0	($1,283,474,000)	$1,283,474,000
187	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	$0	($126,961,000)	$126,961,000
188	FUNDING ADJUST.—ACA OPT. EXPANSION	$0	$5,414,847,600	($5,414,847,600)	$0
189	FUNDING ADJUST.—OTLICP	$0	$133,038,450	($133,038,450)	$0
190	CCI IHSS RECONCILIATION	$0	($115,000,000)	$115,000,000	$0
191	CMS DEFERRED CLAIMS	$0	($4,000,000)	$4,000,000	$0
192	INDIAN HEALTH SERVICES FUNDING SHIFT	$0	$25,549,500	($25,549,500)	$0
193	DENTAL MANAGED CARE MLR RISK CORRIDOR	($3,000,000)	($1,801,750)	($1,198,250)	$0
194	QUALITY SANCTIONS	($5,549,000)	($3,034,500)	($2,514,500)	$0
195	ASSISTED LIVING WAIVER EXPANSION	($8,222,670)	($3,288,680)	($4,933,980)	$0
196	COUNTY SHARE OF OTLICP-CCS COSTS	($12,456,000)	$0	($12,456,000)	$0
197	HCBA WAIVER EXPANSION	($27,559,750)	($13,724,110)	($13,835,640)	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2024-25

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER				
198	MEDICARE PART A BUY-IN PROGRAM	($41,778,000)	($40,394,000)	($1,384,000)	$0
199	COUNTY BH RECOUPMENTS	($128,319,000)	$0	($128,319,000)	$0
204	L.A. CARE SANCTIONS LEGAL AID GRANTS	$0	$0	$0	$0
	OTHER SUBTOTAL	**$2,147,281,060**	**$6,403,405,490**	**($5,961,903,430)**	**$1,705,779,000**
	GRAND TOTAL	**$47,247,207,380**	**$33,372,597,780**	**($13,274,041,150)**	**$27,148,650,750**

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

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
FISCAL YEAR 2024-25

SERVICE CATEGORY	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
PROFESSIONAL	$10,237,665,850	$5,491,907,720	$3,592,446,540	$1,153,311,590
PHYSICIANS	$714,937,290	$347,950,750	$297,647,430	$69,339,120
OTHER MEDICAL	$7,255,837,180	$3,979,751,010	$3,090,232,230	$185,853,940
CO. & COMM. OUTPATIENT	$2,266,891,380	$1,164,205,970	$204,566,880	$898,118,530
PHARMACY	$14,759,092,100	$6,688,325,240	$5,763,922,930	$2,306,843,940
HOSPITAL INPATIENT	$10,729,148,030	$6,343,145,650	$1,469,687,100	$2,916,315,290
COUNTY INPATIENT	$3,611,606,970	$2,160,086,870	($2,106,190)	$1,453,626,290
COMMUNITY INPATIENT	$7,117,541,070	$4,183,058,780	$1,471,793,290	$1,462,689,000
LONG TERM CARE	$1,038,076,780	$571,588,990	$446,986,590	$19,501,200
NURSING FACILITIES	$978,183,340	$540,583,050	$419,095,740	$18,504,550
ICF-DD	$59,893,440	$31,005,940	$27,890,850	$996,650
OTHER SERVICES	$2,788,092,800	$1,968,814,490	$687,680,720	$131,597,590
MEDICAL TRANSPORTATION	$47,289,850	$20,454,600	$26,108,130	$727,120
OTHER SERVICES	$2,625,343,960	$1,896,704,260	$599,309,110	$129,330,590
HOME HEALTH	$115,458,990	$51,655,630	$62,263,480	$1,539,870
TOTAL FEE-FOR-SERVICE	**$39,552,075,570**	**$21,063,782,090**	**$11,960,723,880**	**$6,527,569,600**
MANAGED CARE	$89,963,616,850	$54,562,164,290	$15,173,304,550	$20,228,148,000
TWO PLAN MODEL	$50,571,750,680	$30,626,564,710	$8,301,631,230	$11,643,554,740
COUNTY ORGANIZED HEALTH SYSTEMS	$26,431,181,930	$16,077,254,810	$4,197,684,440	$6,156,242,690
GEOGRAPHIC MANAGED CARE	$10,244,976,030	$6,368,447,430	$1,607,557,170	$2,268,971,430
PHP & OTHER MANAG. CARE	$2,032,739,560	$1,036,577,090	$977,757,180	$18,405,290
REGIONAL MODEL	$682,968,650	$453,320,250	$88,674,540	$140,973,860
DENTAL	$2,230,841,840	$1,055,037,970	$1,095,008,380	$80,795,480
MENTAL HEALTH	$6,397,579,580	$3,818,574,780	$222,826,970	$2,356,177,830
AUDITS/ LAWSUITS	$8,767,990	$522,000	$8,246,000	$0
EPSDT SCREENS	$0	$0	$0	$0
MEDICARE PAYMENTS	$8,309,695,000	$1,948,353,000	$6,361,342,000	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$18,440,000	$18,440,000	$0	$0
MISC. SERVICES	$20,166,036,000	$18,473,653,000	$1,546,374,810	$146,008,190
RECOVERIES	($892,354,000)	($532,710,650)	($359,643,350)	$0
DRUG MEDI-CAL	$1,247,848,120	$957,602,580	$176,645,890	$113,599,650
GRAND TOTAL MEDI-CAL	**$167,002,546,930**	**$101,365,419,050**	**$36,184,829,140**	**$29,452,298,750**

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
NOVEMBER 2024 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2024-25

SERVICE CATEGORY	2024-25 APPROPRIATION	NOV. 2024 EST. FOR 2024-25	DOLLAR DIFFERENCE	% CHANGE
PROFESSIONAL	$9,448,035,200	$10,237,665,850	$789,630,660	8.36%
PHYSICIANS	$718,911,300	$714,937,290	($3,974,010)	-0.55%
OTHER MEDICAL	$6,446,969,170	$7,255,837,180	$808,868,010	12.55%
CO. & COMM. OUTPATIENT	$2,282,154,720	$2,266,891,380	($15,263,340)	-0.67%
PHARMACY	$13,657,729,420	$14,759,092,100	$1,101,362,690	8.06%
HOSPITAL INPATIENT	$10,919,841,930	$10,729,148,030	($190,693,900)	-1.75%
COUNTY INPATIENT	$3,639,023,050	$3,611,606,970	($27,416,080)	-0.75%
COMMUNITY INPATIENT	$7,280,818,880	$7,117,541,070	($163,277,820)	-2.24%
LONG TERM CARE	$1,118,012,140	$1,038,076,780	($79,935,360)	-7.15%
NURSING FACILITIES	$865,427,250	$978,183,340	$112,756,090	13.03%
ICF-DD	$252,584,890	$59,893,440	($192,691,450)	-76.29%
OTHER SERVICES	$2,911,390,990	$2,788,092,800	($123,298,190)	-4.24%
MEDICAL TRANSPORTATION	$51,412,070	$47,289,850	($4,122,220)	-8.02%
OTHER SERVICES	$2,723,890,830	$2,625,343,960	($98,546,870)	-3.62%
HOME HEALTH	$136,088,090	$115,458,990	($20,629,100)	-15.16%
TOTAL FEE-FOR-SERVICE	**$38,055,009,680**	**$39,552,075,570**	**$1,497,065,890**	**3.93%**
MANAGED CARE	$82,670,057,540	$89,963,616,850	$7,293,559,310	8.82%
TWO PLAN MODEL	$45,722,338,460	$50,571,750,680	$4,849,412,220	10.61%
COUNTY ORGANIZED HEALTH SYSTEMS	$23,295,389,870	$26,431,181,930	$3,135,792,060	13.46%
GEOGRAPHIC MANAGED CARE	$9,078,964,160	$10,244,976,030	$1,166,011,870	12.84%
PHP & OTHER MANAG. CARE	$1,967,547,690	$2,032,739,560	$65,191,860	3.31%
REGIONAL MODEL	$2,605,817,350	$682,968,650	($1,922,848,710)	-73.79%
DENTAL	$2,263,255,660	$2,230,841,840	($32,413,830)	-1.43%
MENTAL HEALTH	$4,219,337,880	$6,397,579,580	$2,178,241,700	51.63%
AUDITS/ LAWSUITS	$1,350,000	$8,767,990	$7,417,990	549.48%
MEDICARE PAYMENTS	$8,155,626,000	$8,309,695,000	$154,069,000	1.89%
STATE HOSP./DEVELOPMENTAL CNTRS.	$17,550,000	$18,440,000	$890,000	5.07%
MISC. SERVICES	$18,293,007,000	$20,166,036,000	$1,873,029,000	10.24%
RECOVERIES	($790,698,000)	($892,354,000)	($101,656,000)	12.86%
DRUG MEDI-CAL	$801,644,910	$1,247,848,120	$446,203,210	55.66%
GRAND TOTAL MEDI-CAL	**$153,686,140,660**	**$167,002,546,930**	**$13,316,406,270**	**8.66%**
GENERAL FUNDS	**$33,384,085,120**	**$36,184,829,140**	**$2,800,744,010**	**8.39%**
OTHER STATE FUNDS	**$27,357,277,990**	**$29,452,298,750**	**$2,095,020,750**	**7.66%**

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2024 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2024-25

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2024-25 APPROPRIATION		NOV. 2024 EST. FOR 2024-25		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		ELIGIBILITY						
7	1	CALAIM - INMATE PRE-RELEASE PROGRAM	$47,916,000	$16,291,000	$48,758,000	$16,578,000	$842,000	$287,000
3	2	MEDI-CAL STATE INMATE PROGRAMS	$39,011,000	$0	$38,066,000	$0	($945,000)	$0
4	3	BREAST AND CERVICAL CANCER TREATMENT	$27,366,000	$10,590,200	$19,736,000	$9,491,400	($7,630,000)	($1,098,800)
6	4	HEALTH ENROLLMENT NAVIGATORS FOR CLINICS	$16,000,000	$8,000,000	$7,490,000	$3,745,000	($8,510,000)	($4,255,000)
9	6	NON-OTLICP CHIP	$0	($116,491,200)	$0	($106,656,300)	$0	$9,834,900
10	7	NON-EMERGENCY FUNDING ADJUSTMENT	$0	$1,808,385,200	$0	$3,054,378,750	$0	$1,245,993,550
11	8	SCHIP FUNDING FOR PRENATAL CARE	$0	($78,715,650)	$0	($70,822,050)	$0	$7,893,600
12	9	MEDI-CAL COUNTY INMATE REIMBURSEMENT	$0	($1,660,000)	$0	($1,703,000)	$0	($43,000)
13	10	CS3 PROXY ADJUSTMENT	$0	($66,125,000)	$0	($67,383,500)	$0	($1,258,500)
8	11	REFUGEE MEDICAL ASSISTANCE	$0	($120,000)	$0	($346,000)	$0	($226,000)
--	201	SB 525 MINIMUM WAGE - CASELOAD IMPACT	$0	$0	($79,031,000)	($31,612,300)	($79,031,000)	($31,612,300)
1	--	UNDOCUMENTED EXPANSION AGES 26 THROUGH 49	$3,237,627,000	$2,827,769,000	$0	$0	($3,237,627,000)	($2,827,769,000)
2	--	POSTPARTUM CARE EXTENSION	$275,635,000	$136,472,000	$0	$0	($275,635,000)	($136,472,000)
5	--	PHASING IN THE MEDI-CAL ASSET LIMIT REPEAL	$227,230,000	$113,615,000	$0	$0	($227,230,000)	($113,615,000)
		ELIGIBILITY SUBTOTAL	**$3,870,785,000**	**$4,658,010,550**	**$35,019,000**	**$2,805,670,000**	**($3,835,766,000)**	**($1,852,340,550)**
		AFFORDABLE CARE ACT						
14	12	COMMUNITY FIRST CHOICE OPTION	$8,659,979,000	$0	$9,133,032,000	$0	$473,053,000	$0
15	13	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	$16,368,000	$0	$18,208,000	$0	$1,840,000	$0
16	14	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	($6,037,000)	$0	($5,393,000)	$0	$644,000
17	15	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	$0	($34,793,600)	$0	($33,933,400)	$0	$860,200
18	16	ACA DSH REDUCTION	($1,315,465,000)	($197,788,000)	($1,475,611,000)	($198,074,000)	($160,146,000)	($286,000)

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2024 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2024-25

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2024-25 APPROPRIATION		NOV. 2024 EST. FOR 2024-25		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		AFFORDABLE CARE ACT SUBTOTAL	**$7,360,882,000**	**($238,618,600)**	**$7,675,629,000**	**($237,400,400)**	**$314,747,000**	**$1,218,200**
		BENEFITS						
19	17	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$977,075,000	$0	$954,239,000	$0	($22,836,000)	$0
20	18	FAMILY PACT PROGRAM	$180,864,000	$43,918,600	$141,858,000	$34,715,500	($39,006,000)	($9,203,100)
22	19	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$65,024,000	$13,074,000	$101,991,000	$41,761,500	$36,967,000	$28,687,500
21	20	MULTIPURPOSE SENIOR SERVICES PROGRAM	$63,951,000	$31,975,500	$63,951,000	$31,975,500	$0	$0
23	21	BEHAVIORAL HEALTH TREATMENT	$13,319,000	$6,316,450	$19,392,000	$9,696,000	$6,073,000	$3,379,550
222	22	CYBHI WELLNESS COACH BENEFIT	$9,513,000	$4,123,450	$12,687,000	$5,501,500	$3,174,000	$1,378,050
25	23	MEDICAL INTERPRETER PILOT PROJECT	$923,000	$923,000	$0	$0	($923,000)	($923,000)
27	24	HEARING AID COVERAGE FOR CHILDREN PROGRAM	$1,615,000	$1,615,000	$654,000	$654,000	($961,000)	($961,000)
28	25	CCT FUND TRANSFER TO CDSS	$106,000	$0	$65,000	$0	($41,000)	$0
24	--	CYBHI - DYADIC SERVICES	$140,579,000	$55,717,050	$0	$0	($140,579,000)	($55,717,050)
29	--	DOULA BENEFIT	$1,130,000	$457,300	$0	$0	($1,130,000)	($457,300)
229	--	BIOMARKER TESTING	$25,190,000	$9,061,550	$0	$0	($25,190,000)	($9,061,550)
230	--	PHARMACOGENOMIC TESTING	$18,000,000	$6,474,900	$0	$0	($18,000,000)	($6,474,900)
		BENEFITS SUBTOTAL	**$1,497,289,000**	**$173,656,800**	**$1,294,837,000**	**$124,304,000**	**($202,452,000)**	**($49,352,800)**
		PHARMACY						
223	26	RESPIRATORY SYNCYTIAL VIRUS VACCINES	$205,424,000	$90,740,300	$214,043,000	$95,198,850	$8,619,000	$4,458,550
38	27	PHARMACY RETROACTIVE ADJUSTMENTS	$0	$48,859,000	$11,000,000	$43,763,200	$11,000,000	($5,095,800)
33	28	MEDICATION THERAPY MANAGEMENT PROGRAM	$2,407,000	$781,750	$144,000	$45,250	($2,263,000)	($736,500)
34	29	MEDI-CAL DRUG REBATE FUND	$0	($2,258,631,000)	$0	($2,095,877,000)	$0	$162,754,000

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2024 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2024-25

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2024-25 APPROPRIATION		NOV. 2024 EST. FOR 2024-25		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		PHARMACY						
--	30	LITIGATION SETTLEMENTS	$0	$0	($276,000)	($276,000)	($276,000)	($276,000)
36	31	BCCTP DRUG REBATES	($3,877,000)	$0	($2,251,000)	$0	$1,626,000	$0
37	32	FAMILY PACT DRUG REBATES	($2,373,000)	$0	($2,284,000)	$0	$89,000	$0
39	33	MEDICAL SUPPLY REBATES	($130,500,000)	($65,250,000)	($188,800,000)	($94,400,000)	($58,300,000)	($29,150,000)
40	34	STATE SUPPLEMENTAL DRUG REBATES	($208,996,000)	$0	($403,519,000)	$0	($194,523,000)	$0
41	35	FEDERAL DRUG REBATES	($4,155,992,000)	$0	($4,397,108,000)	$0	($241,116,000)	$0
		PHARMACY SUBTOTAL	**($4,293,907,000)**	**($2,183,499,950)**	**($4,769,051,000)**	**($2,051,545,700)**	**($475,144,000)**	**$131,954,250**
		DRUG MEDI-CAL						
43	37	HCBS SP - CONTINGENCY MANAGEMENT	$61,077,000	$0	$35,085,000	$0	($25,992,000)	$0
44	39	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	$20,496,000	$1,289,750	$20,290,000	$1,495,450	($206,000)	$205,700
46	40	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	($463,000)	($37,000)	$927,000	$108,000	$1,390,000	$145,000
		DRUG MEDI-CAL SUBTOTAL	**$81,110,000**	**$1,252,750**	**$56,302,000**	**$1,603,450**	**($24,808,000)**	**$350,700**
		MENTAL HEALTH						
49	43	BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE	$326,135,000	$326,135,000	$530,635,000	$350,135,000	$204,500,000	$24,000,000
50	44	MHP COSTS FOR FFPSA	$41,019,000	$10,178,000	$60,616,000	$14,983,000	$19,597,000	$4,805,000
54	45	CALAIM - BH - CONNECT DEMONSTRATION	$39,043,000	$655,000	$29,593,000	$655,000	($9,450,000)	$0
52	46	MHP COSTS FOR CONTINUUM OF CARE REFORM	$3,919,000	$2,843,050	$3,970,000	$2,867,350	$51,000	$24,300
53	47	OUT OF STATE YOUTH - SMHS	$2,163,000	$1,081,500	$1,070,000	$535,000	($1,093,000)	($546,500)
55	49	SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS	$0	$159,000	$0	$141,000	$0	($18,000)
56	50	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	$0	($200,000)	$0	($200,000)	$0	$0

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2024 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2024-25

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2024-25 APPROPRIATION		NOV. 2024 EST. FOR 2024-25		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		MENTAL HEALTH						
58	51	INTERIM AND FINAL COST SETTLEMENTS - SMHS	($327,060,000)	$174,000	($588,782,000)	$1,932,000	($261,722,000)	$1,758,000
57	--	CHART REVIEW	($14,000)	$0	$0	$0	$14,000	$0
242	--	BEHAVIORAL HEALTH CONTINUUM INFRA. REDUCTION	($70,000,000)	($70,000,000)	$0	$0	$70,000,000	$70,000,000
		MENTAL HEALTH SUBTOTAL	**$15,205,000**	**$271,025,550**	**$37,102,000**	**$371,048,350**	**$21,897,000**	**$100,022,800**
		WAIVER--MH/UCD & BTR						
59	52	GLOBAL PAYMENT PROGRAM	$2,851,787,000	$0	$2,936,500,000	$0	$84,713,000	$0
60	53	CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES	$1,385,743,000	$560,920,500	$1,709,080,000	$729,048,800	$323,337,000	$168,128,300
61	54	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	$586,000	$0	$534,000	$0	($52,000)	$0
225	55	ENHANCED CARE MANAGEMENT RISK CORRIDOR	($45,359,000)	($18,508,300)	($195,602,000)	($79,813,300)	($150,243,000)	($61,305,000)
		WAIVER--MH/UCD & BTR SUBTOTAL	**$4,192,757,000**	**$542,412,200**	**$4,450,512,000**	**$649,235,500**	**$257,755,000**	**$106,823,300**
		MANAGED CARE						
66	58	2023 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	$9,914,615,000	$3,967,767,050	$14,095,818,000	$5,638,327,150	$4,181,203,000	$1,670,560,100
68	60	MANAGED CARE HEALTH CARE FINANCING PROGRAM	$2,581,510,000	$911,968,500	$2,622,195,000	$886,614,050	$40,685,000	($25,354,450)
69	61	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	$2,232,379,000	$609,954,100	$2,232,379,000	$610,214,500	$0	$260,400
71	62	MANAGED CARE PUBLIC HOSPITAL EPP	$1,913,968,000	$552,676,650	$1,944,701,000	$557,915,700	$30,733,000	$5,239,050
75	64	WORKFORCE & QUALITY INCENTIVE PROGRAM	$291,505,000	$145,342,050	$297,468,000	$148,777,250	$5,963,000	$3,435,200
79	65	MANAGED CARE PUBLIC DP-NF PASS-THROUGH PYMT PROG	$113,102,000	$52,624,900	$281,681,000	$133,563,300	$168,579,000	$80,938,400
88	68	MANAGED CARE DISTRICT HOSPITAL DIRECTED PAYMENTS	$100,000,000	$0	$100,000,000	$0	$0	$0

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2024 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2024-25

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2024-25 APPROPRIATION		NOV. 2024 EST. FOR 2024-25		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		MANAGED CARE						
77	70	CYBHI - STUDENT BH INCENTIVE PROGRAM	$85,422,000	$42,711,000	$94,202,000	$47,101,000	$8,780,000	$4,390,000
--	71	NON-HOSPITAL 340B CLINIC DIRECTED PAYMENTS	$0	$0	$43,750,000	$21,875,000	$43,750,000	$21,875,000
81	73	CCI-QUALITY WITHHOLD REPAYMENTS	$13,886,000	$6,943,000	$13,886,000	$6,943,000	$0	$0
89	81	2023 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	$0	($3,960,627,000)	$0	($5,638,327,000)	$0	($1,677,700,000)
90	82	2023 MCO ENROLLMENT TAX MANAGED CARE PLANS	$0	($4,636,914,000)	$0	($7,941,724,000)	$0	($3,304,810,000)
91	83	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	$0	($2,242,642,000)	$0	($2,268,062,000)	$0	($25,420,000)
92	84	COORDINATED CARE INITIATIVE RISK MITIGATION	($111,260,000)	($55,630,000)	($27,380,000)	($13,690,000)	$83,880,000	$41,940,000
93	85	PROP 56 - DIRECTED PAYMENT RISK MITIGATION	($600,000,000)	($181,601,400)	($600,000,000)	($181,601,400)	$0	$0
74	86	RETRO MC RATE ADJUSTMENTS	($131,323,000)	($35,873,900)	($1,169,110,000)	($787,659,100)	($1,037,787,000)	($751,785,200)
--	202	HCBS SP - HOUSING AND HOMELESSNESS INCENTIVE PROG	$0	$0	$1,838,000	$0	$1,838,000	$0
87	--	CAPITATED RATE ADJUSTMENT FOR FY 2024-25	$1,388,691,000	$538,849,050	$0	$0	($1,388,691,000)	($538,849,050)
239	--	CHILDREN'S HOSPITAL DIRECTED PAYMENT	$230,000,000	$115,000,000	$0	$0	($230,000,000)	($115,000,000)
249	--	2023 MCO TAX AMENDMENT - MEDICARE	$1,494,859,000	($1,769,600,000)	$0	$0	($1,494,859,000)	$1,769,600,000
250	--	2023 MCO TAX - GENERAL FUND OFFSET	$0	($509,600,000)	$0	$0	$0	$509,600,000
		MANAGED CARE SUBTOTAL	**$19,517,354,000**	**($6,448,652,000)**	**$19,931,428,000**	**($8,779,732,550)**	**$414,074,000**	**($2,331,080,550)**
		PROVIDER RATES						
94	87	RATE INCREASE FOR FQHCS/RHCS/CBRCS	$483,520,000	$176,015,850	$653,011,000	$235,344,650	$169,491,000	$59,328,800
96	88	PP-GEMT IGT PROGRAM	$228,545,000	($7,385,000)	$321,745,000	$0	$93,200,000	$7,385,000
226	89	MEDI-CAL PROVIDER PAYMENT INCREASES 2025 & LATER	$273,800,000	$133,400,000	$153,980,000	$61,592,000	($119,820,000)	($71,808,000)

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2024 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2024-25

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2024-25 APPROPRIATION		NOV. 2024 EST. FOR 2024-25		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		PROVIDER RATES						
101	90	DPH INTERIM & FINAL RECONS	$152,574,000	$0	$208,277,000	$0	$55,703,000	$0
99	91	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	$129,912,000	($6,105,000)	$161,216,000	($26,000,000)	$31,304,000	($19,895,000)
100	92	FQHC/RHC/CBRC RECONCILIATION PROCESS	$129,288,000	$47,064,850	$128,915,000	$46,460,900	($373,000)	($603,950)
98	93	NURSING FACILITY RATE ADJUSTMENTS	$778,812,000	$369,156,800	$763,290,000	$361,799,400	($15,522,000)	($7,357,400)
105	94	LTC RATE ADJUSTMENT	$153,101,000	$74,092,450	$207,853,000	$99,686,200	$54,752,000	$25,593,750
107	95	HOSPICE RATE INCREASES	$3,694,000	$1,693,100	$14,142,000	$5,623,850	$10,448,000	$3,930,750
97	96	MEDI-CAL PROVIDER PAYMENT INCREASE	$727,000,000	$291,000,000	$727,000,000	$291,000,000	$0	$0
106	97	GDSP NBS & PNS FEE ADJUSTMENTS	$7,106,000	$2,794,750	$5,543,000	$2,178,900	($1,563,000)	($615,850)
109	100	DPH INTERIM RATE	$0	($403,982,800)	$0	($347,999,700)	$0	$55,983,100
110	101	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	$0	($571,142,000)	$0	($604,900,000)	$0	($33,758,000)
95	102	MEDI-CAL PROVIDER PAYMENT RESERVE FUND	$17,600,000	($424,400,000)	$0	($166,449,000)	($17,600,000)	$257,951,000
111	103	REDUCTION TO RADIOLOGY RATES	($5,616,000)	($2,304,250)	($1,678,000)	($739,900)	$3,938,000	$1,564,350
113	104	LABORATORY RATE METHODOLOGY CHANGE	($14,148,000)	($6,025,250)	($14,148,000)	($6,001,300)	$0	$23,950
--	203	PROP 35 - PROVIDER PAYMENT INCREASE FUNDING	$0	$0	$0	($186,143,000)	$0	($186,143,000)
103	--	AB 97 ELIMINATIONS	$28,423,000	$11,028,400	$0	$0	($28,423,000)	($11,028,400)
104	--	DPH INTERIM RATE GROWTH	$36,505,000	$11,838,100	$0	$0	($36,505,000)	($11,838,100)
108	--	ACUPUNCTURE RATE INCREASE	$27,487,000	$8,320,300	$0	$0	($27,487,000)	($8,320,300)
112	--	GDSP PRENATAL SCREENING PROGRAM FEE INCREASE	$3,953,000	$1,550,050	$0	$0	($3,953,000)	($1,550,050)
		PROVIDER RATES SUBTOTAL	**$3,161,556,000**	**($293,389,650)**	**$3,329,146,000**	**($234,547,000)**	**$167,590,000**	**$58,842,650**
		SUPPLEMENTAL PMNTS.						
114	105	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	$4,550,530,000	$0	$4,550,530,000	$0	$0	$0

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2024 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2024-25

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2024-25 APPROPRIATION		NOV. 2024 EST. FOR 2024-25		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		SUPPLEMENTAL PMNTS.						
116	106	HOSPITAL QAF - FFS PAYMENTS	$3,530,277,000	$0	$3,530,277,000	$0	$0	$0
115	107	HOSPITAL QAF - MANAGED CARE PAYMENTS	$1,297,400,000	$0	$1,297,400,000	$0	$0	$0
118	108	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	$617,141,000	$0	$850,473,000	$0	$233,332,000	$0
119	109	PRIVATE HOSPITAL DSH REPLACEMENT	$741,620,000	$370,810,000	$746,417,000	$373,039,500	$4,797,000	$2,229,500
121	110	PROP 56 - MEDI-CAL FAMILY PLANNING	$475,066,000	$189,857,800	$528,133,000	$212,135,800	$53,067,000	$22,278,000
122	111	DSH PAYMENT	$475,536,000	$37,919,000	$475,352,000	$37,825,000	($184,000)	($94,000)
120	112	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	$459,628,000	$118,400,000	$446,253,000	$118,400,000	($13,375,000)	$0
123	113	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$268,834,000	$0	$233,064,000	$0	($35,770,000)	$0
124	114	FFP FOR LOCAL TRAUMA CENTERS	$181,100,000	$0	$144,174,000	$0	($36,926,000)	$0
126	115	DPH PHYSICIAN & NON-PHYS. COST	$113,787,000	$0	$120,572,000	$0	$6,785,000	$0
125	116	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	$115,149,000	($467,000)	$116,334,000	($567,000)	$1,185,000	($100,000)
129	117	CAPITAL PROJECT DEBT REIMBURSEMENT	$89,640,000	$27,332,000	$87,354,000	$26,429,500	($2,286,000)	($902,500)
131	118	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	$31,097,000	$0	$61,315,000	$0	$30,218,000	$0
128	119	NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS	$105,000,000	$52,500,000	$52,500,000	$26,250,000	($52,500,000)	($26,250,000)
127	120	NDPH IGT SUPPLEMENTAL PAYMENTS	$36,709,000	($1,285,000)	$52,164,000	($1,595,000)	$15,455,000	($310,000)
130	121	PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS	$805,331,000	$324,517,050	$788,999,000	$320,030,700	($16,332,000)	($4,486,350)
132	122	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	$21,251,000	$0	$16,326,000	$0	($4,925,000)	$0
134	123	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	$10,000,000	$5,000,000	$10,000,000	$5,000,000	$0	$0
136	124	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	$8,000,000	$4,000,000	$8,000,000	$4,000,000	$0	$0
137	125	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	$58,433,000	$24,649,000	$56,728,000	$24,451,000	($1,705,000)	($198,000)

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2024 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2024-25

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2024-25 APPROPRIATION		NOV. 2024 EST. FOR 2024-25		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		SUPPLEMENTAL PMNTS.						
138	126	NDPH SUPPLEMENTAL PAYMENT	$14,826,000	$1,900,000	$4,207,000	$1,900,000	($10,619,000)	$0
140	127	FREE CLINICS AUGMENTATION	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$0	$0
139	128	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	$1,002,000	$0	$1,002,000	$0	$0	$0
141	129	IGT ADMIN. & PROCESSING FEE	$0	($12,946,000)	$0	($15,360,000)	$0	($2,414,000)
142	130	PROPOSITION 56 FUNDING	$0	($738,947,000)	$0	($628,655,000)	$0	$110,292,000
133	131	GEMT SUPPLEMENTAL PAYMENT PROGRAM	($15,499,000)	$0	($17,708,000)	$0	($2,209,000)	$0
117	--	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	$1,228,135,000	$522,631,650	$0	$0	($1,228,135,000)	($522,631,650)
231	--	PROP 56 - FUNDING REDUCTION	($193,405,000)	($77,107,000)	$0	$0	$193,405,000	$77,107,000
246	--	IGT ADMIN FEE FOR THE EPP AND QIP	($37,000,000)	($37,000,000)	$0	$0	$37,000,000	$37,000,000
		SUPPLEMENTAL PMNTS. SUBTOTAL	**$14,991,588,000**	**$813,764,500**	**$14,161,866,000**	**$505,284,500**	**($829,722,000)**	**($308,480,000)**
		COVID-19						
150	132	COVID-19 REDETERMINATIONS IMPACT	($2,701,547,000)	($961,823,350)	$798,398,000	$279,471,050	$3,499,945,000	$1,241,294,400
145	133	PHARMACY-BASED COVID-19 TESTS	$14,843,000	$4,819,950	$6,657,000	$2,161,950	($8,186,000)	($2,658,000)
144	134	COVID-19 BEHAVIORAL HEALTH	$973,000	$69,700	$1,876,000	$148,100	$903,000	$78,400
146	135	COVID-19 VACCINE FUNDING ADJUSTMENT	$0	($18,966,000)	$0	($53,539,000)	$0	($34,573,000)
143	137	COVID-19 VACCINES	$173,480,000	$62,341,400	$130,536,000	$46,574,250	($42,944,000)	($15,767,150)
147	--	CONTINUOUS CHIP COVERAGE DURING THE COVID-19 PHE	$0	$54,318,000	$0	$0	$0	($54,318,000)
149	--	COVID-19 INCREASED FMAP - DHCS	$0	($30,745,000)	$0	$0	$0	$30,745,000
		COVID-19 SUBTOTAL	**($2,512,251,000)**	**($889,985,300)**	**$937,467,000**	**$274,816,350**	**$3,449,718,000**	**$1,164,801,650**
		STATE-ONLY CLAIMING						
151	138	STATE-ONLY CLAIMING ADJUSTMENTS - RETRO ADJ.	$0	$205,222,000	$0	$439,360,000	$0	$234,138,000
		STATE-ONLY CLAIMING SUBTOTAL	**$0**	**$205,222,000**	**$0**	**$439,360,000**	**$0**	**$234,138,000**

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2024 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2024-25

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2024-25 APPROPRIATION		NOV. 2024 EST. FOR 2024-25		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER DEPARTMENTS						
152	139	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$698,591,000	$0	$791,808,000	$0	$93,217,000	$0
		OTHER DEPARTMENTS SUBTOTAL	**$698,591,000**	**$0**	**$791,808,000**	**$0**	**$93,217,000**	**$0**
		OTHER						
159	146	BEHAVIORAL HEALTH BRIDGE HOUSING	$456,587,000	$456,587,000	$272,087,000	$272,087,000	($184,500,000)	($184,500,000)
161	148	CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY	$450,000,000	$450,000,000	$70,000,000	$70,000,000	($380,000,000)	($380,000,000)
--	149	MEDICAL PROVIDER INTERIM PAYMENT LOAN REPAYMENT	$0	$0	$310,922,000	$310,922,000	$310,922,000	$310,922,000
164	150	QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES	$248,139,000	$37,221,000	$245,666,000	$36,850,000	($2,473,000)	($371,000)
163	151	CYBHI - EVIDENCE-BASED BH PRACTICES	$248,994,000	$248,994,000	$219,285,000	$219,285,000	($29,709,000)	($29,709,000)
165	152	SELF-DETERMINATION PROGRAM - CDDS	$171,314,000	$0	$202,734,000	$0	$31,420,000	$0
158	153	HCBS SP CDDS	$105,028,000	$0	$431,814,000	$0	$326,786,000	$0
169	154	CALAIM - PATH WPC	$43,772,000	$0	$91,898,000	$0	$48,126,000	$0
167	155	CYBHI - URGENT NEEDS AND EMERGENT ISSUES	$69,800,000	$69,800,000	$44,500,000	$44,500,000	($25,300,000)	($25,300,000)
173	156	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	$63,843,000	$0	$98,775,000	$0	$34,932,000	$0
174	157	MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG	$63,259,000	$0	$62,240,000	$0	($1,019,000)	$0
195	158	QAF WITHHOLD TRANSFER	$45,930,000	$22,965,000	$59,276,000	$29,638,000	$13,346,000	$6,673,000
--	159	CALAIM - PATH FOR CLINICS	$0	$0	$40,000,000	$40,000,000	$40,000,000	$40,000,000
180	160	CARE ACT	$37,837,000	$37,837,000	$36,621,000	$36,621,000	($1,216,000)	($1,216,000)
--	161	MISC. ONE-TIME PAYMENTS	$0	$0	$31,500,000	$31,500,000	$31,500,000	$31,500,000
184	162	INFANT DEVELOPMENT PROGRAM	$20,654,000	$0	$23,567,000	$0	$2,913,000	$0

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2024 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2024-25

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2024-25 APPROPRIATION		NOV. 2024 EST. FOR 2024-25		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER						
181	164	CYBHI - CALHOPE STUDENT SUPPORT	$978,000	$978,000	$10,475,000	$10,475,000	$9,497,000	$9,497,000
172	166	EQUITY & PRACTICE TRANSFORMATION PAYMENTS	$135,000,000	$67,500,000	$22,592,000	$11,296,000	($112,408,000)	($56,204,000)
178	167	INDIAN HEALTH SERVICES	$29,849,000	$9,949,500	$18,726,000	$6,242,000	($11,123,000)	($3,707,500)
175	168	CALHOPE	$16,830,000	$4,411,000	$23,602,000	$20,543,000	$6,772,000	$16,132,000
185	169	ABORTION SUPPLEMENTAL PAYMENT PROGRAM	$11,144,000	$11,144,000	$14,858,000	$14,858,000	$3,714,000	$3,714,000
190	170	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	$11,061,000	$5,054,000	$16,992,000	$7,773,000	$5,931,000	$2,719,000
191	171	CYBHI - FEE SCHEDULE THIRD PARTY ADMINISTRATOR	$7,333,000	$0	$10,000,000	$0	$2,667,000	$0
186	173	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	$84,446,000	$48,573,000	$7,522,000	$4,137,000	($76,924,000)	($44,436,000)
220	174	ASSET LIMIT INCREASE & ELIM. - CNTY BH FUNDING	$6,084,000	$6,084,000	$6,084,000	$6,084,000	$0	$0
192	175	FOSTER YOUTH SUBSTANCE USE DISORDER GRANT PROGRAM	$2,500,000	$2,500,000	$0	$0	($2,500,000)	($2,500,000)
--	176	SECTION 19.56 LEGISLATIVE PRIORITIES	$0	$0	$2,357,000	$2,357,000	$2,357,000	$2,357,000
219	177	ADVISORY COUNCIL ON PHYS. FIT. & MENTAL WELL-BEING	$1,000,000	$0	$1,000,000	$0	$0	$0
198	178	WPCS WORKERS' COMPENSATION	$620,000	$310,000	$620,000	$310,000	$0	$0
196	180	HCBS SP - CALBRIDGE BH NAVIGATOR PROGRAM	$90,000	$0	$75,000	$0	($15,000)	$0
--	181	HCBS SP - NON-IHSS CARE ECONOMY PMTS	$0	$0	$70,000	$0	$70,000	$0
--	182	HCBS SP - ETSB FOR LAGUNA HONDA HOSPITAL RESIDENTS	$0	$0	$49,000	$0	$49,000	$0
203	183	HCBS SP - ALW FUNDING SHIFT	$0	($46,313,000)	$0	($105,788,000)	$0	($59,475,000)
244	184	HEALTH CARE SVCS. FINES AND PENALTIES	$0	($78,891,000)	$0	($69,930,000)	$0	$8,961,000
205	185	IMD ANCILLARY SERVICES	$0	$62,004,000	$0	$68,429,000	$0	$6,425,000
209	186	HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	($1,261,900,000)	$0	($1,283,474,000)	$0	($21,574,000)

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2024 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2024-25

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2024-25 APPROPRIATION		NOV. 2024 EST. FOR 2024-25		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER						
206	187	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	($125,167,000)	$0	($126,961,000)	$0	($1,794,000)
207	188	FUNDING ADJUST.—ACA OPT. EXPANSION	$0	($4,774,097,200)	$0	($5,414,847,600)	$0	($640,750,400)
208	189	FUNDING ADJUST.—OTLICP	$0	($117,735,300)	$0	($133,038,450)	$0	($15,303,150)
--	190	CCI IHSS RECONCILIATION	$0	$0	$0	$115,000,000	$0	$115,000,000
210	191	CMS DEFERRED CLAIMS	$0	($23,127,000)	$0	$4,000,000	$0	$27,127,000
211	192	INDIAN HEALTH SERVICES FUNDING SHIFT	$0	($32,312,500)	$0	($25,549,500)	$0	$6,763,000
--	193	DENTAL MANAGED CARE MLR RISK CORRIDOR	$0	$0	($3,000,000)	($1,198,250)	($3,000,000)	($1,198,250)
--	194	QUALITY SANCTIONS	$0	$0	($5,549,000)	($2,514,500)	($5,549,000)	($2,514,500)
171	195	ASSISTED LIVING WAIVER EXPANSION	$187,971,000	$108,120,000	($8,576,000)	($5,146,000)	($196,547,000)	($113,266,000)
214	196	COUNTY SHARE OF OTLICP-CCS COSTS	($13,232,000)	($13,232,000)	($12,456,000)	($12,456,000)	$776,000	$776,000
166	197	HCBA WAIVER EXPANSION	$385,175,000	$221,551,000	($29,901,000)	($15,011,000)	($415,076,000)	($236,562,000)
227	198	MEDICARE PART A BUY-IN PROGRAM	($41,415,000)	($1,272,000)	($41,778,000)	($1,384,000)	($363,000)	($112,000)
216	199	COUNTY BH RECOUPMENTS	($64,160,000)	($64,160,000)	($128,319,000)	($128,319,000)	($64,159,000)	($64,159,000)
--	204	L.A. CARE SANCTIONS LEGAL AID GRANTS	$0	$0	$0	$0	$0	$0
183	--	PEER SUPPORT SPECIALIST SERVICES	$27,258,000	$0	$0	$0	($27,258,000)	$0
212	--	CALAIM - DENTAL INITIATIVES	$291,716,000	$130,101,050	$0	$0	($291,716,000)	($130,101,050)
236	--	CALAIM ICF/DD & SUBACUTE TRANSITION FFS BASE ADJ.	($516,547,000)	($244,392,250)	$0	$0	$516,547,000	$244,392,250
241	--	BEHAVIORAL HEALTH BRIDGE HOUSING REDUCTION	($132,500,000)	($132,500,000)	$0	$0	$132,500,000	$132,500,000
245	--	EQUITY & PRACTICE TRANSFORMATION PYMTS REDUCTION	($87,500,000)	($43,750,000)	$0	$0	$87,500,000	$43,750,000
247	--	CYBHI - EVIDENCE-BASED BH PRACTICES REDUCTION	($47,135,000)	($47,135,000)	$0	$0	$47,135,000	$47,135,000
248	--	CYBHI - SCHOOL BH PARTNERSHIPS & CAP. REDUCTION	($120,000,000)	($120,000,000)	$0	$0	$120,000,000	$120,000,000

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2024 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2024-25

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2024-25 APPROPRIATION		NOV. 2024 EST. FOR 2024-25		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER						
251	--	RECONCILIATION - BENEFITS	($18,312,000)	($10,889,000)	$0	$0	$18,312,000	$10,889,000
252	--	HOPE THE MISSION FOR MOBILE MENTAL HEALTH EQUIP.	$1,000,000	$1,000,000	$0	$0	($1,000,000)	($1,000,000)
		OTHER SUBTOTAL	**$2,184,411,000**	**($5,134,189,700)**	**$2,146,328,000**	**($5,962,710,300)**	**($38,083,000)**	**($828,520,600)**
		GRAND TOTAL	**$50,765,370,000**	**($8,522,990,850)**	**$50,078,393,000**	**($12,094,613,800)**	**($686,977,000)**	**($3,571,622,950)**

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

FISCAL YEAR 2024-25 COST PER ELIGIBLE BASED ON NOVEMBER 2024 ESTIMATE

SERVICE CATEGORY	PA-OAS	NEWLY	PA-ATD	PA-AFDC	LT-OAS	H-PE
PHYSICIANS	$825,660	$133,554,820	$50,102,210	$40,544,220	$1,000,510	$80,286,060
OTHER MEDICAL	$133,955,750	$2,318,305,800	$515,067,250	$525,975,630	$9,103,060	$48,401,830
CO. & COMM. OUTPATIENT	$526,120	$114,958,210	$108,632,900	$46,779,750	$115,820	$62,110,960
PHARMACY	$73,165,290	$7,148,383,130	$2,633,037,960	$607,016,340	$11,731,140	$41,281,900
COUNTY INPATIENT	$1,012,550	$393,734,570	$20,212,520	$39,061,490	$661,080	$104,040,590
COMMUNITY INPATIENT	$8,157,230	$961,393,790	$347,240,430	$297,659,150	$3,286,320	$417,808,370
NURSING FACILITIES	$31,892,360	$62,103,390	$107,034,420	$3,241,040	$271,955,430	$3,862,600
ICF-DD	$440,720	$1,629,310	$8,515,390	$387,140	$5,764,550	$0
MEDICAL TRANSPORTATION	$291,060	$23,331,830	$5,789,280	$4,480,090	$229,320	$13,485,450
OTHER SERVICES	$183,033,090	$326,826,560	$1,059,913,600	$127,730,080	$24,205,100	$3,609,620
HOME HEALTH	$3,627,400	$1,066,800	$53,621,270	$7,238,310	$230	$187,060
FFS SUBTOTAL	**$436,927,230**	**$11,485,288,220**	**$4,909,167,230**	**$1,700,113,220**	**$328,052,550**	**$775,074,450**
DENTAL	$54,545,260	$520,951,960	$129,486,470	$250,123,550	$9,451,240	$2,007,920
MENTAL HEALTH	$50,451,880	$1,871,889,180	$1,416,586,040	$1,127,340,220	$0	$0
TWO PLAN MODEL	$1,968,596,100	$14,350,038,950	$5,293,954,230	$1,961,655,810	$2,073,578,730	$0
COUNTY ORGANIZED HEALTH SYSTEMS	$931,834,280	$7,190,507,090	$2,450,353,220	$687,913,530	$519,139,400	$0
GEOGRAPHIC MANAGED CARE	$306,904,230	$2,692,284,110	$1,030,924,780	$352,484,890	$329,962,680	$0
PHP & OTHER MANAG. CARE	$452,773,510	$25,772,490	$280,012,070	$6,539,110	$18,614,000	$0
MEDICARE PAYMENTS	$2,065,508,040	$490,811,000	$1,869,092,310	$0	$158,252,750	$0
MISC. SERVICES	$122,958,790	$0	$410,873,120	$3,882,490	$0	$0
DRUG MEDI-CAL	$33,937,530	$426,611,680	$77,963,800	$101,196,530	$2,773,670	$11,660
REGIONAL MODEL	$5,808,330	$151,278,980	$65,050,090	$13,499,120	$38,455,400	$0
NON-FFS SUBTOTAL	**$5,993,317,940**	**$27,720,145,460**	**$13,024,296,140**	**$4,504,635,240**	**$3,150,227,860**	**$2,019,580**
TOTAL DOLLARS (1)	**$6,430,245,170**	**$39,205,433,670**	**$17,933,463,370**	**$6,204,748,460**	**$3,478,280,410**	**$777,094,030**
ELIGIBLES * **	**423,300**	**5,077,000**	**815,100**	**1,131,600**	**38,600**	**43,300**
ANNUAL $/ELIGIBLE	**$15,191**	**$7,722**	**$22,002**	**$5,483**	**$90,111**	**$17,947**
AVG. MO. $/ELIGIBLE	**$1,266**	**$644**	**$1,833**	**$457**	**$7,509**	**$1,496**

(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 2024-25 COST PER ELIGIBLE BASED ON NOVEMBER 2024 ESTIMATE

SERVICE CATEGORY	LT-ATD	POV 250	MN-OAS	MN-ATD	MN-AFDC	MI-C
PHYSICIANS	$330,320	$19,871,960	$13,584,690	$6,271,260	$70,649,890	$29,190,120
OTHER MEDICAL	$3,429,760	$283,112,320	$389,294,040	$103,369,210	$1,889,825,180	$125,631,460
CO. & COMM. OUTPATIENT	$74,300	$27,014,780	$14,514,800	$7,688,810	$101,700,960	$17,032,230
PHARMACY	$5,055,840	$335,549,280	$635,912,160	$245,868,890	$2,578,819,170	$95,504,510
COUNTY INPATIENT	$177,650	$6,229,180	$27,981,140	$4,658,090	$69,735,970	$15,234,460
COMMUNITY INPATIENT	$2,958,300	$96,944,520	$86,075,780	$26,725,320	$571,675,030	$77,522,740
NURSING FACILITIES	$41,871,170	$1,152,990	$290,159,800	$36,892,330	$9,414,380	$6,754,860
ICF-DD	$20,066,070	$0	$2,167,020	$1,055,700	$361,860	$1,240,580
MEDICAL TRANSPORTATION	$144,800	$690,760	$2,989,230	$1,147,250	$5,741,470	$3,696,450
OTHER SERVICES	$5,819,920	$62,333,840	$315,934,210	$210,534,620	$105,049,590	$65,831,210
HOME HEALTH	$630	$8,747,470	$1,518,950	$11,794,080	$10,096,590	$9,277,770
FFS SUBTOTAL	**$79,928,760**	**$841,647,090**	**$1,780,131,830**	**$656,005,570**	**$5,413,070,080**	**$446,916,400**
DENTAL	$2,429,680	$181,044,780	$88,108,200	$26,748,800	$616,602,160	$26,080,630
MENTAL HEALTH	$0	$309,233,670	$94,818,070	$229,613,490	$1,408,640,660	$241,500,880
TWO PLAN MODEL	$439,200,120	$852,526,620	$3,728,788,980	$1,134,825,450	$5,917,258,810	$66,363,910
COUNTY ORGANIZED HEALTH SYSTEMS	$84,079,050	$467,248,780	$2,153,039,720	$708,642,870	$3,444,498,960	$51,451,420
GEOGRAPHIC MANAGED CARE	$70,972,040	$169,623,840	$547,251,400	$237,614,210	$1,159,474,830	$10,764,470
PHP & OTHER MANAG. CARE	$667,340	$131,500	$937,560,770	$60,005,210	$101,580	$0
MEDICARE PAYMENTS	$0	$0	$2,770,945,040	$799,214,310	$155,871,540	$0
MISC. SERVICES	$0	$0	$236,503,420	$100,627,890	$12,194,290	$664,430
DRUG MEDI-CAL	$562,770	$72,042,440	$65,306,930	$17,630,040	$315,232,550	$16,914,320
REGIONAL MODEL	$3,146,570	$11,879,940	$31,687,800	$22,138,140	$68,017,030	$485,260
NON-FFS SUBTOTAL	**$601,057,570**	**$2,063,731,570**	**$10,654,010,350**	**$3,337,060,400**	**$13,097,892,410**	**$414,225,330**
TOTAL DOLLARS (1)	**$680,986,330**	**$2,905,378,660**	**$12,434,142,180**	**$3,993,065,970**	**$18,510,962,490**	**$861,141,730**
ELIGIBLES * **	**7,100**	**916,500**	**992,100**	**223,200**	**3,818,800**	**156,800**
ANNUAL $/ELIGIBLE	**$95,914**	**$3,170**	**$12,533**	**$17,890**	**$4,847**	**$5,492**
AVG. MO. $/ELIGIBLE	**$7,993**	**$264**	**$1,044**	**$1,491**	**$404**	**$458**

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*** Eligibles include the estimated impact of eligibility policy changes.
Refer to page following for listing of excluded policy changes.

FISCAL YEAR 2024-25 COST PER ELIGIBLE BASED ON NOVEMBER 2024 ESTIMATE

SERVICE CATEGORY	MI-A	REFUGEE	OBRA	POV 185	POV 133	POV 100
PHYSICIANS	$305,610	$163,210	$0	$53,916,940	$18,317,220	$6,000,350
OTHER MEDICAL	$458,730	$3,411,150	$0	$279,446,230	$277,435,950	$106,272,100
CO. & COMM. OUTPATIENT	$39,100	$183,500	$10	$32,722,260	$50,434,480	$11,701,030
PHARMACY	$2,730,570	$3,973,220	$190	$72,942,130	$131,802,370	$128,963,000
COUNTY INPATIENT	$3,901,730	$88,190	$0	$45,199,970	$5,295,030	$3,807,620
COMMUNITY INPATIENT	$2,319,770	$375,640	$0	$420,723,390	$93,234,390	$32,871,940
NURSING FACILITIES	$9,701,120	$0	$10	$29,360	$1,346,340	$0
ICF-DD	$619,810	$0	$0	$0	$319,540	$0
MEDICAL TRANSPORTATION	$38,280	$34,000	$20	$1,631,140	$551,010	$201,860
OTHER SERVICES	$822,450	$69,450	$20	$8,969,020	$37,650,610	$13,719,150
HOME HEALTH	$0	$0	$0	$2,145,040	$4,153,810	$1,610,170
FFS SUBTOTAL	**$20,937,160**	**$8,298,360**	**$250**	**$917,725,490**	**$620,540,750**	**$305,147,230**
DENTAL	$178,480	$1,427,850	$0	$17,390,940	$209,933,480	$85,016,600
MENTAL HEALTH	$0	$0	$0	$0	$124,044,700	$234,087,410
TWO PLAN MODEL	$1,357,800	$3,179,860	$0	$385,050,040	$659,778,510	$303,780,400
COUNTY ORGANIZED HEALTH SYSTEMS	$1,266,820	$3,142,240	$0	$250,575,200	$341,707,750	$156,355,340
GEOGRAPHIC MANAGED CARE	$295,900	$1,786,910	$0	$91,923,450	$129,717,790	$53,492,890
PHP & OTHER MANAG. CARE	$0	$0	$0	$115,580	$104,700	$104,700
MEDICARE PAYMENTS	$0	$0	$0	$0	$0	$0
MISC. SERVICES	$400	$0	$0	$42,310	$2,304,760	$1,085,100
DRUG MEDI-CAL	$249,230	$281,390	$0	$27,476,400	$60,558,780	$28,561,790
REGIONAL MODEL	$7,330	$0	$0	$4,068,760	$6,594,930	$2,842,600
NON-FFS SUBTOTAL	**$3,355,970**	**$9,818,250**	**$0**	**$776,642,690**	**$1,534,745,390**	**$865,326,830**
TOTAL DOLLARS (1)	**$24,293,130**	**$18,116,610**	**$250**	**$1,694,368,180**	**$2,155,286,140**	**$1,170,474,050**
ELIGIBLES * **	**3,400**	**4,100**	**0**	**338,300**	**711,000**	**304,400**
ANNUAL $/ELIGIBLE	**$7,145**	**$4,419**		**$5,008**	**$3,031**	**$3,845**
AVG. MO. $/ELIGIBLE	**$595**	**$368**		**$417**	**$253**	**$320**

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Refer to page following for listing of excluded policy changes.

FISCAL YEAR 2024-25 COST PER ELIGIBLE BASED ON NOVEMBER 2024 ESTIMATE

SERVICE CATEGORY	TOTAL
PHYSICIANS	**$524,915,040**
OTHER MEDICAL	**$7,012,495,450**
CO. & COMM. OUTPATIENT	**$596,230,020**
PHARMACY	**$14,751,737,110**
COUNTY INPATIENT	**$741,031,820**
COMMUNITY INPATIENT	**$3,446,972,130**
NURSING FACILITIES	**$877,411,600**
ICF-DD	**$42,567,680**
MEDICAL TRANSPORTATION	**$64,473,290**
OTHER SERVICES	**$2,552,052,150**
HOME HEALTH	**$115,085,580**
FFS SUBTOTAL	**$30,724,971,870**
DENTAL	**$2,221,528,000**
MENTAL HEALTH	**$7,108,206,200**
TWO PLAN MODEL	**$39,139,934,320**
COUNTY ORGANIZED HEALTH SYSTEMS	**$19,441,755,670**
GEOGRAPHIC MANAGED CARE	**$7,185,478,440**
PHP & OTHER MANAG. CARE	**$1,782,502,550**
MEDICARE PAYMENTS	**$8,309,695,000**
MISC. SERVICES	**$891,137,000**
DRUG MEDI-CAL	**$1,247,311,500**
REGIONAL MODEL	**$424,960,280**
NON-FFS SUBTOTAL	**$87,752,508,960**
TOTAL DOLLARS (1)	**$118,477,480,830**
ELIGIBLES * **	**15,004,600**
ANNUAL $/ELIGIBLE	**$7,896**
AVG. MO. $/ELIGIBLE	**$658**

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*** Eligibles include the estimated impact of eligibility policy changes.
Refer to page following for listing of excluded policy changes.

FISCAL YEAR 2024-25 COST PER ELIGIBLE BASED ON NOVEMBER 2024 ESTIMATE

EXCLUDED POLICY CHANGES: 113

	QAF WITHHOLD TRANSFER ADJUSTMENT
	QAF WITHHOLD ADJUSTMENT
3	BREAST AND CERVICAL CANCER TREATMENT
4	HEALTH ENROLLMENT NAVIGATORS FOR CLINICS
10	CS3 PROXY ADJUSTMENT
12	COMMUNITY FIRST CHOICE OPTION
14	1% FMAP INCREASE FOR PREVENTIVE SERVICES
15	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.
16	ACA DSH REDUCTION
18	FAMILY PACT PROGRAM
19	CALIFORNIA COMMUNITY TRANSITIONS COSTS
23	MEDICAL INTERPRETER PILOT PROJECT
27	PHARMACY RETROACTIVE ADJUSTMENTS
30	LITIGATION SETTLEMENTS
32	FAMILY PACT DRUG REBATES
40	DRUG MEDI-CAL PROGRAM COST SETTLEMENT
43	BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE
49	SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS
50	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT
51	INTERIM AND FINAL COST SETTLEMENTS - SMHS
52	GLOBAL PAYMENT PROGRAM
53	CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES
54	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG
55	ENHANCED CARE MANAGEMENT RISK CORRIDOR
58	2023 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.
67	DENTAL MANAGED CARE (Other M/C)
70	CYBHI - STUDENT BH INCENTIVE PROGRAM
71	NON-HOSPITAL 340B CLINIC DIRECTED PAYMENTS
72	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL
75	COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM
76	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL
78	MEDI-CAL MANAGED CARE QUALITY WITHHOLD RELEASE
81	2023 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ
82	2023 MCO ENROLLMENT TAX MANAGED CARE PLANS

FISCAL YEAR 2024-25 COST PER ELIGIBLE BASED ON NOVEMBER 2024 ESTIMATE

EXCLUDED POLICY CHANGES: 113

83	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND
85	PROP 56 - DIRECTED PAYMENT RISK MITIGATION
91	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF
101	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES
102	MEDI-CAL PROVIDER PAYMENT RESERVE FUND
105	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS
106	HOSPITAL QAF - FFS PAYMENTS
107	HOSPITAL QAF - MANAGED CARE PAYMENTS
108	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS
109	PRIVATE HOSPITAL DSH REPLACEMENT
110	PROP 56 - MEDI-CAL FAMILY PLANNING
111	DSH PAYMENT
112	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
113	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS
114	FFP FOR LOCAL TRAUMA CENTERS
115	DPH PHYSICIAN & NON-PHYS. COST
116	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS
117	CAPITAL PROJECT DEBT REIMBURSEMENT
118	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS
119	NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS
120	NDPH IGT SUPPLEMENTAL PAYMENTS
121	PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS
122	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS
123	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH
124	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH
125	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS
126	NDPH SUPPLEMENTAL PAYMENT
127	FREE CLINICS AUGMENTATION
128	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS
129	IGT ADMIN. & PROCESSING FEE
130	PROPOSITION 56 FUNDING
131	GEMT SUPPLEMENTAL PAYMENT PROGRAM
138	STATE-ONLY CLAIMING ADJUSTMENTS - RETRO ADJ.
139	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS

FISCAL YEAR 2024-25 COST PER ELIGIBLE BASED ON NOVEMBER 2024 ESTIMATE

EXCLUDED POLICY CHANGES: 113

142	PERSONAL CARE SERVICES (Misc. Svcs.)
143	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)
146	BEHAVIORAL HEALTH BRIDGE HOUSING
147	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)
148	CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY
149	MEDICAL PROVIDER INTERIM PAYMENT LOAN REPAYMENT
151	CYBHI - EVIDENCE-BASED BH PRACTICES
152	SELF-DETERMINATION PROGRAM - CDDS
154	CALAIM - PATH WPC
155	CYBHI - URGENT NEEDS AND EMERGENT ISSUES
156	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS
157	MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG
158	QAF WITHHOLD TRANSFER
159	CALAIM - PATH FOR CLINICS
161	MISC. ONE-TIME PAYMENTS
162	INFANT DEVELOPMENT PROGRAM
163	MEDI-CAL TCM PROGRAM
164	CYBHI - CALHOPE STUDENT SUPPORT
165	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC
166	EQUITY & PRACTICE TRANSFORMATION PAYMENTS
168	CALHOPE
169	ABORTION SUPPLEMENTAL PAYMENT PROGRAM
170	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS
171	CYBHI - FEE SCHEDULE THIRD PARTY ADMINISTRATOR
172	LAWSUITS/CLAIMS
173	MINIMUM WAGE INCREASE FOR HCBS WAIVERS
174	ASSET LIMIT INCREASE & ELIM. - CNTY BH FUNDING
175	FOSTER YOUTH SUBSTANCE USE DISORDER GRANT PROGRAM
176	SECTION 19.56 LEGISLATIVE PRIORITIES
177	ADVISORY COUNCIL ON PHYS. FIT. & MENTAL WELL-BEING
180	HCBS SP - CALBRIDGE BH NAVIGATOR PROGRAM
181	HCBS SP - NON-IHSS CARE ECONOMY PMTS
182	HCBS SP - ETSB FOR LAGUNA HONDA HOSPITAL RESIDENTS
186	HOSPITAL QAF - CHILDREN'S HEALTH CARE

FISCAL YEAR 2024-25 COST PER ELIGIBLE BASED ON NOVEMBER 2024 ESTIMATE

EXCLUDED POLICY CHANGES: 113

187	CIGARETTE AND TOBACCO SURTAX FUNDS
190	CCI IHSS RECONCILIATION
191	CMS DEFERRED CLAIMS
193	DENTAL MANAGED CARE MLR RISK CORRIDOR
194	QUALITY SANCTIONS
195	ASSISTED LIVING WAIVER EXPANSION
196	COUNTY SHARE OF OTLICP-CCS COSTS
197	HCBA WAIVER EXPANSION
198	MEDICARE PART A BUY-IN PROGRAM
199	COUNTY BH RECOUPMENTS
200	BASE RECOVERIES
203	PROP 35 - PROVIDER PAYMENT INCREASE FUNDING
204	L.A. CARE SANCTIONS LEGAL AID GRANTS

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BUDGET YEAR

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

MEDI-CAL PROGRAM ESTIMATE SUMMARY
FISCAL YEAR 2025-26

	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
I. BASE ESTIMATES				
A. B/Y FFS BASE	$34,921,364,120	$17,460,682,060	$17,460,682,060	$0
B. B/Y BASE POLICY CHANGES	$87,517,386,010	$52,121,179,540	$33,725,665,460	$1,670,541,000
C. BASE ADJUSTMENTS	($3,177,800,000)	($924,353,150)	($2,253,446,850)	$0
D. ADJUSTED BASE	**$119,260,950,130**	**$68,657,508,460**	**$48,932,900,670**	**$1,670,541,000**
II. REGULAR POLICY CHANGES				
A. ELIGIBILITY	$18,946,000	($2,762,023,550)	$2,778,855,550	$2,114,000
B. AFFORDABLE CARE ACT	$8,344,968,000	$9,161,350,400	($257,989,400)	($558,393,000)
C. BENEFITS	$1,218,951,700	$1,102,948,400	$116,003,300	$0
D. PHARMACY	($4,877,252,090)	($4,913,173,470)	($1,918,022,620)	$1,953,944,000
E. DRUG MEDI-CAL	$64,973,030	$51,904,620	$1,245,950	$11,822,460
F. MENTAL HEALTH	$1,005,370,000	$311,421,000	$457,714,000	$236,235,000
G. WAIVER--MH/UCD & BTR	$4,143,361,000	$2,205,838,500	$475,113,500	$1,462,409,000
H. MANAGED CARE	$24,731,834,000	$15,346,733,250	($2,904,247,250)	$12,289,348,000
I. PROVIDER RATES	$9,346,830,410	$6,045,476,770	($695,780,080)	$3,997,133,720
J. SUPPLEMENTAL PMNTS.	$14,219,838,190	$8,786,937,250	$183,833,540	$5,249,067,400
K. COVID-19	$1,155,037,000	$660,915,150	$494,121,850	$0
L. STATE-ONLY CLAIMING	$0	($944,000)	$944,000	$0
M. OTHER DEPARTMENTS	$900,026,000	$900,026,000	$0	$0
N. OTHER	$927,865,000	$6,561,087,100	($7,053,517,100)	$1,420,295,000
O. TOTAL CHANGES	**$61,200,748,250**	**$43,458,497,430**	**($8,321,724,760)**	**$26,063,975,580**
III. TOTAL MEDI-CAL ESTIMATE	**$180,461,698,380**	**$112,116,005,890**	**$40,611,175,910**	**$27,734,516,580**

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2025-26

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	ELIGIBILITY				
1	CALAIM - INMATE PRE-RELEASE PROGRAM	$146,073,000	$110,136,000	$35,937,000	$0
2	MEDI-CAL STATE INMATE PROGRAMS	$38,037,000	$38,037,000	$0	$0
3	BREAST AND CERVICAL CANCER TREATMENT	$15,862,000	$7,723,650	$8,138,350	$0
4	HEALTH ENROLLMENT NAVIGATORS FOR CLINICS	$7,510,000	$3,755,000	$3,755,000	$0
6	NON-OTLICP CHIP	$0	$107,574,600	($107,574,600)	$0
7	NON-EMERGENCY FUNDING ADJUSTMENT	$0	($3,054,378,750)	$3,054,378,750	$0
8	SCHIP FUNDING FOR PRENATAL CARE	$0	$70,822,050	($70,822,050)	$0
9	MEDI-CAL COUNTY INMATE REIMBURSEMENT	$0	$0	($1,802,000)	$1,802,000
10	CS3 PROXY ADJUSTMENT	$0	$67,428,500	($67,428,500)	$0
11	REFUGEE MEDICAL ASSISTANCE	$0	$0	($312,000)	$312,000
201	SB 525 MINIMUM WAGE - CASELOAD IMPACT	($188,536,000)	($113,121,600)	($75,414,400)	$0
	ELIGIBILITY SUBTOTAL	**$18,946,000**	**($2,762,023,550)**	**$2,778,855,550**	**$2,114,000**
	AFFORDABLE CARE ACT				
12	COMMUNITY FIRST CHOICE OPTION	$10,038,990,000	$10,038,990,000	$0	$0
13	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	$18,208,000	$18,208,000	$0	$0
14	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	$5,393,000	($5,393,000)	$0
15	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	$0	$36,510,400	($36,510,400)	$0
16	ACA DSH REDUCTION	($1,712,230,000)	($937,751,000)	($216,086,000)	($558,393,000)
	AFFORDABLE CARE ACT SUBTOTAL	**$8,344,968,000**	**$9,161,350,400**	**($257,989,400)**	**($558,393,000)**
	BENEFITS				
17	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$842,467,000	$842,467,000	$0	$0
18	FAMILY PACT PROGRAM	$144,214,000	$108,921,600	$35,292,400	$0
19	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$111,173,000	$88,816,000	$22,357,000	$0
20	MULTIPURPOSE SENIOR SERVICES PROGRAM	$63,951,000	$31,975,500	$31,975,500	$0
21	BEHAVIORAL HEALTH TREATMENT	$12,537,000	$6,268,500	$6,268,500	$0
22	CYBHI WELLNESS COACH BENEFIT	$43,142,000	$24,434,800	$18,707,200	$0
24	HEARING AID COVERAGE FOR CHILDREN PROGRAM	$1,402,700	$0	$1,402,700	$0
25	CCT FUND TRANSFER TO CDSS	$65,000	$65,000	$0	$0
	BENEFITS SUBTOTAL	**$1,218,951,700**	**$1,102,948,400**	**$116,003,300**	**$0**
	PHARMACY				
26	RESPIRATORY SYNCYTIAL VIRUS VACCINES	$197,642,910	$109,738,230	$87,904,680	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2025-26

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	PHARMACY				
28	MEDICATION THERAPY MANAGEMENT PROGRAM	$0	$0	$0	$0
29	MEDI-CAL DRUG REBATE FUND	$0	$0	($1,953,944,000)	$1,953,944,000
31	BCCTP DRUG REBATES	($2,391,000)	($2,391,000)	$0	$0
32	FAMILY PACT DRUG REBATES	($2,171,000)	($2,171,000)	$0	$0
33	MEDICAL SUPPLY REBATES	($136,800,000)	($84,816,700)	($51,983,300)	$0
34	STATE SUPPLEMENTAL DRUG REBATES	($417,946,000)	($417,946,000)	$0	$0
35	FEDERAL DRUG REBATES	($4,515,587,000)	($4,515,587,000)	$0	$0
	PHARMACY SUBTOTAL	**($4,877,252,090)**	**($4,913,173,470)**	**($1,918,022,620)**	**$1,953,944,000**
	DRUG MEDI-CAL				
37	HCBS SP - CONTINGENCY MANAGEMENT	$48,581,000	$39,049,000	$0	$9,532,000
39	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	$15,518,030	$12,084,630	$1,142,950	$2,290,460
40	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	$874,000	$771,000	$103,000	$0
	DRUG MEDI-CAL SUBTOTAL	**$64,973,030**	**$51,904,630**	**$1,245,950**	**$11,822,460**
	MENTAL HEALTH				
43	BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE	$411,695,000	$0	$411,695,000	$0
44	MHP COSTS FOR FFPSA	$37,299,000	$18,651,000	$9,324,000	$9,324,000
45	CALAIM - BH - CONNECT DEMONSTRATION	$784,384,000	$526,006,000	$31,667,000	$226,711,000
46	MHP COSTS FOR CONTINUUM OF CARE REFORM	$3,494,000	$860,000	$2,634,000	$0
47	OUT OF STATE YOUTH - SMHS	$986,000	$493,000	$493,000	$0
48	CALAIM - BH - CONNECT WORKFORCE INITIATIVE	$95,095,000	$95,095,000	$0	$0
49	SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS	$0	($142,000)	$142,000	$0
50	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	$0	$0	($200,000)	$200,000
51	INTERIM AND FINAL COST SETTLEMENTS - SMHS	($327,583,000)	($329,542,000)	$1,959,000	$0
	MENTAL HEALTH SUBTOTAL	**$1,005,370,000**	**$311,421,000**	**$457,714,000**	**$236,235,000**
	WAIVER--MH/UCD & BTR				
52	GLOBAL PAYMENT PROGRAM	$2,924,821,000	$1,462,412,000	$0	$1,462,409,000
53	CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES	$1,217,962,000	$742,848,500	$475,113,500	$0
54	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	$578,000	$578,000	$0	$0
	WAIVER--MH/UCD & BTR SUBTOTAL	**$4,143,361,000**	**$2,205,838,500**	**$475,113,500**	**$1,462,409,000**
	MANAGED CARE				
58	2023 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	$12,673,059,000	$7,603,831,000	$5,069,228,000	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2025-26

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	MANAGED CARE				
60	MANAGED CARE HEALTH CARE FINANCING PROGRAM	$3,197,407,000	$2,047,728,350	$1,149,678,650	$0
61	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	$2,209,565,000	$1,571,843,000	$637,722,000	$0
62	MANAGED CARE PUBLIC HOSPITAL EPP	$2,369,726,000	$1,657,550,650	$712,175,350	$0
64	WORKFORCE & QUALITY INCENTIVE PROGRAM	$309,967,000	$154,418,650	$155,548,350	$0
65	MANAGED CARE PUBLIC DP-NF PASS-THROUGH PYMT PROG	$74,666,000	$38,497,300	$36,168,700	$0
68	MANAGED CARE DISTRICT HOSPITAL DIRECTED PAYMENTS	$203,645,000	$137,399,000	$0	$66,246,000
71	NON-HOSPITAL 340B CLINIC DIRECTED PAYMENTS	$105,000,000	$52,500,000	$52,500,000	$0
73	CCI-QUALITY WITHHOLD REPAYMENTS	$17,414,000	$8,707,000	$8,707,000	$0
77	CAPITATED RATE ADJUSTMENT FOR FY 2025-26	$2,976,538,000	$1,765,898,550	$1,210,639,450	$0
78	MEDI-CAL MANAGED CARE QUALITY WITHHOLD RELEASE	$250,577,000	$147,569,450	$103,007,550	$0
79	CHILDREN'S HOSPITAL DIRECTED PAYMENT	$115,000,000	$57,500,000	$57,500,000	$0
80	MANAGED CARE DIRECTED PAYMENTS MLK COMM HOSPITAL	$28,905,000	$20,821,850	$8,083,150	$0
81	2023 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	$0	$0	($5,069,228,000)	$5,069,228,000
82	2023 MCO ENROLLMENT TAX MANAGED CARE PLANS	$0	$0	($4,373,496,000)	$4,373,496,000
83	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	$0	$0	($2,780,378,000)	$2,780,378,000
84	COORDINATED CARE INITIATIVE RISK MITIGATION	($83,880,000)	($41,940,000)	($41,940,000)	$0
86	RETRO MC RATE ADJUSTMENTS	$284,245,000	$124,408,450	$159,836,550	$0
	MANAGED CARE SUBTOTAL	**$24,731,834,000**	**$15,346,733,250**	**($2,904,247,250)**	**$12,289,348,000**
	PROVIDER RATES				
87	RATE INCREASE FOR FQHCS/RHCS/CBRCS	$900,602,310	$576,026,200	$324,576,110	$0
88	PP-GEMT IGT PROGRAM	$311,068,530	$202,492,310	$0	$108,576,220
89	MEDI-CAL PROVIDER PAYMENT INCREASES 2025 & LATER	$7,417,883,000	$4,450,730,000	$2,967,153,000	$0
90	DPH INTERIM & FINAL RECONS	$17,839,000	$17,839,000	$0	$0
91	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	$151,664,850	$104,380,670	($5,483,320)	$52,767,500
92	FQHC/RHC/CBRC RECONCILIATION PROCESS	$133,942,000	$85,669,300	$48,272,700	$0
93	NURSING FACILITY RATE ADJUSTMENTS	$93,853,240	$49,366,800	$44,486,440	$0
94	LTC RATE ADJUSTMENT	$16,359,600	$8,513,550	$7,846,050	$0
95	HOSPICE RATE INCREASES	$15,548,800	$9,365,550	$6,183,250	$0
96	MEDI-CAL PROVIDER PAYMENT INCREASE	$11,995,500	$7,194,000	$4,801,500	$0
97	GDSP NBS & PNS FEE ADJUSTMENTS	$6,747,000	$4,094,950	$2,652,050	$0

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SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2025-26

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	PROVIDER RATES				
98	SKILLED NURSING FACILITY (SNF) BACK-UP POWER	$249,603,000	$151,371,600	$98,231,400	$0
99	DPH INTERIM RATE GROWTH	$39,818,000	$26,762,200	$13,055,800	$0
100	DPH INTERIM RATE	$0	$363,298,300	($363,298,300)	$0
101	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	$0	$0	($577,637,000)	$577,637,000
103	REDUCTION TO RADIOLOGY RATES	($16,004,000)	($9,272,300)	($6,731,700)	$0
104	LABORATORY RATE METHODOLOGY CHANGE	($4,090,410)	($2,355,360)	($1,735,050)	$0
203	PROP 35 - PROVIDER PAYMENT INCREASE FUNDING	$0	$0	($3,258,153,000)	$3,258,153,000
	PROVIDER RATES SUBTOTAL	**$9,346,830,410**	**$6,045,476,770**	**($695,780,080)**	**$3,997,133,720**
	SUPPLEMENTAL PMNTS.				
105	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	$6,289,994,000	$4,016,535,100	$0	$2,273,458,900
106	HOSPITAL QAF - FFS PAYMENTS	$2,744,188,000	$1,425,112,000	$0	$1,319,076,000
107	HOSPITAL QAF - MANAGED CARE PAYMENTS	$1,200,000,000	$817,026,500	$0	$382,973,500
108	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	$925,573,000	$520,375,000	$0	$405,198,000
109	PRIVATE HOSPITAL DSH REPLACEMENT	$757,152,000	$378,576,000	$378,576,000	$0
110	PROP 56 - MEDI-CAL FAMILY PLANNING	$538,793,210	$322,103,980	$216,689,220	$0
111	DSH PAYMENT	$487,442,000	$351,729,000	$38,000,000	$97,713,000
112	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	$487,085,000	$258,953,000	$118,400,000	$109,732,000
113	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$217,964,000	$217,964,000	$0	$0
114	FFP FOR LOCAL TRAUMA CENTERS	$182,691,000	$98,681,000	$0	$84,010,000
115	DPH PHYSICIAN & NON-PHYS. COST	$123,553,000	$123,553,000	$0	$0
116	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	$126,279,000	$73,422,000	($1,770,000)	$54,627,000
117	CAPITAL PROJECT DEBT REIMBURSEMENT	$91,283,000	$64,930,000	$26,353,000	$0
118	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	$26,513,000	$26,513,000	$0	$0
120	NDPH IGT SUPPLEMENTAL PAYMENTS	$53,938,000	$30,158,000	($1,595,000)	$25,375,000
121	PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS	$45,891,760	$27,287,680	$18,604,080	$0
122	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	$16,016,000	$16,016,000	$0	$0
123	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	$10,000,000	$5,000,000	$5,000,000	$0
124	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	$8,000,000	$4,000,000	$4,000,000	$0
125	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	$6,251,220	$3,539,990	$2,711,230	$0
126	NDPH SUPPLEMENTAL PAYMENT	$16,479,000	$8,448,000	$1,900,000	$6,131,000
127	FREE CLINICS AUGMENTATION	$2,000,000	$0	$2,000,000	$0
129	IGT ADMIN. & PROCESSING FEE	$0	$0	($18,313,000)	$18,313,000

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2025-26

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	SUPPLEMENTAL PMNTS.				
130	PROPOSITION 56 FUNDING	($134,262,000)	$0	($606,722,000)	$472,460,000
131	GEMT SUPPLEMENTAL PAYMENT PROGRAM	($2,986,000)	($2,986,000)	$0	$0
	SUPPLEMENTAL PMNTS. SUBTOTAL	**$14,219,838,190**	**$8,786,937,250**	**$183,833,540**	**$5,249,067,400**
	COVID-19				
132	COVID-19 REDETERMINATIONS IMPACT	$1,140,179,000	$691,942,800	$448,236,200	$0
133	PHARMACY-BASED COVID-19 TESTS	$14,858,000	$10,033,350	$4,824,650	$0
135	COVID-19 VACCINE FUNDING ADJUSTMENT	$0	$13,257,000	($13,257,000)	$0
136	CONTINUOUS CHIP COVERAGE DURING THE COVID-19 PHE	$0	($54,318,000)	$54,318,000	$0
137	COVID-19 VACCINES	$0	$0	$0	$0
	COVID-19 SUBTOTAL	**$1,155,037,000**	**$660,915,150**	**$494,121,850**	**$0**
	STATE-ONLY CLAIMING				
138	STATE-ONLY CLAIMING ADJUSTMENTS - RETRO ADJ.	$0	($944,000)	$944,000	$0
	STATE-ONLY CLAIMING SUBTOTAL	**$0**	**($944,000)**	**$944,000**	**$0**
	OTHER DEPARTMENTS				
139	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$900,026,000	$900,026,000	$0	$0
	OTHER DEPARTMENTS SUBTOTAL	**$900,026,000**	**$900,026,000**	**$0**	**$0**
	OTHER				
146	BEHAVIORAL HEALTH BRIDGE HOUSING	$243,587,000	$0	$243,587,000	$0
150	QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES	$323,831,000	$275,256,000	$48,575,000	$0
151	CYBHI - EVIDENCE-BASED BH PRACTICES	$41,592,000	$0	$41,592,000	$0
152	SELF-DETERMINATION PROGRAM - CDDS	$296,578,000	$296,578,000	$0	$0
155	CYBHI - URGENT NEEDS AND EMERGENT ISSUES	$12,130,000	$0	$12,130,000	$0
156	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	$65,958,000	$65,958,000	$0	$0
157	MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG	$51,227,000	$0	$0	$51,227,000
158	QAF WITHHOLD TRANSFER	($50,000)	($25,000)	($25,000)	$0
160	CARE ACT	$47,125,000	$0	$47,125,000	$0
162	INFANT DEVELOPMENT PROGRAM	$20,671,000	$20,671,000	$0	$0
166	EQUITY & PRACTICE TRANSFORMATION PAYMENTS	$40,600,000	$20,300,000	$20,300,000	$0
167	INDIAN HEALTH SERVICES	$17,493,000	$11,662,000	$5,831,000	$0
170	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	$11,536,000	$6,264,000	$5,272,000	$0
173	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	$45,456,000	$20,455,000	$25,001,000	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2025-26

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER				
174	ASSET LIMIT INCREASE & ELIM. - CNTY BH FUNDING	$4,413,000	$0	$4,413,000	$0
178	WPCS WORKERS' COMPENSATION	$620,000	$310,000	$310,000	$0
185	IMD ANCILLARY SERVICES	$0	($63,576,000)	$63,576,000	$0
186	HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	$0	($1,261,900,000)	$1,261,900,000
187	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	$0	($107,168,000)	$107,168,000
188	FUNDING ADJUST.—ACA OPT. EXPANSION	$0	$5,786,183,600	($5,786,183,600)	$0
189	FUNDING ADJUST.—OTLICP	$0	$136,980,000	($136,980,000)	$0
191	CMS DEFERRED CLAIMS	$0	$109,127,000	($109,127,000)	$0
192	INDIAN HEALTH SERVICES FUNDING SHIFT	$0	$27,294,500	($27,294,500)	$0
194	QUALITY SANCTIONS	($3,500,000)	($1,750,000)	($1,750,000)	$0
195	ASSISTED LIVING WAIVER EXPANSION	($24,880,000)	($9,952,000)	($14,928,000)	$0
196	COUNTY SHARE OF OTLICP-CCS COSTS	($12,456,000)	$0	($12,456,000)	$0
197	HCBA WAIVER EXPANSION	($86,738,000)	($43,193,000)	($43,545,000)	$0
198	MEDICARE PART A BUY-IN PROGRAM	($103,168,000)	($97,456,000)	($5,712,000)	$0
199	COUNTY BH RECOUPMENTS	($64,160,000)	$0	($64,160,000)	$0
	OTHER SUBTOTAL	**$927,865,000**	**$6,561,087,100**	**($7,053,517,100)**	**$1,420,295,000**
	GRAND TOTAL	**$61,200,748,250**	**$43,458,497,430**	**($8,321,724,760)**	**$26,063,975,580**

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

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
FISCAL YEAR 2025-26

SERVICE CATEGORY	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
PROFESSIONAL	$10,137,965,700	$5,717,295,500	$3,530,801,280	$889,868,930
PHYSICIANS	$687,204,470	$376,032,700	$252,740,430	$58,431,350
OTHER MEDICAL	$7,493,548,540	$4,255,058,480	$3,070,289,090	$168,200,970
CO. & COMM. OUTPATIENT	$1,957,212,690	$1,086,204,310	$207,771,760	$663,236,610
PHARMACY	$15,184,914,880	$7,523,026,840	$5,488,083,280	$2,173,804,750
HOSPITAL INPATIENT	$10,071,906,500	$6,107,788,010	$1,408,541,510	$2,555,576,980
COUNTY INPATIENT	$3,479,734,190	$2,069,341,200	($22,845,560)	$1,433,238,550
COMMUNITY INPATIENT	$6,592,172,310	$4,038,446,810	$1,431,387,070	$1,122,338,430
LONG TERM CARE	$1,021,082,060	$547,267,000	$455,445,320	$18,369,740
NURSING FACILITIES	$978,383,100	$525,401,550	$435,615,240	$17,366,320
ICF-DD	$42,698,960	$21,865,450	$19,830,080	$1,003,430
OTHER SERVICES	$2,620,752,260	$1,868,132,050	$731,024,100	$21,596,110
MEDICAL TRANSPORTATION	$62,736,900	$35,465,420	$26,529,090	$742,390
OTHER SERVICES	$2,443,151,770	$1,781,312,080	$642,520,090	$19,319,600
HOME HEALTH	$114,863,590	$51,354,540	$61,974,930	$1,534,120
TOTAL FEE-FOR-SERVICE	**$39,036,621,400**	**$21,763,509,400**	**$11,613,895,480**	**$5,659,216,520**
MANAGED CARE	$103,140,479,500	$62,784,544,530	$20,424,805,900	$19,931,129,070
TWO PLAN MODEL	$58,227,143,210	$35,431,190,880	$11,291,871,300	$11,504,081,030
COUNTY ORGANIZED HEALTH SYSTEMS	$29,813,001,040	$18,280,456,600	$5,524,566,260	$6,007,978,190
GEOGRAPHIC MANAGED CARE	$11,664,822,580	$7,240,193,950	$2,191,159,150	$2,233,469,480
PHP & OTHER MANAG. CARE	$2,377,925,050	$1,157,784,700	$1,203,970,140	$16,170,210
REGIONAL MODEL	$1,057,587,610	$674,918,400	$213,239,040	$169,430,170
DENTAL	$2,216,315,770	$1,201,194,250	$938,101,990	$77,019,530
MENTAL HEALTH	$5,988,321,250	$3,765,977,140	$294,292,440	$1,928,051,670
AUDITS/ LAWSUITS	$1,350,000	$109,802,000	($108,452,000)	$0
EPSDT SCREENS	$0	$0	$0	$0
MEDICARE PAYMENTS	$8,798,436,000	$2,021,331,500	$6,777,104,500	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$18,581,000	$18,581,000	$0	$0
MISC. SERVICES	$21,228,137,680	$20,265,467,000	$909,742,350	$52,928,330
RECOVERIES	($929,648,000)	($554,974,350)	($374,673,650)	$0
DRUG MEDI-CAL	$963,103,790	$740,573,420	$136,358,910	$86,171,460
GRAND TOTAL MEDI-CAL	**$180,461,698,380**	**$112,116,005,890**	**$40,611,175,910**	**$27,734,516,580**

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2024-25 AND 2025-26

SERVICE CATEGORY	NOV. 2024 EST. FOR 2024-25	NOV. 2024 EST. FOR 2025-26	DOLLAR DIFFERENCE	% CHANGE
PROFESSIONAL	$10,237,665,850	$10,137,965,700	($99,700,150)	-0.97%
PHYSICIANS	$714,937,290	$687,204,470	($27,732,810)	-3.88%
OTHER MEDICAL	$7,255,837,180	$7,493,548,540	$237,711,360	3.28%
CO. & COMM. OUTPATIENT	$2,266,891,380	$1,957,212,690	($309,678,700)	-13.66%
PHARMACY	$14,759,092,100	$15,184,914,880	$425,822,770	2.89%
HOSPITAL INPATIENT	$10,729,148,030	$10,071,906,500	($657,241,530)	-6.13%
COUNTY INPATIENT	$3,611,606,970	$3,479,734,190	($131,872,780)	-3.65%
COMMUNITY INPATIENT	$7,117,541,070	$6,592,172,310	($525,368,760)	-7.38%
LONG TERM CARE	$1,038,076,780	$1,021,082,060	($16,994,710)	-1.64%
NURSING FACILITIES	$978,183,340	$978,383,100	$199,760	0.02%
ICF-DD	$59,893,440	$42,698,960	($17,194,480)	-28.71%
OTHER SERVICES	$2,788,092,800	$2,620,752,260	($167,340,540)	-6.00%
MEDICAL TRANSPORTATION	$47,289,850	$62,736,900	$15,447,050	32.66%
OTHER SERVICES	$2,625,343,960	$2,443,151,770	($182,192,190)	-6.94%
HOME HEALTH	$115,458,990	$114,863,590	($595,400)	-0.52%
TOTAL FEE-FOR-SERVICE	**$39,552,075,570**	**$39,036,621,400**	**($515,454,170)**	**-1.30%**
MANAGED CARE	$89,963,616,850	$103,140,479,500	$13,176,862,650	14.65%
TWO PLAN MODEL	$50,571,750,680	$58,227,143,210	$7,655,392,540	15.14%
COUNTY ORGANIZED HEALTH SYSTEMS	$26,431,181,930	$29,813,001,040	$3,381,819,110	12.79%
GEOGRAPHIC MANAGED CARE	$10,244,976,030	$11,664,822,580	$1,419,846,550	13.86%
PHP & OTHER MANAG. CARE	$2,032,739,560	$2,377,925,050	$345,185,490	16.98%
REGIONAL MODEL	$682,968,650	$1,057,587,610	$374,618,960	54.85%
DENTAL	$2,230,841,840	$2,216,315,770	($14,526,070)	-0.65%
MENTAL HEALTH	$6,397,579,580	$5,988,321,250	($409,258,330)	-6.40%
AUDITS/ LAWSUITS	$8,767,990	$1,350,000	($7,417,990)	-84.60%
MEDICARE PAYMENTS	$8,309,695,000	$8,798,436,000	$488,741,000	5.88%
STATE HOSP./DEVELOPMENTAL CNTRS.	$18,440,000	$18,581,000	$141,000	0.76%
MISC. SERVICES	$20,166,036,000	$21,228,137,680	$1,062,101,680	5.27%
RECOVERIES	($892,354,000)	($929,648,000)	($37,294,000)	4.18%
DRUG MEDI-CAL	$1,247,848,120	$963,103,790	($284,744,320)	-22.82%
GRAND TOTAL MEDI-CAL	**$167,002,546,930**	**$180,461,698,380**	**$13,459,151,450**	**8.06%**
GENERAL FUNDS	**$36,184,829,140**	**$40,611,175,910**	**$4,426,346,780**	**12.23%**
OTHER STATE FUNDS	**$29,452,298,750**	**$27,734,516,580**	**($1,717,782,170)**	**-5.83%**

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2024-25 AND 2025-26

NO.	POLICY CHANGE TITLE	NOV. 2024 EST. FOR 2024-25		NOV. 2024 EST. FOR 2025-26		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	ELIGIBILITY						
1	CALAIM - INMATE PRE-RELEASE PROGRAM	$48,758,000	$16,578,000	$146,073,000	$35,937,000	$97,315,000	$19,359,000
2	MEDI-CAL STATE INMATE PROGRAMS	$38,066,000	$0	$38,037,000	$0	($29,000)	$0
3	BREAST AND CERVICAL CANCER TREATMENT	$19,736,000	$9,491,400	$15,862,000	$8,138,350	($3,874,000)	($1,353,050)
4	HEALTH ENROLLMENT NAVIGATORS FOR CLINICS	$7,490,000	$3,745,000	$7,510,000	$3,755,000	$20,000	$10,000
6	NON-OTLICP CHIP	$0	($106,656,300)	$0	($107,574,600)	$0	($918,300)
7	NON-EMERGENCY FUNDING ADJUSTMENT	$0	$3,054,378,750	$0	$3,054,378,750	$0	$0
8	SCHIP FUNDING FOR PRENATAL CARE	$0	($70,822,050)	$0	($70,822,050)	$0	$0
9	MEDI-CAL COUNTY INMATE REIMBURSEMENT	$0	($1,703,000)	$0	($1,802,000)	$0	($99,000)
10	CS3 PROXY ADJUSTMENT	$0	($67,383,500)	$0	($67,428,500)	$0	($45,000)
11	REFUGEE MEDICAL ASSISTANCE	$0	($346,000)	$0	($312,000)	$0	$34,000
201	SB 525 MINIMUM WAGE - CASELOAD IMPACT	($79,031,000)	($31,612,300)	($188,536,000)	($75,414,400)	($109,505,000)	($43,802,100)
	ELIGIBILITY SUBTOTAL	**$35,019,000**	**$2,805,670,000**	**$18,946,000**	**$2,778,855,550**	**($16,073,000)**	**($26,814,450)**
	AFFORDABLE CARE ACT						
12	COMMUNITY FIRST CHOICE OPTION	$9,133,032,000	$0	$10,038,990,000	$0	$905,958,000	$0
13	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	$18,208,000	$0	$18,208,000	$0	$0	$0
14	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	($5,393,000)	$0	($5,393,000)	$0	$0
15	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	$0	($33,933,400)	$0	($36,510,400)	$0	($2,577,000)
16	ACA DSH REDUCTION	($1,475,611,000)	($198,074,000)	($1,712,230,000)	($216,086,000)	($236,619,000)	($18,012,000)
	AFFORDABLE CARE ACT SUBTOTAL	**$7,675,629,000**	**($237,400,400)**	**$8,344,968,000**	**($257,989,400)**	**$669,339,000**	**($20,589,000)**
	BENEFITS						
17	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$954,239,000	$0	$842,467,000	$0	($111,772,000)	$0
18	FAMILY PACT PROGRAM	$141,858,000	$34,715,500	$144,214,000	$35,292,400	$2,356,000	$576,900

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2024-25 AND 2025-26

NO.	POLICY CHANGE TITLE	NOV. 2024 EST. FOR 2024-25		NOV. 2024 EST. FOR 2025-26		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	BENEFITS						
19	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$101,991,000	$41,761,500	$111,173,000	$22,357,000	$9,182,000	($19,404,500)
20	MULTIPURPOSE SENIOR SERVICES PROGRAM	$63,951,000	$31,975,500	$63,951,000	$31,975,500	$0	$0
21	BEHAVIORAL HEALTH TREATMENT	$19,392,000	$9,696,000	$12,537,000	$6,268,500	($6,855,000)	($3,427,500)
22	CYBHI WELLNESS COACH BENEFIT	$12,687,000	$5,501,500	$43,142,000	$18,707,200	$30,455,000	$13,205,700
23	MEDICAL INTERPRETER PILOT PROJECT	$0	$0	$0	$0	$0	$0
24	HEARING AID COVERAGE FOR CHILDREN PROGRAM	$654,000	$654,000	$1,552,000	$1,552,000	$898,000	$898,000
25	CCT FUND TRANSFER TO CDSS	$65,000	$0	$65,000	$0	$0	$0
	BENEFITS SUBTOTAL	**$1,294,837,000**	**$124,304,000**	**$1,219,101,000**	**$116,152,600**	**($75,736,000)**	**($8,151,400)**
	PHARMACY						
26	RESPIRATORY SYNCYTIAL VIRUS VACCINES	$214,043,000	$95,198,850	$227,228,000	$101,063,100	$13,185,000	$5,864,250
27	PHARMACY RETROACTIVE ADJUSTMENTS	$11,000,000	$43,763,200	$0	$0	($11,000,000)	($43,763,200)
28	MEDICATION THERAPY MANAGEMENT PROGRAM	$144,000	$45,250	$144,000	$45,250	$0	$0
29	MEDI-CAL DRUG REBATE FUND	$0	($2,095,877,000)	$0	($1,953,944,000)	$0	$141,933,000
30	LITIGATION SETTLEMENTS	($276,000)	($276,000)	$0	$0	$276,000	$276,000
31	BCCTP DRUG REBATES	($2,251,000)	$0	($2,391,000)	$0	($140,000)	$0
32	FAMILY PACT DRUG REBATES	($2,284,000)	$0	($2,171,000)	$0	$113,000	$0
33	MEDICAL SUPPLY REBATES	($188,800,000)	($94,400,000)	($136,800,000)	($51,983,300)	$52,000,000	$42,416,700
34	STATE SUPPLEMENTAL DRUG REBATES	($403,519,000)	$0	($417,946,000)	$0	($14,427,000)	$0
35	FEDERAL DRUG REBATES	($4,397,108,000)	$0	($4,515,587,000)	$0	($118,479,000)	$0
	PHARMACY SUBTOTAL	**($4,769,051,000)**	**($2,051,545,700)**	**($4,847,523,000)**	**($1,904,818,950)**	**($78,472,000)**	**$146,726,750**
	DRUG MEDI-CAL						
37	HCBS SP - CONTINGENCY MANAGEMENT	$35,085,000	$0	$48,581,000	$0	$13,496,000	$0
39	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	$20,290,000	$1,495,450	$21,416,000	$1,577,350	$1,126,000	$81,900

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2024-25 AND 2025-26

NO.	POLICY CHANGE TITLE	NOV. 2024 EST. FOR 2024-25 TOTAL FUNDS	NOV. 2024 EST. FOR 2024-25 GENERAL FUNDS	NOV. 2024 EST. FOR 2025-26 TOTAL FUNDS	NOV. 2024 EST. FOR 2025-26 GENERAL FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE GENERAL FUNDS
	DRUG MEDI-CAL						
40	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	$927,000	$108,000	$874,000	$103,000	($53,000)	($5,000)
	DRUG MEDI-CAL SUBTOTAL	**$56,302,000**	**$1,603,450**	**$70,871,000**	**$1,680,350**	**$14,569,000**	**$76,900**
	MENTAL HEALTH						
43	BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE	$530,635,000	$350,135,000	$411,695,000	$411,695,000	($118,940,000)	$61,560,000
44	MHP COSTS FOR FFPSA	$60,616,000	$14,983,000	$37,299,000	$9,324,000	($23,317,000)	($5,659,000)
45	CALAIM - BH - CONNECT DEMONSTRATION	$29,593,000	$655,000	$784,384,000	$31,667,000	$754,791,000	$31,012,000
46	MHP COSTS FOR CONTINUUM OF CARE REFORM	$3,970,000	$2,867,350	$3,494,000	$2,634,000	($476,000)	($233,350)
47	OUT OF STATE YOUTH - SMHS	$1,070,000	$535,000	$986,000	$493,000	($84,000)	($42,000)
48	CALAIM - BH - CONNECT WORKFORCE INITIATIVE	$0	$0	$95,095,000	$0	$95,095,000	$0
49	SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS	$0	$141,000	$0	$142,000	$0	$1,000
50	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	$0	($200,000)	$0	($200,000)	$0	$0
51	INTERIM AND FINAL COST SETTLEMENTS - SMHS	($588,782,000)	$1,932,000	($327,583,000)	$1,959,000	$261,199,000	$27,000
	MENTAL HEALTH SUBTOTAL	**$37,102,000**	**$371,048,350**	**$1,005,370,000**	**$457,714,000**	**$968,268,000**	**$86,665,650**
	WAIVER--MH/UCD & BTR						
52	GLOBAL PAYMENT PROGRAM	$2,936,500,000	$0	$2,924,821,000	$0	($11,679,000)	$0
53	CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES	$1,709,080,000	$729,048,800	$1,217,962,000	$475,113,500	($491,118,000)	($253,935,300)
54	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	$534,000	$0	$578,000	$0	$44,000	$0
55	ENHANCED CARE MANAGEMENT RISK CORRIDOR	($195,602,000)	($79,813,300)	$0	$0	$195,602,000	$79,813,300

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2024-25 AND 2025-26

NO.	POLICY CHANGE TITLE	NOV. 2024 EST. FOR 2024-25 TOTAL FUNDS	NOV. 2024 EST. FOR 2024-25 GENERAL FUNDS	NOV. 2024 EST. FOR 2025-26 TOTAL FUNDS	NOV. 2024 EST. FOR 2025-26 GENERAL FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE GENERAL FUNDS
	WAIVER--MH/UCD & BTR SUBTOTAL	**$4,450,512,000**	**$649,235,500**	**$4,143,361,000**	**$475,113,500**	**($307,151,000)**	**($174,122,000)**
	MANAGED CARE						
58	2023 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	$14,095,818,000	$5,638,327,150	$12,673,059,000	$5,069,228,000	($1,422,759,000)	($569,099,150)
60	MANAGED CARE HEALTH CARE FINANCING PROGRAM	$2,622,195,000	$886,614,050	$3,197,407,000	$1,149,678,650	$575,212,000	$263,064,600
61	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	$2,232,379,000	$610,214,500	$2,209,565,000	$637,722,000	($22,814,000)	$27,507,500
62	MANAGED CARE PUBLIC HOSPITAL EPP	$1,944,701,000	$557,915,700	$2,369,726,000	$712,175,350	$425,025,000	$154,259,650
64	WORKFORCE & QUALITY INCENTIVE PROGRAM	$297,468,000	$148,777,250	$309,967,000	$155,548,350	$12,499,000	$6,771,100
65	MANAGED CARE PUBLIC DP-NF PASS-THROUGH PYMT PROG	$281,681,000	$133,563,300	$74,666,000	$36,168,700	($207,015,000)	($97,394,600)
68	MANAGED CARE DISTRICT HOSPITAL DIRECTED PAYMENTS	$100,000,000	$0	$203,645,000	$0	$103,645,000	$0
70	CYBHI - STUDENT BH INCENTIVE PROGRAM	$94,202,000	$47,101,000	$0	$0	($94,202,000)	($47,101,000)
71	NON-HOSPITAL 340B CLINIC DIRECTED PAYMENTS	$43,750,000	$21,875,000	$105,000,000	$52,500,000	$61,250,000	$30,625,000
73	CCI-QUALITY WITHHOLD REPAYMENTS	$13,886,000	$6,943,000	$17,414,000	$8,707,000	$3,528,000	$1,764,000
77	CAPITATED RATE ADJUSTMENT FOR FY 2025-26	$0	$0	$2,976,538,000	$1,210,639,450	$2,976,538,000	$1,210,639,450
78	MEDI-CAL MANAGED CARE QUALITY WITHHOLD RELEASE	$0	$0	$250,577,000	$103,007,550	$250,577,000	$103,007,550
79	CHILDREN'S HOSPITAL DIRECTED PAYMENT	$0	$0	$115,000,000	$57,500,000	$115,000,000	$57,500,000
80	MANAGED CARE DIRECTED PAYMENTS MLK COMM HOSPITAL	$0	$0	$28,905,000	$8,083,150	$28,905,000	$8,083,150
81	2023 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	$0	($5,638,327,000)	$0	($5,069,228,000)	$0	$569,099,000
82	2023 MCO ENROLLMENT TAX MANAGED CARE PLANS	$0	($7,941,724,000)	$0	($4,373,496,000)	$0	$3,568,228,000
83	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	$0	($2,268,062,000)	$0	($2,780,378,000)	$0	($512,316,000)

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2024-25 AND 2025-26

NO.	POLICY CHANGE TITLE	NOV. 2024 EST. FOR 2024-25		NOV. 2024 EST. FOR 2025-26		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	MANAGED CARE						
84	COORDINATED CARE INITIATIVE RISK MITIGATION	($27,380,000)	($13,690,000)	($83,880,000)	($41,940,000)	($56,500,000)	($28,250,000)
85	PROP 56 - DIRECTED PAYMENT RISK MITIGATION	($600,000,000)	($181,601,400)	$0	$0	$600,000,000	$181,601,400
86	RETRO MC RATE ADJUSTMENTS	($1,169,110,000)	($787,659,100)	$284,245,000	$159,836,550	$1,453,355,000	$947,495,650
202	HCBS SP - HOUSING AND HOMELESSNESS INCENTIVE PROG	$1,838,000	$0	$0	$0	($1,838,000)	$0
	MANAGED CARE SUBTOTAL	**$19,931,428,000**	**($8,779,732,550)**	**$24,731,834,000**	**($2,904,247,250)**	**$4,800,406,000**	**$5,875,485,300**
	PROVIDER RATES						
87	RATE INCREASE FOR FQHCS/RHCS/CBRCS	$653,011,000	$235,344,650	$1,134,117,000	$408,734,550	$481,106,000	$173,389,900
88	PP-GEMT IGT PROGRAM	$321,745,000	$0	$319,405,000	$0	($2,340,000)	$0
89	MEDI-CAL PROVIDER PAYMENT INCREASES 2025 & LATER	$153,980,000	$61,592,000	$7,417,883,000	$2,967,153,000	$7,263,903,000	$2,905,561,000
90	DPH INTERIM & FINAL RECONS	$208,277,000	$0	$17,839,000	$0	($190,438,000)	$0
91	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	$161,216,000	($26,000,000)	$160,424,000	($5,800,000)	($792,000)	$20,200,000
92	FQHC/RHC/CBRC RECONCILIATION PROCESS	$128,915,000	$46,460,900	$133,942,000	$48,272,700	$5,027,000	$1,811,800
93	NURSING FACILITY RATE ADJUSTMENTS	$763,290,000	$361,799,400	$783,416,000	$371,339,200	$20,126,000	$9,539,800
94	LTC RATE ADJUSTMENT	$207,853,000	$99,686,200	$203,731,000	$97,709,250	($4,122,000)	($1,976,950)
95	HOSPICE RATE INCREASES	$14,142,000	$5,623,850	$16,934,000	$6,734,100	$2,792,000	$1,110,250
96	MEDI-CAL PROVIDER PAYMENT INCREASE	$727,000,000	$291,000,000	$727,000,000	$291,000,000	$0	$0
97	GDSP NBS & PNS FEE ADJUSTMENTS	$5,543,000	$2,178,900	$6,747,000	$2,652,050	$1,204,000	$473,150
98	SKILLED NURSING FACILITY (SNF) BACK-UP POWER	$0	$0	$249,603,000	$98,231,400	$249,603,000	$98,231,400
99	DPH INTERIM RATE GROWTH	$0	$0	$39,818,000	$13,055,800	$39,818,000	$13,055,800
100	DPH INTERIM RATE	$0	($347,999,700)	$0	($363,298,300)	$0	($15,298,600)
101	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	$0	($604,900,000)	$0	($577,637,000)	$0	$27,263,000
102	MEDI-CAL PROVIDER PAYMENT RESERVE FUND	$0	($166,449,000)	$0	$0	$0	$166,449,000

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2024-25 AND 2025-26

NO.	POLICY CHANGE TITLE	NOV. 2024 EST. FOR 2024-25		NOV. 2024 EST. FOR 2025-26		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	PROVIDER RATES						
103	REDUCTION TO RADIOLOGY RATES	($1,678,000)	($739,900)	($16,004,000)	($6,731,700)	($14,326,000)	($5,991,800)
104	LABORATORY RATE METHODOLOGY CHANGE	($14,148,000)	($6,001,300)	($10,345,000)	($4,388,100)	$3,803,000	$1,613,200
203	PROP 35 - PROVIDER PAYMENT INCREASE FUNDING	$0	($186,143,000)	$0	($3,258,153,000)	$0	($3,072,010,000)
	PROVIDER RATES SUBTOTAL	**$3,329,146,000**	**($234,547,000)**	**$11,184,510,000**	**$88,873,950**	**$7,855,364,000**	**$323,420,950**
	SUPPLEMENTAL PMNTS.						
105	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	$4,550,530,000	$0	$6,289,994,000	$0	$1,739,464,000	$0
106	HOSPITAL QAF - FFS PAYMENTS	$3,530,277,000	$0	$2,744,188,000	$0	($786,089,000)	$0
107	HOSPITAL QAF - MANAGED CARE PAYMENTS	$1,297,400,000	$0	$1,200,000,000	$0	($97,400,000)	$0
108	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	$850,473,000	$0	$925,573,000	$0	$75,100,000	$0
109	PRIVATE HOSPITAL DSH REPLACEMENT	$746,417,000	$373,039,500	$757,152,000	$378,576,000	$10,735,000	$5,536,500
110	PROP 56 - MEDI-CAL FAMILY PLANNING	$528,133,000	$212,135,800	$554,314,000	$222,931,300	$26,181,000	$10,795,500
111	DSH PAYMENT	$475,352,000	$37,825,000	$487,442,000	$38,000,000	$12,090,000	$175,000
112	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	$446,253,000	$118,400,000	$487,085,000	$118,400,000	$40,832,000	$0
113	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$233,064,000	$0	$217,964,000	$0	($15,100,000)	$0
114	FFP FOR LOCAL TRAUMA CENTERS	$144,174,000	$0	$182,691,000	$0	$38,517,000	$0
115	DPH PHYSICIAN & NON-PHYS. COST	$120,572,000	$0	$123,553,000	$0	$2,981,000	$0
116	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	$116,334,000	($567,000)	$126,279,000	($1,770,000)	$9,945,000	($1,203,000)
117	CAPITAL PROJECT DEBT REIMBURSEMENT	$87,354,000	$26,429,500	$91,283,000	$26,353,000	$3,929,000	($76,500)
118	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	$61,315,000	$0	$26,513,000	$0	($34,802,000)	$0
119	NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS	$52,500,000	$26,250,000	$0	$0	($52,500,000)	($26,250,000)
120	NDPH IGT SUPPLEMENTAL PAYMENTS	$52,164,000	($1,595,000)	$53,938,000	($1,595,000)	$1,774,000	$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 2024-25 AND 2025-26

NO.	POLICY CHANGE TITLE	NOV. 2024 EST. FOR 2024-25		NOV. 2024 EST. FOR 2025-26		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	SUPPLEMENTAL PMNTS.						
121	PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS	$788,999,000	$320,030,700	$880,840,000	$357,084,150	$91,841,000	$37,053,450
122	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	$16,326,000	$0	$16,016,000	$0	($310,000)	$0
123	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	$10,000,000	$5,000,000	$10,000,000	$5,000,000	$0	$0
124	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	$8,000,000	$4,000,000	$8,000,000	$4,000,000	$0	$0
125	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	$56,728,000	$24,451,000	$56,881,000	$24,670,000	$153,000	$219,000
126	NDPH SUPPLEMENTAL PAYMENT	$4,207,000	$1,900,000	$16,479,000	$1,900,000	$12,272,000	$0
127	FREE CLINICS AUGMENTATION	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$0	$0
128	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	$1,002,000	$0	$0	$0	($1,002,000)	$0
129	IGT ADMIN. & PROCESSING FEE	$0	($15,360,000)	$0	($18,313,000)	$0	($2,953,000)
130	PROPOSITION 56 FUNDING	$0	($628,655,000)	($134,262,000)	($606,722,000)	($134,262,000)	$21,933,000
131	GEMT SUPPLEMENTAL PAYMENT PROGRAM	($17,708,000)	$0	($2,986,000)	$0	$14,722,000	$0
	SUPPLEMENTAL PMNTS. SUBTOTAL	**$14,161,866,000**	**$505,284,500**	**$15,120,937,000**	**$550,514,450**	**$959,071,000**	**$45,229,950**
	COVID-19						
132	COVID-19 REDETERMINATIONS IMPACT	$798,398,000	$279,471,050	$1,140,179,000	$448,236,200	$341,781,000	$168,765,150
133	PHARMACY-BASED COVID-19 TESTS	$6,657,000	$2,161,950	$14,858,000	$4,824,650	$8,201,000	$2,662,700
134	COVID-19 BEHAVIORAL HEALTH	$1,876,000	$148,100	$0	$0	($1,876,000)	($148,100)
135	COVID-19 VACCINE FUNDING ADJUSTMENT	$0	($53,539,000)	$0	($13,257,000)	$0	$40,282,000
136	CONTINUOUS CHIP COVERAGE DURING THE COVID-19 PHE	$0	$0	$0	$54,318,000	$0	$54,318,000
137	COVID-19 VACCINES	$130,536,000	$46,574,250	$120,849,000	$43,118,000	($9,687,000)	($3,456,250)
	COVID-19 SUBTOTAL	**$937,467,000**	**$274,816,350**	**$1,275,886,000**	**$537,239,850**	**$338,419,000**	**$262,423,500**

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 2024-25 AND 2025-26

NO.	POLICY CHANGE TITLE	NOV. 2024 EST. FOR 2024-25		NOV. 2024 EST. FOR 2025-26		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	STATE-ONLY CLAIMING						
138	STATE-ONLY CLAIMING ADJUSTMENTS - RETRO ADJ.	$0	$439,360,000	$0	$944,000	$0	($438,416,000)
	STATE-ONLY CLAIMING SUBTOTAL	**$0**	**$439,360,000**	**$0**	**$944,000**	**$0**	**($438,416,000)**
	OTHER DEPARTMENTS						
139	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$791,808,000	$0	$900,026,000	$0	$108,218,000	$0
	OTHER DEPARTMENTS SUBTOTAL	**$791,808,000**	**$0**	**$900,026,000**	**$0**	**$108,218,000**	**$0**
	OTHER						
146	BEHAVIORAL HEALTH BRIDGE HOUSING	$272,087,000	$272,087,000	$243,587,000	$243,587,000	($28,500,000)	($28,500,000)
148	CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY	$70,000,000	$70,000,000	$0	$0	($70,000,000)	($70,000,000)
149	MEDICAL PROVIDER INTERIM PAYMENT LOAN REPAYMENT	$310,922,000	$310,922,000	$0	$0	($310,922,000)	($310,922,000)
150	QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES	$245,666,000	$36,850,000	$323,831,000	$48,575,000	$78,165,000	$11,725,000
151	CYBHI - EVIDENCE-BASED BH PRACTICES	$219,285,000	$219,285,000	$41,592,000	$41,592,000	($177,693,000)	($177,693,000)
152	SELF-DETERMINATION PROGRAM - CDDS	$202,734,000	$0	$296,578,000	$0	$93,844,000	$0
153	HCBS SP CDDS	$431,814,000	$0	$0	$0	($431,814,000)	$0
154	CALAIM - PATH WPC	$91,898,000	$0	$0	$0	($91,898,000)	$0
155	CYBHI - URGENT NEEDS AND EMERGENT ISSUES	$44,500,000	$44,500,000	$12,130,000	$12,130,000	($32,370,000)	($32,370,000)
156	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	$98,775,000	$0	$65,958,000	$0	($32,817,000)	$0
157	MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG	$62,240,000	$0	$51,227,000	$0	($11,013,000)	$0
158	QAF WITHHOLD TRANSFER	$59,276,000	$29,638,000	($50,000)	($25,000)	($59,326,000)	($29,663,000)
159	CALAIM - PATH FOR CLINICS	$40,000,000	$40,000,000	$0	$0	($40,000,000)	($40,000,000)
160	CARE ACT	$36,621,000	$36,621,000	$47,125,000	$47,125,000	$10,504,000	$10,504,000
161	MISC. ONE-TIME PAYMENTS	$31,500,000	$31,500,000	$0	$0	($31,500,000)	($31,500,000)

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2024-25 AND 2025-26

NO.	POLICY CHANGE TITLE	NOV. 2024 EST. FOR 2024-25		NOV. 2024 EST. FOR 2025-26		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER						
162	INFANT DEVELOPMENT PROGRAM	$23,567,000	$0	$20,671,000	$0	($2,896,000)	$0
164	CYBHI - CALHOPE STUDENT SUPPORT	$10,475,000	$10,475,000	$0	$0	($10,475,000)	($10,475,000)
166	EQUITY & PRACTICE TRANSFORMATION PAYMENTS	$22,592,000	$11,296,000	$40,600,000	$20,300,000	$18,008,000	$9,004,000
167	INDIAN HEALTH SERVICES	$18,726,000	$6,242,000	$17,493,000	$5,831,000	($1,233,000)	($411,000)
168	CALHOPE	$23,602,000	$20,543,000	$0	$0	($23,602,000)	($20,543,000)
169	ABORTION SUPPLEMENTAL PAYMENT PROGRAM	$14,858,000	$14,858,000	$0	$0	($14,858,000)	($14,858,000)
170	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	$16,992,000	$7,773,000	$11,536,000	$5,272,000	($5,456,000)	($2,501,000)
171	CYBHI - FEE SCHEDULE THIRD PARTY ADMINISTRATOR	$10,000,000	$0	$0	$0	($10,000,000)	$0
173	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	$7,522,000	$4,137,000	$45,456,000	$25,001,000	$37,934,000	$20,864,000
174	ASSET LIMIT INCREASE & ELIM. - CNTY BH FUNDING	$6,084,000	$6,084,000	$4,413,000	$4,413,000	($1,671,000)	($1,671,000)
175	FOSTER YOUTH SUBSTANCE USE DISORDER GRANT PROGRAM	$0	$0	$0	$0	$0	$0
176	SECTION 19.56 LEGISLATIVE PRIORITIES	$2,357,000	$2,357,000	$0	$0	($2,357,000)	($2,357,000)
177	ADVISORY COUNCIL ON PHYS. FIT. & MENTAL WELL-BEING	$1,000,000	$0	$0	$0	($1,000,000)	$0
178	WPCS WORKERS' COMPENSATION	$620,000	$310,000	$620,000	$310,000	$0	$0
180	HCBS SP - CALBRIDGE BH NAVIGATOR PROGRAM	$75,000	$0	$0	$0	($75,000)	$0
181	HCBS SP - NON-IHSS CARE ECONOMY PMTS	$70,000	$0	$0	$0	($70,000)	$0
182	HCBS SP - ETSB FOR LAGUNA HONDA HOSPITAL RESIDENTS	$49,000	$0	$0	$0	($49,000)	$0
183	HCBS SP - ALW FUNDING SHIFT	$0	($105,788,000)	$0	$0	$0	$105,788,000
184	HEALTH CARE SVCS. FINES AND PENALTIES	$0	($69,930,000)	$0	$0	$0	$69,930,000
185	IMD ANCILLARY SERVICES	$0	$68,429,000	$0	$63,576,000	$0	($4,853,000)
186	HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	($1,283,474,000)	$0	($1,261,900,000)	$0	$21,574,000
187	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	($126,961,000)	$0	($107,168,000)	$0	$19,793,000

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2024-25 AND 2025-26

NO.	POLICY CHANGE TITLE	NOV. 2024 EST. FOR 2024-25 TOTAL FUNDS	NOV. 2024 EST. FOR 2024-25 GENERAL FUNDS	NOV. 2024 EST. FOR 2025-26 TOTAL FUNDS	NOV. 2024 EST. FOR 2025-26 GENERAL FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE GENERAL FUNDS
	OTHER						
188	FUNDING ADJUST.—ACA OPT. EXPANSION	$0	($5,414,847,600)	$0	($5,786,183,600)	$0	($371,336,000)
189	FUNDING ADJUST.—OTLICP	$0	($133,038,450)	$0	($136,980,000)	$0	($3,941,550)
190	CCI IHSS RECONCILIATION	$0	$115,000,000	$0	$0	$0	($115,000,000)
191	CMS DEFERRED CLAIMS	$0	$4,000,000	$0	($109,127,000)	$0	($113,127,000)
192	INDIAN HEALTH SERVICES FUNDING SHIFT	$0	($25,549,500)	$0	($27,294,500)	$0	($1,745,000)
193	DENTAL MANAGED CARE MLR RISK CORRIDOR	($3,000,000)	($1,198,250)	$0	$0	$3,000,000	$1,198,250
194	QUALITY SANCTIONS	($5,549,000)	($2,514,500)	($3,500,000)	($1,750,000)	$2,049,000	$764,500
195	ASSISTED LIVING WAIVER EXPANSION	($8,576,000)	($5,146,000)	($24,880,000)	($14,928,000)	($16,304,000)	($9,782,000)
196	COUNTY SHARE OF OTLICP-CCS COSTS	($12,456,000)	($12,456,000)	($12,456,000)	($12,456,000)	$0	$0
197	HCBA WAIVER EXPANSION	($29,901,000)	($15,011,000)	($86,738,000)	($43,545,000)	($56,837,000)	($28,534,000)
198	MEDICARE PART A BUY-IN PROGRAM	($41,778,000)	($1,384,000)	($103,168,000)	($5,712,000)	($61,390,000)	($4,328,000)
199	COUNTY BH RECOUPMENTS	($128,319,000)	($128,319,000)	($64,160,000)	($64,160,000)	$64,159,000	$64,159,000
204	L.A. CARE SANCTIONS LEGAL AID GRANTS	$0	$0	$0	$0	$0	$0
	OTHER SUBTOTAL	**$2,146,328,000**	**($5,962,710,300)**	**$927,865,000**	**($7,053,517,100)**	**($1,218,463,000)**	**($1,090,806,800)**
	GRAND TOTAL	**$50,078,393,000**	**($12,094,613,800)**	**$64,096,152,000**	**($7,113,484,450)**	**$14,017,759,000**	**$4,981,129,350**

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

FISCAL YEAR 2025-26 COST PER ELIGIBLE BASED ON NOVEMBER 2024 ESTIMATE

SERVICE CATEGORY	PA-OAS	NEWLY	PA-ATD	PA-AFDC	LT-OAS	H-PE
PHYSICIANS	$808,450	$125,283,530	$49,008,400	$39,203,700	$907,920	$80,167,160
OTHER MEDICAL	$141,140,150	$2,412,484,560	$553,332,610	$564,721,150	$9,743,270	$48,176,910
CO. & COMM. OUTPATIENT	$511,380	$110,569,200	$112,407,590	$43,777,250	$111,630	$61,269,780
PHARMACY	$74,529,460	$7,447,770,920	$2,686,608,720	$655,528,500	$11,897,820	$41,223,980
COUNTY INPATIENT	$1,187,560	$325,974,930	$18,993,950	$35,475,170	$583,750	$107,667,940
COMMUNITY INPATIENT	$9,257,350	$955,726,210	$368,449,190	$303,215,120	$3,441,040	$416,041,320
NURSING FACILITIES	$33,274,080	$67,231,600	$114,303,510	$3,175,860	$286,983,140	$3,863,670
ICF-DD	$357,190	$1,267,390	$6,696,090	$272,950	$4,273,430	$0
MEDICAL TRANSPORTATION	$320,430	$23,083,900	$6,097,140	$4,564,310	$252,660	$13,703,970
OTHER SERVICES	$176,508,450	$312,315,710	$996,403,970	$118,425,790	$24,383,300	$3,595,180
HOME HEALTH	$3,780,370	$1,083,690	$53,369,240	$7,248,550	$270	$186,830
FFS SUBTOTAL	**$441,674,870**	**$11,782,791,640**	**$4,965,670,410**	**$1,775,608,360**	**$342,578,230**	**$775,896,750**
DENTAL	$55,372,340	$510,566,780	$131,449,900	$253,916,220	$9,594,550	$2,080,860
MENTAL HEALTH	$38,560,630	$1,454,655,720	$1,117,782,000	$975,753,480	$0	$0
TWO PLAN MODEL	$2,381,306,150	$16,924,274,690	$6,376,465,140	$2,365,649,350	$2,253,060,020	$0
COUNTY ORGANIZED HEALTH SYSTEMS	$1,118,694,940	$8,410,947,740	$2,941,804,020	$827,285,450	$565,383,740	$0
GEOGRAPHIC MANAGED CARE	$373,647,770	$3,226,719,180	$1,250,193,410	$427,974,890	$358,679,210	$0
PHP & OTHER MANAG. CARE	$540,488,070	$30,975,840	$335,327,130	$7,270,290	$22,372,440	$0
MEDICARE PAYMENTS	$2,187,203,730	$519,444,740	$1,979,070,770	$0	$167,570,030	$0
MISC. SERVICES	$102,511,190	$0	$193,202,690	$2,475,360	$0	$0
DRUG MEDI-CAL	$25,320,330	$333,613,420	$62,476,500	$78,361,240	$2,065,050	$11,660
REGIONAL MODEL	$10,227,090	$273,533,070	$114,964,220	$24,015,390	$43,693,120	$0
NON-FFS SUBTOTAL	**$6,833,332,240**	**$31,684,731,170**	**$14,502,735,780**	**$4,962,701,680**	**$3,422,418,160**	**$2,092,520**
TOTAL DOLLARS (1)	**$7,275,007,110**	**$43,467,522,810**	**$19,468,406,190**	**$6,738,310,040**	**$3,764,996,390**	**$777,989,270**
ELIGIBLES * **	**427,200**	**5,042,000**	**782,200**	**1,077,800**	**41,300**	**48,100**
ANNUAL $/ELIGIBLE	**$17,030**	**$8,621**	**$24,889**	**$6,252**	**$91,162**	**$16,174**
AVG. MO. $/ELIGIBLE	**$1,419**	**$718**	**$2,074**	**$521**	**$7,597**	**$1,348**

(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 2025-26 COST PER ELIGIBLE BASED ON NOVEMBER 2024 ESTIMATE

SERVICE CATEGORY	LT-ATD	POV 250	MN-OAS	MN-ATD	MN-AFDC	MI-C
PHYSICIANS	$323,190	$19,360,090	$12,880,430	$6,133,450	$66,987,860	$28,558,720
OTHER MEDICAL	$3,713,040	$305,295,090	$407,659,530	$110,657,780	$1,975,163,120	$131,829,270
CO. & COMM. OUTPATIENT	$70,990	$26,501,530	$15,932,020	$7,318,140	$97,642,070	$17,331,640
PHARMACY	$5,160,000	$349,550,990	$618,306,580	$250,228,500	$2,596,606,520	$99,076,190
COUNTY INPATIENT	$184,170	$6,239,330	$25,172,740	$3,945,100	$62,344,440	$13,707,630
COMMUNITY INPATIENT	$2,979,420	$105,837,640	$87,098,530	$28,999,830	$578,828,050	$80,433,150
NURSING FACILITIES	$44,671,700	$899,780	$304,162,060	$39,818,230	$10,211,190	$7,029,410
ICF-DD	$14,342,130	$0	$1,535,780	$701,080	$263,230	$874,860
MEDICAL TRANSPORTATION	$151,630	$731,040	$3,468,450	$1,207,780	$5,985,850	$3,684,450
OTHER SERVICES	$5,870,060	$59,102,970	$304,709,160	$195,812,990	$89,735,390	$60,645,040
HOME HEALTH	$720	$8,789,020	$1,521,510	$11,517,270	$10,137,690	$9,265,710
FFS SUBTOTAL	**$77,467,050**	**$882,307,470**	**$1,782,446,780**	**$656,340,140**	**$5,493,905,430**	**$452,436,070**
DENTAL	$2,466,520	$183,790,000	$86,351,770	$27,154,390	$604,310,190	$27,028,080
MENTAL HEALTH	$0	$226,812,610	$732,853,050	$178,271,620	$1,198,775,720	$182,113,040
TWO PLAN MODEL	$477,211,310	$1,043,020,970	$4,474,115,980	$1,366,869,000	$6,903,889,820	$80,886,930
COUNTY ORGANIZED HEALTH SYSTEMS	$91,623,560	$569,363,500	$2,546,772,760	$850,604,400	$3,994,021,680	$61,633,580
GEOGRAPHIC MANAGED CARE	$77,124,370	$208,576,450	$663,476,480	$288,088,100	$1,377,524,900	$13,029,150
PHP & OTHER MANAG. CARE	$802,510	$198,540	$1,117,937,130	$72,195,180	$142,840	$19,500
MEDICARE PAYMENTS	$0	$0	$2,933,858,750	$846,258,620	$165,029,350	$0
MISC. SERVICES	$0	$0	$197,171,740	$47,317,060	$7,774,730	$423,620
DRUG MEDI-CAL	$418,990	$53,521,450	$48,410,540	$13,754,260	$241,852,260	$12,983,580
REGIONAL MODEL	$3,585,290	$19,541,800	$55,443,340	$39,278,160	$119,092,760	$862,170
NON-FFS SUBTOTAL	**$653,232,550**	**$2,304,825,310**	**$12,856,391,540**	**$3,729,790,800**	**$14,612,414,260**	**$378,979,640**
TOTAL DOLLARS (1)	**$730,699,600**	**$3,187,132,780**	**$14,638,838,330**	**$4,386,130,940**	**$20,106,319,690**	**$831,415,720**
ELIGIBLES * **	**6,700**	**960,700**	**1,149,200**	**238,200**	**3,682,400**	**147,600**
ANNUAL $/ELIGIBLE	**$109,060**	**$3,318**	**$12,738**	**$18,414**	**$5,460**	**$5,633**
AVG. MO. $/ELIGIBLE	**$9,088**	**$276**	**$1,062**	**$1,534**	**$455**	**$469**

(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 2025-26 COST PER ELIGIBLE BASED ON NOVEMBER 2024 ESTIMATE

SERVICE CATEGORY	MI-A	REFUGEE	OBRA	POV 185	POV 133	POV 100
PHYSICIANS	$305,550	$162,920	$0	$51,415,380	$17,974,130	$5,862,520
OTHER MEDICAL	$444,110	$3,392,260	$0	$294,769,410	$297,943,840	$114,475,830
CO. & COMM. OUTPATIENT	$37,670	$182,680	$10	$31,959,630	$48,490,160	$11,320,100
PHARMACY	$2,705,690	$4,066,450	$210	$71,360,910	$133,972,960	$139,953,270
COUNTY INPATIENT	$3,603,570	$77,600	$0	$39,390,370	$4,646,870	$3,171,550
COMMUNITY INPATIENT	$2,666,430	$386,230	$0	$416,257,040	$93,246,890	$32,607,490
NURSING FACILITIES	$10,247,440	$0	$10	$32,080	$1,544,960	$0
ICF-DD	$460,960	$0	$0	$0	$208,780	$0
MEDICAL TRANSPORTATION	$35,780	$34,810	$20	$1,668,480	$547,740	$194,840
OTHER SERVICES	$836,100	$71,990	$20	$8,613,860	$32,912,250	$11,518,030
HOME HEALTH	$0	$0	$0	$2,038,550	$4,083,360	$1,658,190
FFS SUBTOTAL	**$21,343,290**	**$8,374,930**	**$280**	**$917,505,720**	**$635,571,940**	**$320,761,820**
DENTAL	$184,970	$1,479,720	$0	$17,044,260	$213,116,740	$86,305,720
MENTAL HEALTH	$0	$0	$0	$0	$93,540,680	$176,522,630
TWO PLAN MODEL	$1,628,710	$3,407,040	$0	$450,022,430	$795,643,610	$366,367,080
COUNTY ORGANIZED HEALTH SYSTEMS	$1,515,770	$3,320,650	$0	$291,197,740	$410,784,580	$187,938,970
GEOGRAPHIC MANAGED CARE	$357,640	$1,892,490	$0	$109,393,540	$157,522,360	$64,964,320
PHP & OTHER MANAG. CARE	$89,580	$0	$0	$175,650	$165,680	$165,680
MEDICARE PAYMENTS	$0	$0	$0	$0	$0	$0
MISC. SERVICES	$140	$0	$0	$14,580	$1,418,190	$667,690
DRUG MEDI-CAL	$185,550	$209,500	$0	$20,896,600	$46,305,030	$21,853,890
REGIONAL MODEL	$14,630	$0	$0	$7,194,970	$11,714,710	$5,044,790
NON-FFS SUBTOTAL	**$3,976,980**	**$10,309,390**	**$0**	**$895,939,770**	**$1,730,211,590**	**$909,830,770**
TOTAL DOLLARS (1)	**$25,320,280**	**$18,684,320**	**$280**	**$1,813,445,490**	**$2,365,783,530**	**$1,230,592,590**
ELIGIBLES * **	**3,800**	**3,900**	**0**	**346,600**	**647,600**	**237,600**
ANNUAL $/ELIGIBLE	**$6,663**	**$4,791**		**$5,232**	**$3,653**	**$5,179**
AVG. MO. $/ELIGIBLE	**$555**	**$399**		**$436**	**$304**	**$432**

(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 2025-26 COST PER ELIGIBLE BASED ON NOVEMBER 2024 ESTIMATE

SERVICE CATEGORY	TOTAL
PHYSICIANS	**$505,343,410**
OTHER MEDICAL	**$7,374,941,940**
CO. & COMM. OUTPATIENT	**$585,433,480**
PHARMACY	**$15,188,547,650**
COUNTY INPATIENT	**$652,366,680**
COMMUNITY INPATIENT	**$3,485,470,920**
NURSING FACILITIES	**$927,448,720**
ICF-DD	**$31,253,870**
MEDICAL TRANSPORTATION	**$65,733,280**
OTHER SERVICES	**$2,401,460,260**
HOME HEALTH	**$114,680,970**
FFS SUBTOTAL	**$31,332,681,170**
DENTAL	**$2,212,213,000**
MENTAL HEALTH	**$6,375,641,180**
TWO PLAN MODEL	**$46,263,818,210**
COUNTY ORGANIZED HEALTH SYSTEMS	**$22,872,893,080**
GEOGRAPHIC MANAGED CARE	**$8,599,164,260**
PHP & OTHER MANAG. CARE	**$2,128,326,050**
MEDICARE PAYMENTS	**$8,798,436,000**
MISC. SERVICES	**$552,977,000**
DRUG MEDI-CAL	**$962,239,850**
REGIONAL MODEL	**$728,205,540**
NON-FFS SUBTOTAL	**$99,493,914,160**
TOTAL DOLLARS (1)	**$130,826,595,330**
ELIGIBLES * **	**14,842,900**
ANNUAL $/ELIGIBLE	**$8,814**
AVG. MO. $/ELIGIBLE	**$735**

(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 2025-26 COST PER ELIGIBLE BASED ON NOVEMBER 2024 ESTIMATE

EXCLUDED POLICY CHANGES: 113

	QAF WITHHOLD TRANSFER ADJUSTMENT
	QAF WITHHOLD ADJUSTMENT
3	BREAST AND CERVICAL CANCER TREATMENT
4	HEALTH ENROLLMENT NAVIGATORS FOR CLINICS
10	CS3 PROXY ADJUSTMENT
12	COMMUNITY FIRST CHOICE OPTION
14	1% FMAP INCREASE FOR PREVENTIVE SERVICES
15	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.
16	ACA DSH REDUCTION
18	FAMILY PACT PROGRAM
19	CALIFORNIA COMMUNITY TRANSITIONS COSTS
23	MEDICAL INTERPRETER PILOT PROJECT
27	PHARMACY RETROACTIVE ADJUSTMENTS
30	LITIGATION SETTLEMENTS
32	FAMILY PACT DRUG REBATES
40	DRUG MEDI-CAL PROGRAM COST SETTLEMENT
43	BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE
49	SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS
50	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT
51	INTERIM AND FINAL COST SETTLEMENTS - SMHS
52	GLOBAL PAYMENT PROGRAM
53	CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES
54	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG
55	ENHANCED CARE MANAGEMENT RISK CORRIDOR
58	2023 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.
67	DENTAL MANAGED CARE (Other M/C)
70	CYBHI - STUDENT BH INCENTIVE PROGRAM
71	NON-HOSPITAL 340B CLINIC DIRECTED PAYMENTS
72	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL
75	COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM
76	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL
78	MEDI-CAL MANAGED CARE QUALITY WITHHOLD RELEASE
81	2023 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ
82	2023 MCO ENROLLMENT TAX MANAGED CARE PLANS

FISCAL YEAR 2025-26 COST PER ELIGIBLE BASED ON NOVEMBER 2024 ESTIMATE

EXCLUDED POLICY CHANGES: 113

83	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND
85	PROP 56 - DIRECTED PAYMENT RISK MITIGATION
91	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF
101	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES
102	MEDI-CAL PROVIDER PAYMENT RESERVE FUND
105	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS
106	HOSPITAL QAF - FFS PAYMENTS
107	HOSPITAL QAF - MANAGED CARE PAYMENTS
108	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS
109	PRIVATE HOSPITAL DSH REPLACEMENT
110	PROP 56 - MEDI-CAL FAMILY PLANNING
111	DSH PAYMENT
112	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
113	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS
114	FFP FOR LOCAL TRAUMA CENTERS
115	DPH PHYSICIAN & NON-PHYS. COST
116	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS
117	CAPITAL PROJECT DEBT REIMBURSEMENT
118	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS
119	NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS
120	NDPH IGT SUPPLEMENTAL PAYMENTS
121	PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS
122	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS
123	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH
124	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH
125	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS
126	NDPH SUPPLEMENTAL PAYMENT
127	FREE CLINICS AUGMENTATION
128	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS
129	IGT ADMIN. & PROCESSING FEE
130	PROPOSITION 56 FUNDING
131	GEMT SUPPLEMENTAL PAYMENT PROGRAM
138	STATE-ONLY CLAIMING ADJUSTMENTS - RETRO ADJ.
139	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS

FISCAL YEAR 2025-26 COST PER ELIGIBLE BASED ON NOVEMBER 2024 ESTIMATE

EXCLUDED POLICY CHANGES: 113

142	PERSONAL CARE SERVICES (Misc. Svcs.)
143	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)
146	BEHAVIORAL HEALTH BRIDGE HOUSING
147	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)
148	CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY
149	MEDICAL PROVIDER INTERIM PAYMENT LOAN REPAYMENT
151	CYBHI - EVIDENCE-BASED BH PRACTICES
152	SELF-DETERMINATION PROGRAM - CDDS
154	CALAIM - PATH WPC
155	CYBHI - URGENT NEEDS AND EMERGENT ISSUES
156	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS
157	MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG
158	QAF WITHHOLD TRANSFER
159	CALAIM - PATH FOR CLINICS
161	MISC. ONE-TIME PAYMENTS
162	INFANT DEVELOPMENT PROGRAM
163	MEDI-CAL TCM PROGRAM
164	CYBHI - CALHOPE STUDENT SUPPORT
165	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC
166	EQUITY & PRACTICE TRANSFORMATION PAYMENTS
168	CALHOPE
169	ABORTION SUPPLEMENTAL PAYMENT PROGRAM
170	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS
171	CYBHI - FEE SCHEDULE THIRD PARTY ADMINISTRATOR
172	LAWSUITS/CLAIMS
173	MINIMUM WAGE INCREASE FOR HCBS WAIVERS
174	ASSET LIMIT INCREASE & ELIM. - CNTY BH FUNDING
175	FOSTER YOUTH SUBSTANCE USE DISORDER GRANT PROGRAM
176	SECTION 19.56 LEGISLATIVE PRIORITIES
177	ADVISORY COUNCIL ON PHYS. FIT. & MENTAL WELL-BEING
180	HCBS SP - CALBRIDGE BH NAVIGATOR PROGRAM
181	HCBS SP - NON-IHSS CARE ECONOMY PMTS
182	HCBS SP - ETSB FOR LAGUNA HONDA HOSPITAL RESIDENTS
186	HOSPITAL QAF - CHILDREN'S HEALTH CARE

FISCAL YEAR 2025-26 COST PER ELIGIBLE BASED ON NOVEMBER 2024 ESTIMATE

EXCLUDED POLICY CHANGES: 113

187	CIGARETTE AND TOBACCO SURTAX FUNDS
190	CCI IHSS RECONCILIATION
191	CMS DEFERRED CLAIMS
193	DENTAL MANAGED CARE MLR RISK CORRIDOR
194	QUALITY SANCTIONS
195	ASSISTED LIVING WAIVER EXPANSION
196	COUNTY SHARE OF OTLICP-CCS COSTS
197	HCBA WAIVER EXPANSION
198	MEDICARE PART A BUY-IN PROGRAM
199	COUNTY BH RECOUPMENTS
200	BASE RECOVERIES
203	PROP 35 - PROVIDER PAYMENT INCREASE FUNDING
204	L.A. CARE SANCTIONS LEGAL AID GRANTS

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CASELOAD

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

Estimated Average Monthly Certified Eligibles
November 2024 Estimate
Fiscal Years 2023-2024, 2024-2025, & 2025-2026

(With Estimated Impact of Eligibility Policy Changes)*

	2023-2024	2024-2025	2025-2026	23-24 To 24-25 % Change	24-25 To 25-26 % Change
Public Assistance	**2,472,700**	**2,369,000**	**2,281,100**	**-4.19%**	**-3.71%**
Seniors	420,900	423,300	427,200	0.57%	0.92%
Persons with Disabilities	851,100	815,100	782,200	-4.23%	-4.04%
Families [1]	1,200,700	1,130,600	1,071,700	-5.84%	-5.21%
Long Term	**42,000**	**45,700**	**48,000**	**8.81%**	**5.03%**
Seniors	34,900	38,600	41,300	10.60%	6.99%
Persons with Disabilities	7,100	7,100	6,700	0.00%	-5.63%
Medically Needy	**4,977,600**	**4,994,700**	**4,882,500**	**0.34%**	**-2.25%**
Seniors	821,900	982,300	1,121,700	19.52%	14.19%
Persons with Disabilities	205,900	218,900	233,900	6.31%	6.85%
Families [1]	3,949,800	3,793,500	3,526,900	-3.96%	-7.03%
Medically Indigent	**169,100**	**160,200**	**151,400**	**-5.26%**	**-5.49%**
Children	166,000	156,800	147,600	-5.54%	-5.87%
Adults	3,100	3,400	3,800	9.68%	11.76%
Other	**7,580,000**	**7,382,800**	**7,126,700**	**-2.60%**	**-3.47%**
Refugees	4,500	4,100	3,900	-8.89%	-4.88%
OBRA [2]	0	0	0	n/a	n/a
185% Poverty [3]	353,100	336,800	337,500	-4.62%	0.21%
133% Poverty	782,400	710,100	642,100	-9.24%	-9.58%
100% Poverty	375,900	304,400	237,600	-19.02%	-21.94%
Opt. Targeted Low Income Children	881,200	915,800	956,500	3.93%	4.44%
ACA Optional Expansion	5,119,800	5,051,300	4,884,000	-1.34%	-3.31%
Hospital PE	41,100	43,300	48,100	5.35%	11.09%
Medi-Cal Access Program	10,100	6,300	6,300	-37.62%	0.00%
QMB	11,900	10,700	10,700	-10.08%	0.00%
GRAND TOTAL [4]	**15,241,400**	**14,952,400**	**14,489,700**	**-1.90%**	**-3.09%**
Seniors	**1,277,700**	**1,444,200**	**1,590,200**	13.03%	10.11%
Persons with Disabilities	**1,064,100**	**1,041,100**	**1,022,800**	-2.16%	-1.76%
Families and Children [5]	**7,709,100**	**7,348,000**	**6,919,900**	-4.68%	-5.83%
ACA Optional Expansion	**5,119,800**	**5,051,300**	**4,884,000**	-1.34%	-3.31%

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

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

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

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

	2023-2024	2024-2025	2025-2026
Presumptive Eligibility	26,200	27,800	27,800

[4] The following Medi-Cal special program eligibles (average monthly during FY 2023-24 shown in parenthesis are not included above: BCCTP (2,653), Tuberculosis (34), Dialysis (92), TPN (1), TCVAP (774) Family PACT eligibles are also not included above.

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

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

Policy Change	Budget Aid Category	Caseload Change Average Monthly Eligibles *not* in the Base Estimate 2023-24	2024-25	2025-26
PC 2 Medi-Cal State Inmates	LT Seniors	1	1	1
	MN Seniors	29	38	38
	MN Persons with Disabilities	6	8	8
	MI Children	2	3	3
	185% Poverty	2	3	3
	ACA Optional Expansion	174	204	204
	Total	**213**	**255**	**255**
PC 72 Medi-Cal Access Program Mothers 213-322%	MCAP Mothers	7,452	5,492	5,492
	Total	**7,452**	**5,492**	**5,492**
PC 76 Medi-Cal Access Program Infants 266-322%	MCAP Infants	2,694	776	776
	Total	**2,694**	**776**	**776**
PC 132 COVID-19 Redeterminations Impact	PA Seniors		1,449	5,342
	PA Persons with Disabilities		(18,069)	(50,952)
	PA Families		(25,088)	(79,090)
	LT Seniors		1,961	4,658
	LT Persons with Disabilities		103	(274)
	MN Seniors		76,676	206,264
	MN Persons with Disabilities		10,316	25,270
	MN Families		(25,840)	(151,174)
	MI Children		(10,921)	(20,142)
	MI Adults		338	808
	Refugee		362	306
	185% Poverty		9,934	18,249
	133% Poverty		(21,791)	(85,094)
	100% Poverty		(24,431)	(91,048)
	H-PE		1,305	6,032
	OTLICP		19,538	63,533
	ACA Optional Expansion		71,341	51,355
	Total	**0**	**67,184**	**(95,957)**
PC 201 SB 525 Minimum Wage - Caseload Impact	ACA Optional Expansion		(11,432)	(26,454)
	MN Families		(8,599)	(19,898)
	Total	**0**	**(20,031)**	**(46,352)**

	Budget Aid Category	2023-24	2024-25	2025-26
Total by Aid Category	PA Seniors	0	1,449	5,342
	PA Persons with Disabilities	0	(18,069)	(50,952)
	PA Families	0	(25,088)	(79,090)
	LT Seniors	1	1,962	4,659
	LT Persons with Disabilities	0	103	(274)
	MN Seniors	29	76,713	206,302
	MN Persons with Disabilities	6	10,323	25,277
	MN Families	0	(34,439)	(171,072)
	MI Children	2	(10,918)	(20,140)
	MI Adults	0	338	808
	Refugee	0	362	306
	Undocumented Persons	0	0	0
	185% Poverty	2	9,937	18,252
	133% Poverty	0	(21,791)	(85,094)
	100% Poverty	0	(24,431)	(91,048)
	H-PE	0	1,305	6,032
	OTLICP	0	19,538	63,533
	ACA Optional Expansion	174	60,113	25,105
	MCAP Infants	2,694	776	776
	MCAP Mothers	7,452	5,492	5,492
	Total	**10,359**	**53,676**	**(135,786)**

Comparison of Average Monthly Certified Eligibles
November 2024 Estimate
Fiscal Year 2024-25

(With Estimated Impact of Eligibility Policy Changes)

	Appropriaton 2024-2025	Nov 2024 2024-2025	Appropriation to Nov % Change
Public Assistance	**2,419,500**	**2,369,000**	**-2.09%**
Seniors	419,800	423,300	0.83%
Persons with Disabilities	821,100	815,100	-0.73%
Families	1,178,600	1,130,600	-4.07%
Long Term	**41,500**	**45,700**	**10.12%**
Seniors	34,500	38,600	11.88%
Persons with Disabilities	7,000	7,100	1.43%
Medically Needy	**4,710,400**	**4,994,700**	**6.04%**
Seniors	807,500	982,300	21.65%
Persons with Disabilities	201,100	218,900	8.85%
Families	3,701,800	3,793,500	2.48%
Medically Indigent	**204,800**	**160,200**	**-21.78%**
Children	201,700	156,800	-22.26%
Adults	3,100	3,400	9.68%
Other	**7,132,000**	**7,382,800**	**3.52%**
Refugees	3,500	4,100	17.14%
OBRA	0	0	n/a
185% Poverty	330,300	336,800	1.97%
133% Poverty	729,600	710,100	-2.67%
100% Poverty	343,500	304,400	-11.38%
Opt. Targeted Low Income Children	900,500	915,800	1.70%
ACA Optional Expansion	4,755,300	5,051,300	6.22%
Hospital PE	49,100	43,300	-11.81%
Medi-Cal Access Program	7,400	6,300	-14.86%
QMB	12,800	10,700	-16.41%
GRAND TOTAL	**14,508,200**	**14,952,400**	**3.06%**
Seniors	1,261,800	1,444,200	14.46%
Persons with Disabilities	1,029,200	1,041,100	1.16%
Families and Children	7,386,000	7,348,000	-0.51%
ACA Optional Expansion	4,755,300	5,051,300	6.22%

Estimated Average Monthly Certified Eligibles
November 2024 Estimate
Fiscal Years 2023-2024, 2024-2025, & 2025-2026

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

	2023-2024	2024-2025	2025-2026	23-24 To 24-25 % Change	24-25 To 25-26 % Change
Public Assistance	**2,353,334**	**2,252,956**	**2,166,349**	**-4.27%**	**-3.84%**
Seniors	403,909	406,179	411,463	0.56%	1.30%
Persons with Disabilities	823,459	788,584	755,733	-4.24%	-4.17%
Families	1,125,965	1,058,193	999,153	-6.02%	-5.58%
Long Term	**35,939**	**40,748**	**43,064**	**13.38%**	**5.68%**
Seniors	30,167	34,112	36,804	13.08%	7.89%
Persons with Disabilities	5,772	6,636	6,260	14.98%	-5.68%
Medically Needy	**4,507,274**	**4,724,853**	**4,604,451**	**4.83%**	**-2.55%**
Seniors	751,449	896,901	1,028,197	19.36%	14.64%
Persons with Disabilities	193,413	205,086	220,038	6.04%	7.29%
Families	3,562,413	3,622,866	3,356,215	1.70%	-7.36%
Medically Indigent	**68,300**	**68,995**	**60,760**	**1.02%**	**-11.94%**
Children	67,823	67,966	59,261	0.21%	-12.81%
Adults	477	1,029	1,499	115.97%	45.64%
Other	**6,952,579**	**6,869,630**	**6,609,028**	**-1.19%**	**-3.79%**
Refugees	3,330	3,424	3,377	2.82%	-1.36%
OBRA	0	0	0	n/a	n/a
185% Poverty	272,304	260,907	261,620	-4.19%	0.27%
133% Poverty	753,889	681,803	613,903	-9.56%	-9.96%
100% Poverty	367,264	296,371	229,769	-19.30%	-22.47%
Opt. Targeted Low Income Children	848,321	877,840	918,399	3.48%	4.62%
ACA Optional Expansion	4,698,819	4,743,246	4,575,922	0.95%	-3.53%
Medi-Cal Access Program	8,653	6,038	6,038	-30.22%	0.00%
GRAND TOTAL [1]	**13,917,426**	**13,957,183**	**13,483,652**	**0.29%**	**-3.39%**
Percent of Statewide	**91.31%**	**93.34%**	**93.06%**		
Seniors	1,185,525	1,337,192	1,476,465	12.79%	10.42%
Persons with Disabilities	1,022,644	1,000,307	982,030	-2.18%	-1.83%
Families and Children	6,997,978	6,865,948	6,438,321	-1.89%	-6.23%
ACA Optional Expansion	4,698,819	4,743,246	4,575,922	0.95%	-3.53%

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

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

Estimated Average Monthly Certified Eligibles
November 2024 Estimate
Fiscal Years 2023-2024, 2024-2025, & 2025-2026

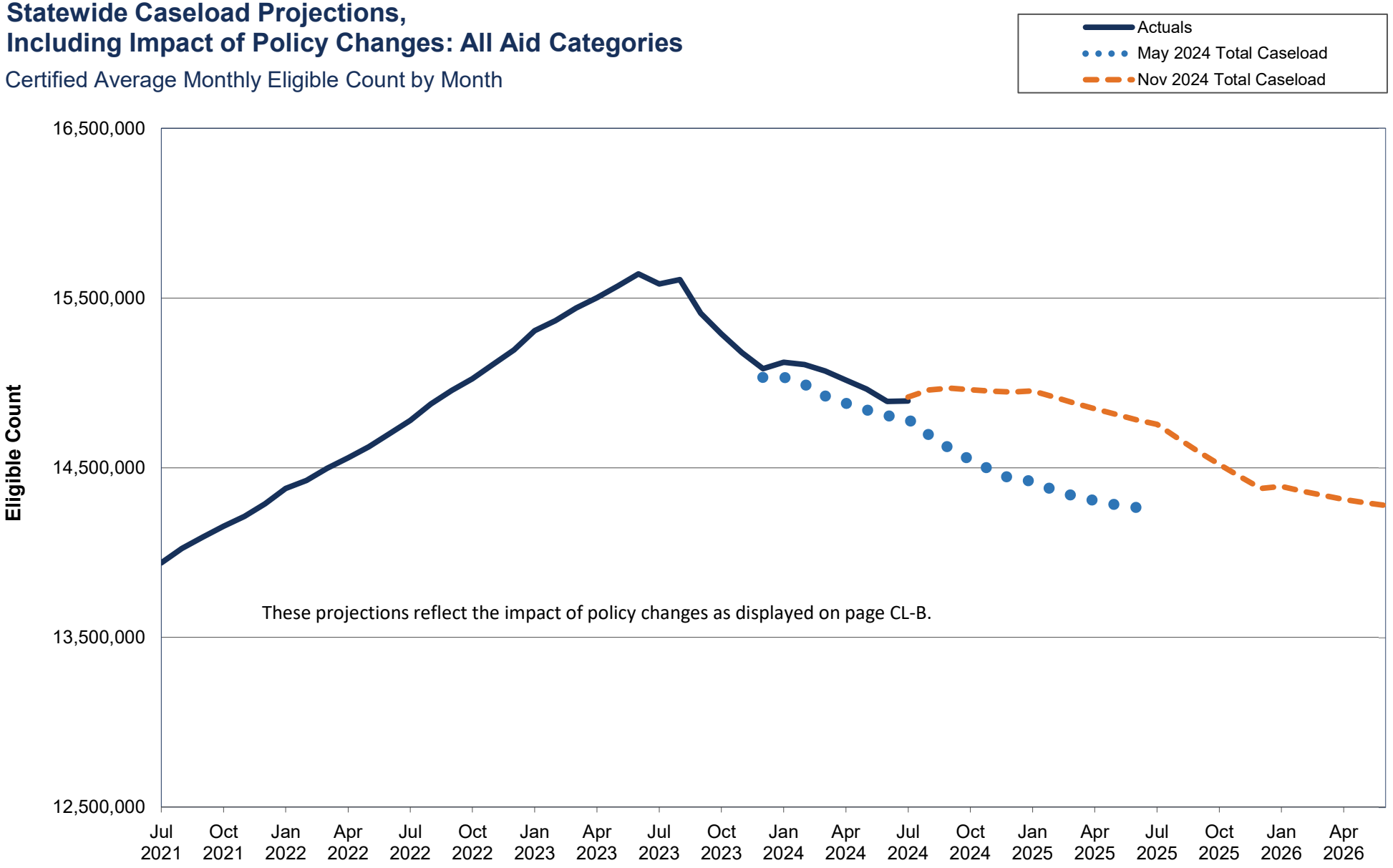
Fee-For-Service
(With Estimated Impact of Eligibility Policy Changes)*

	2023-2024	2024-2025	2025-2026	23-24 To 24-25 % Change	24-25 To 25-26 % Change
Public Assistance	**119,366**	**116,044**	**114,751**	**-2.78%**	**-1.11%**
Seniors	16,991	17,121	15,737	0.77%	-8.08%
Persons with Disabilities	27,641	26,516	26,467	-4.07%	-0.18%
Families	74,735	72,407	72,547	-3.11%	0.19%
Long Term	**6,061**	**4,952**	**4,936**	**-18.30%**	**-0.32%**
Seniors	4,733	4,488	4,496	-5.17%	0.17%
Persons with Disabilities	1,328	464	440	-65.10%	-5.00%
Medically Needy	**470,326**	**269,847**	**278,049**	**-42.63%**	**3.04%**
Seniors	70,451	85,399	93,503	21.22%	9.49%
Persons with Disabilities	12,487	13,814	13,862	10.63%	0.34%
Families	387,387	170,634	170,685	-55.95%	0.03%
Medically Indigent	**100,801**	**91,205**	**90,640**	**-9.52%**	**-0.62%**
Children	98,177	88,834	88,339	-9.52%	-0.56%
Adults	2,624	2,371	2,301	-9.63%	-2.94%
Other	**627,421**	**513,170**	**517,672**	**-18.21%**	**0.88%**
Refugees	1,170	676	523	-42.20%	-22.68%
OBRA	0	(0)	(0)	n/a	9.09%
185% Poverty	80,796	75,893	75,880	-6.07%	-0.02%
133% Poverty	28,511	28,297	28,197	-0.75%	-0.35%
100% Poverty	8,636	8,029	7,831	-7.03%	-2.46%
Opt. Targeted Low Income Children	32,879	37,960	38,101	15.45%	0.37%
ACA Optional Expansion	420,981	308,054	308,078	-26.82%	0.01%
Hospital PE	41,100	43,300	48,100	5.35%	11.09%
Medi-Cal Access Program	1,447	262	262	-81.89%	0.00%
QMB	11,900	10,700	10,700	-10.08%	0.00%
GRAND TOTAL	**1,323,974**	**995,217**	**1,006,048**	**-24.83%**	**1.09%**
Percent of Statewide	**8.69%**	**6.66%**	**6.94%**		
Seniors	92,175	107,008	113,735	16.09%	6.29%
Persons with Disabilities	41,457	40,793	40,770	-1.60%	-0.06%
Families and Children	711,122	482,052	481,579	-32.21%	-0.10%
ACA Optional Expansion	420,981	308,054	308,078	-26.82%	0.01%

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

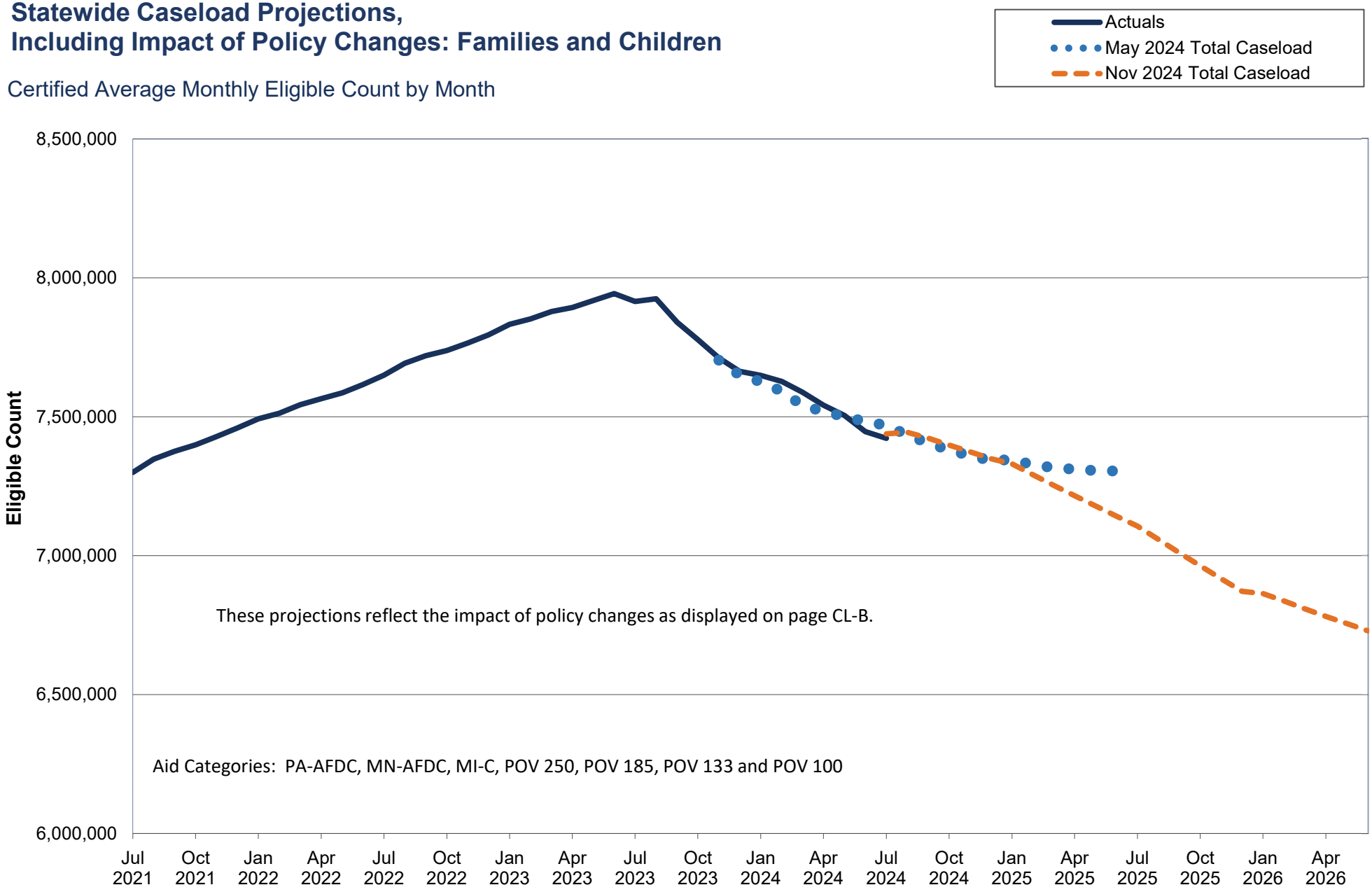
Statewide Caseload Projections, Including Impact of Policy Changes: All Aid Categories

Certified Average Monthly Eligible Count by Month



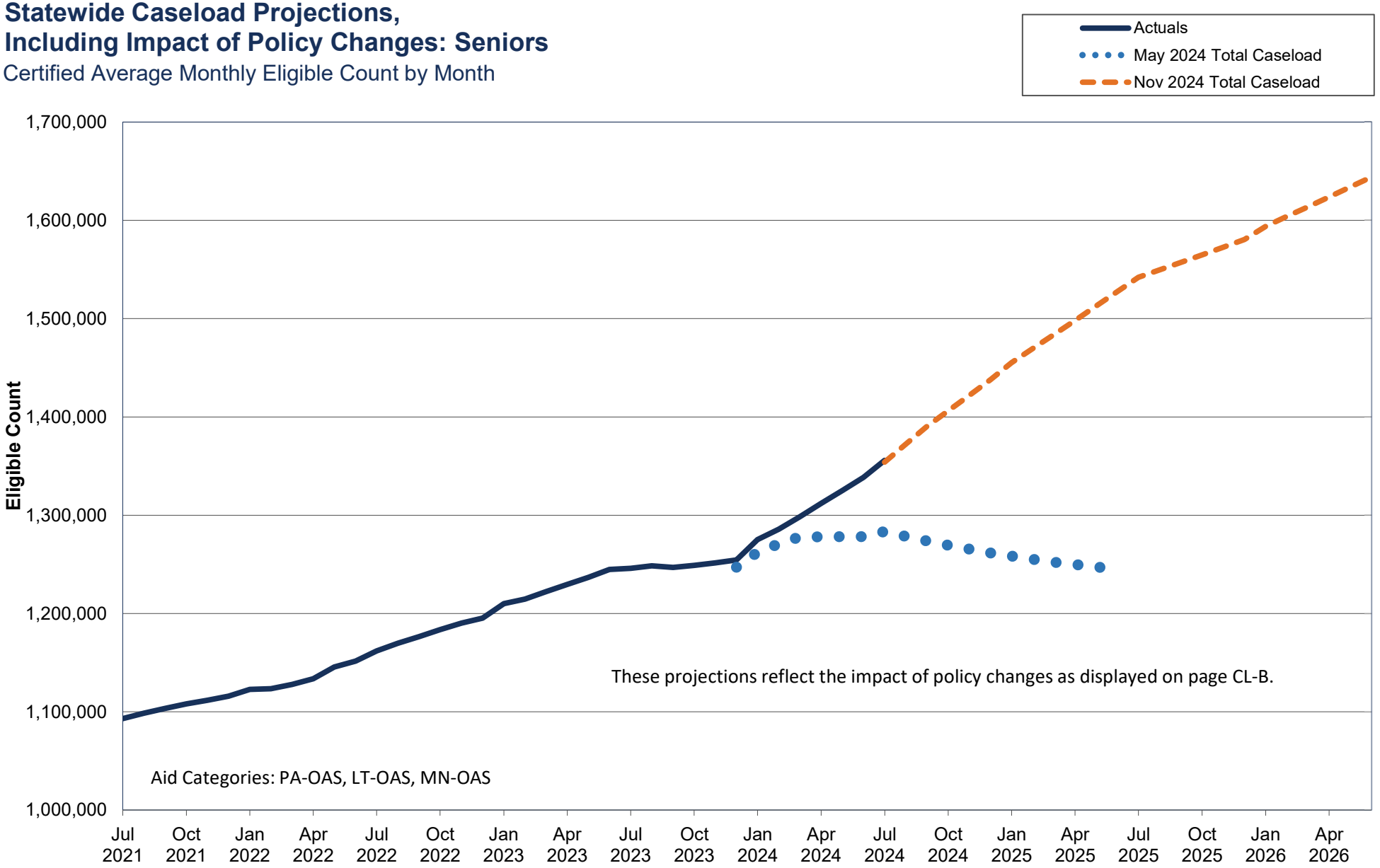
Statewide Caseload Projections, Including Impact of Policy Changes: Families and Children

Certified Average Monthly Eligible Count by Month



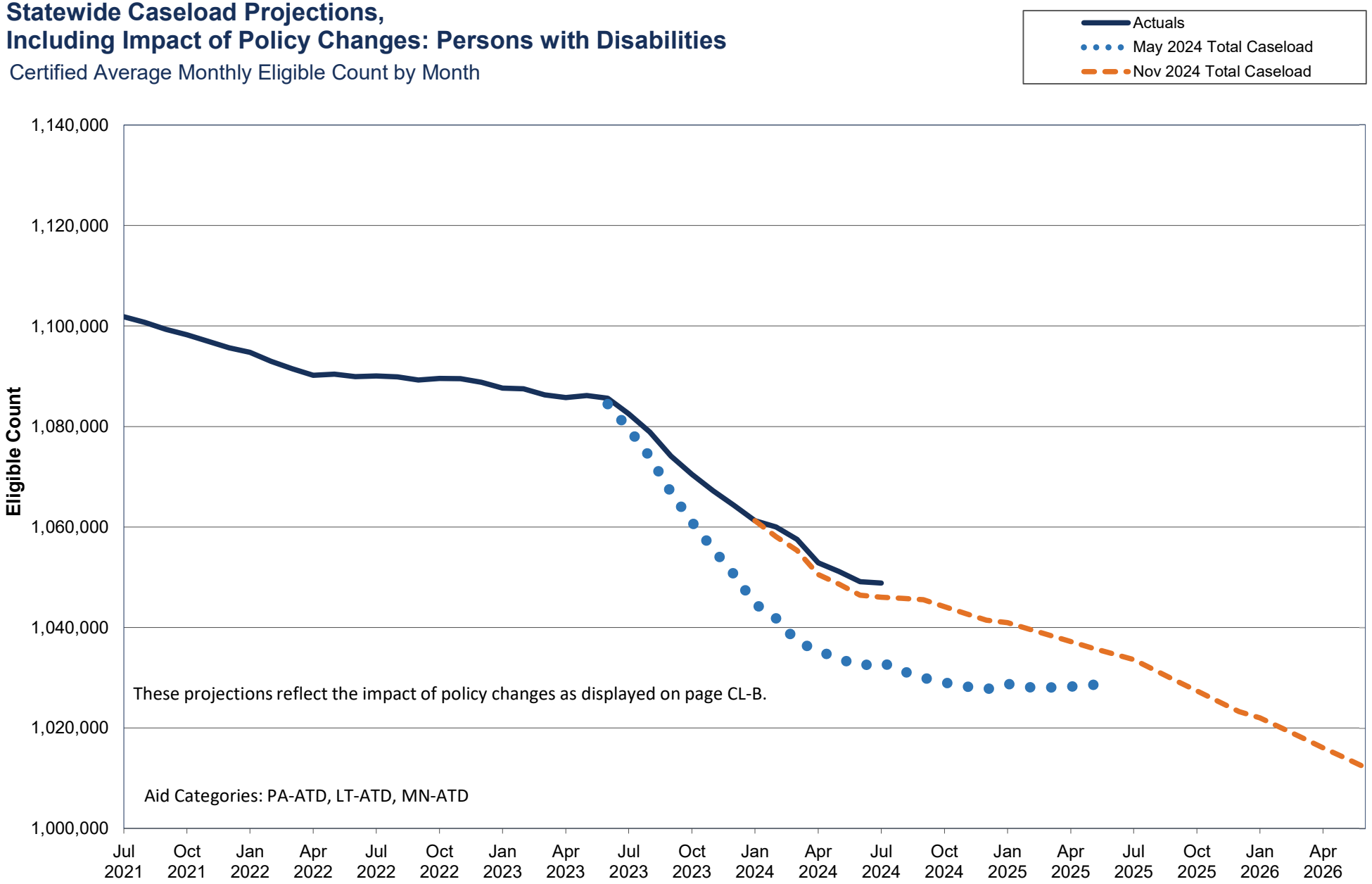
Statewide Caseload Projections, Including Impact of Policy Changes: Seniors

Certified Average Monthly Eligible Count by Month



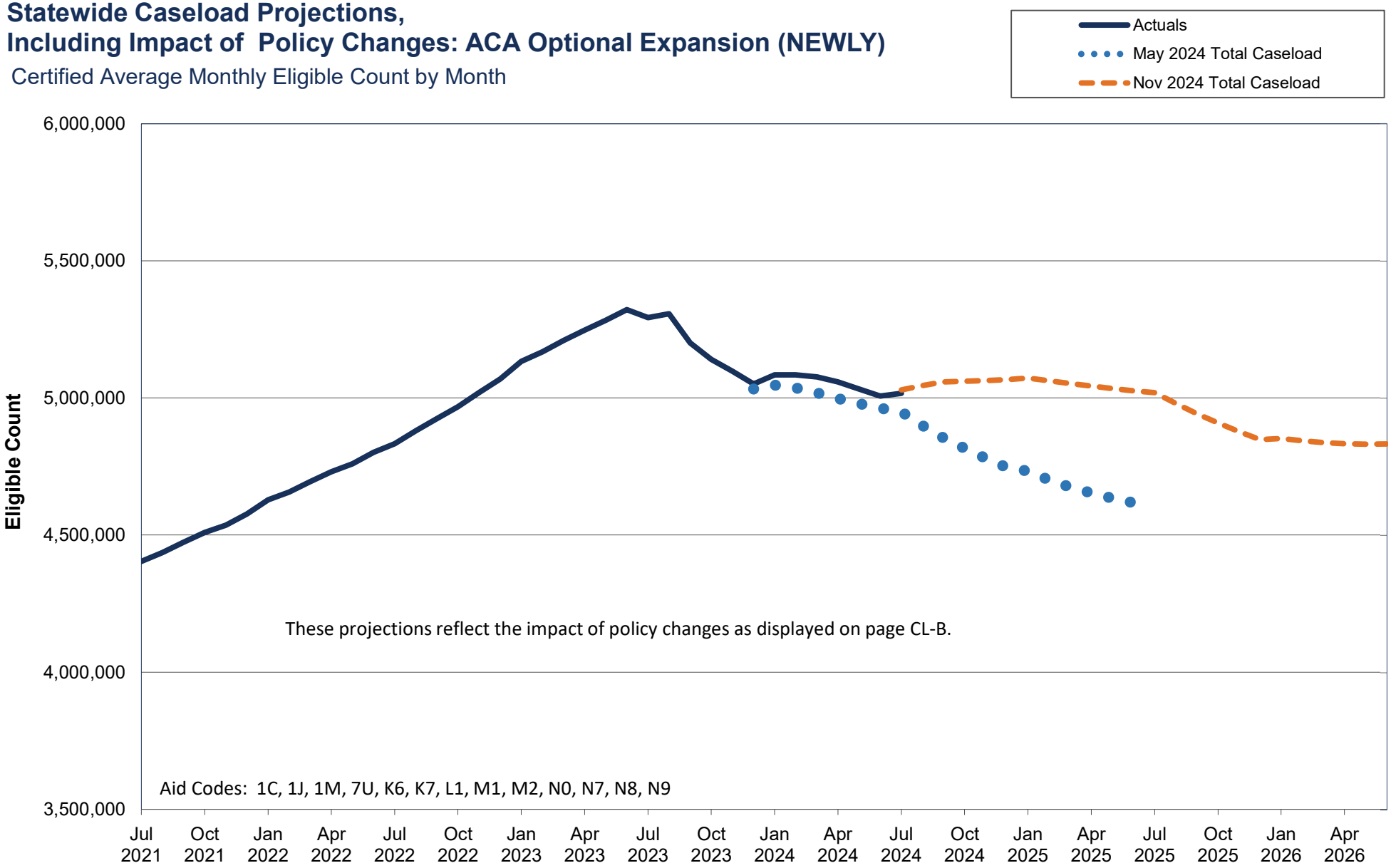
Statewide Caseload Projections, Including Impact of Policy Changes: Persons with Disabilities

Certified Average Monthly Eligible Count by Month



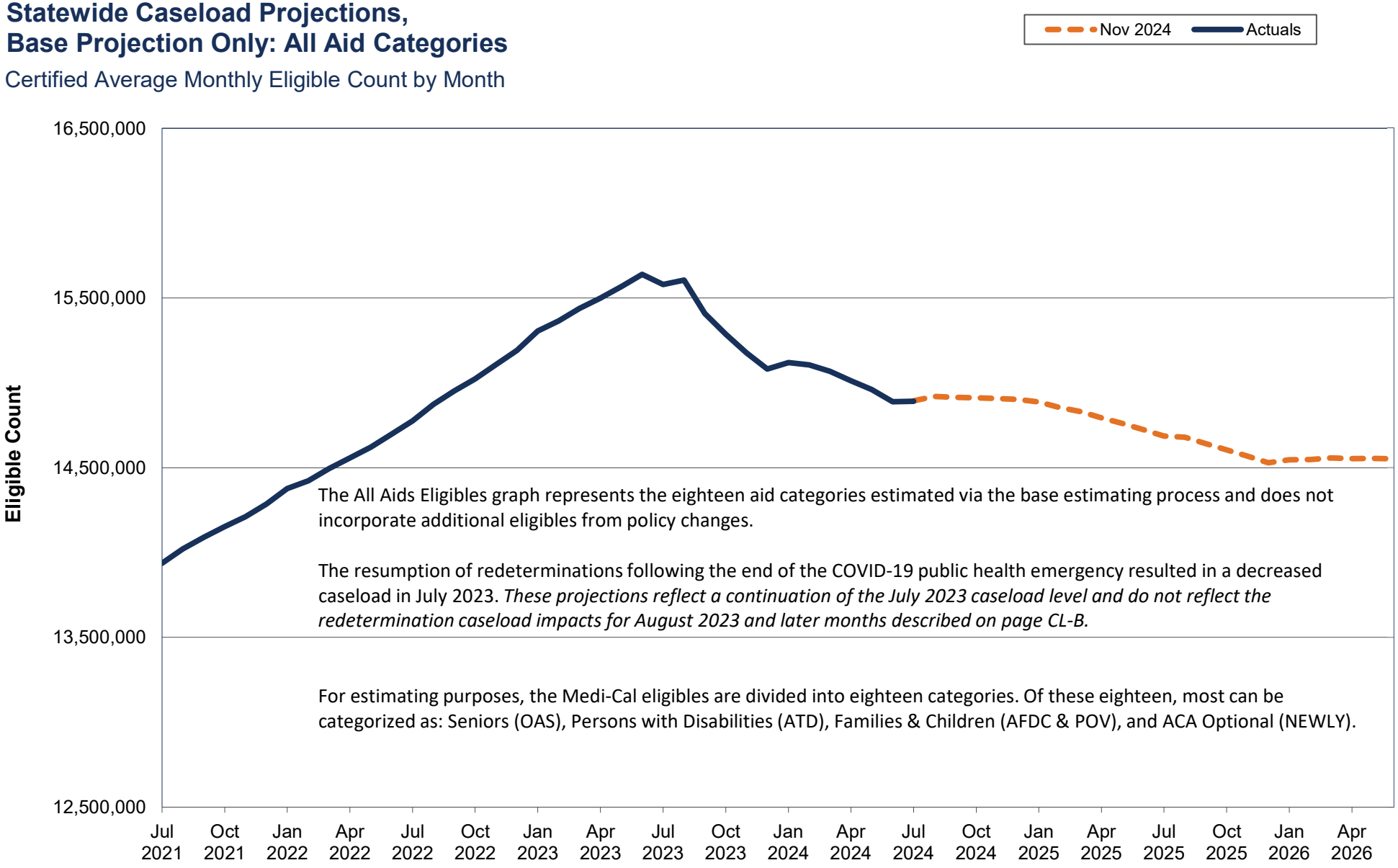
Statewide Caseload Projections, Including Impact of Policy Changes: ACA Optional Expansion (NEWLY)

Certified Average Monthly Eligible Count by Month



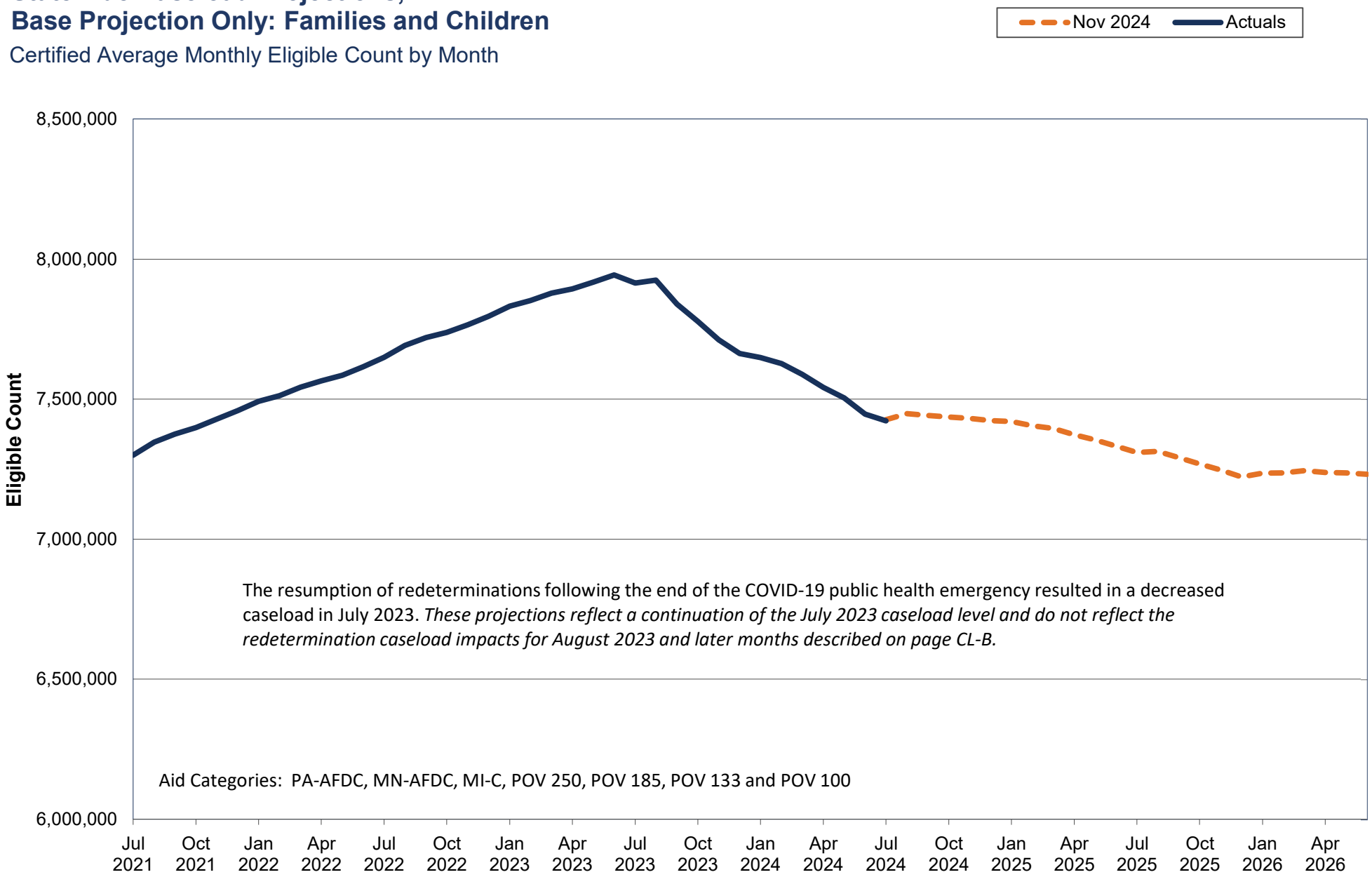
Statewide Caseload Projections, Base Projection Only: All Aid Categories

Certified Average Monthly Eligible Count by Month



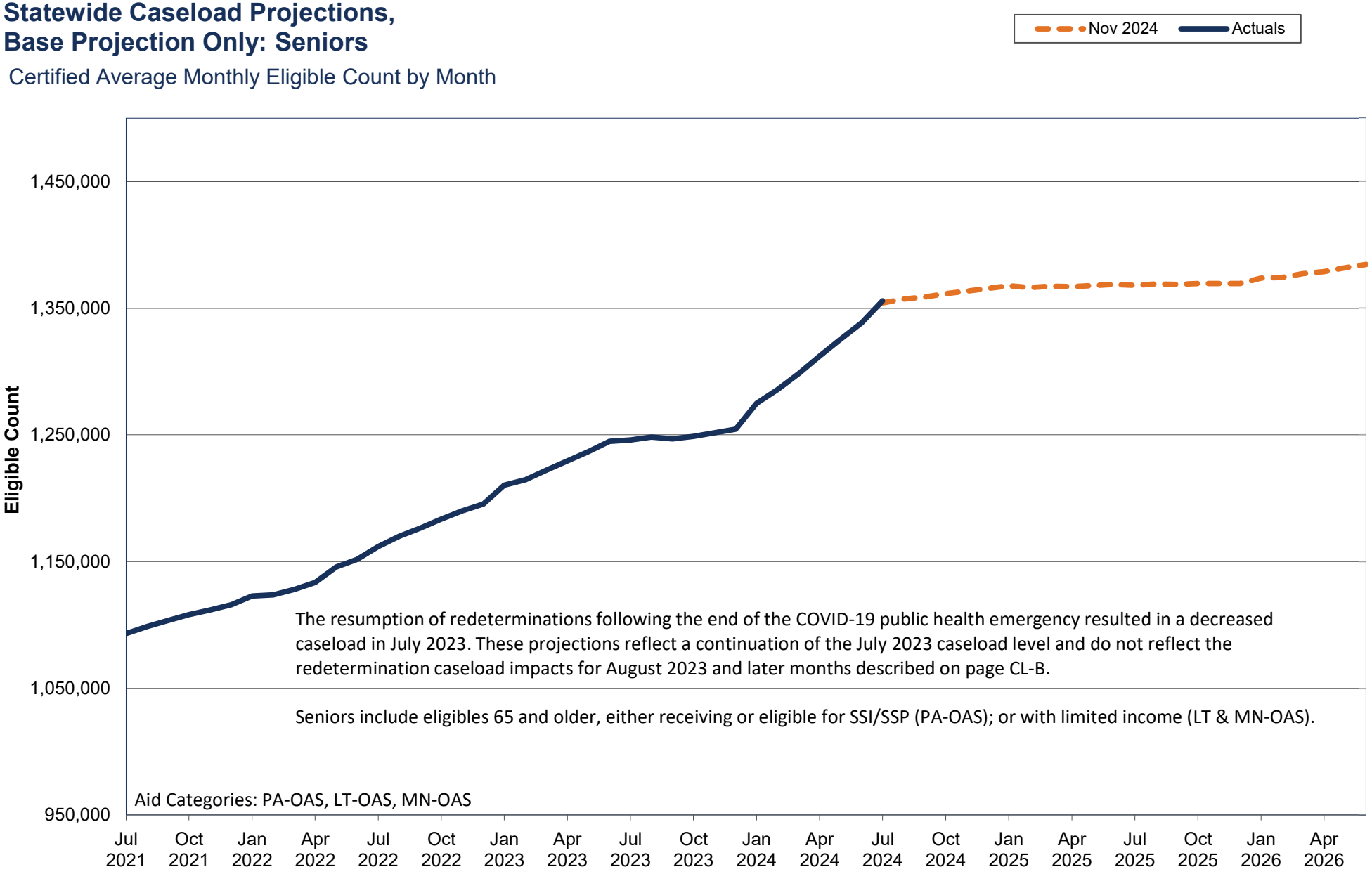
Statewide Caseload Projections, Base Projection Only: Families and Children

Certified Average Monthly Eligible Count by Month



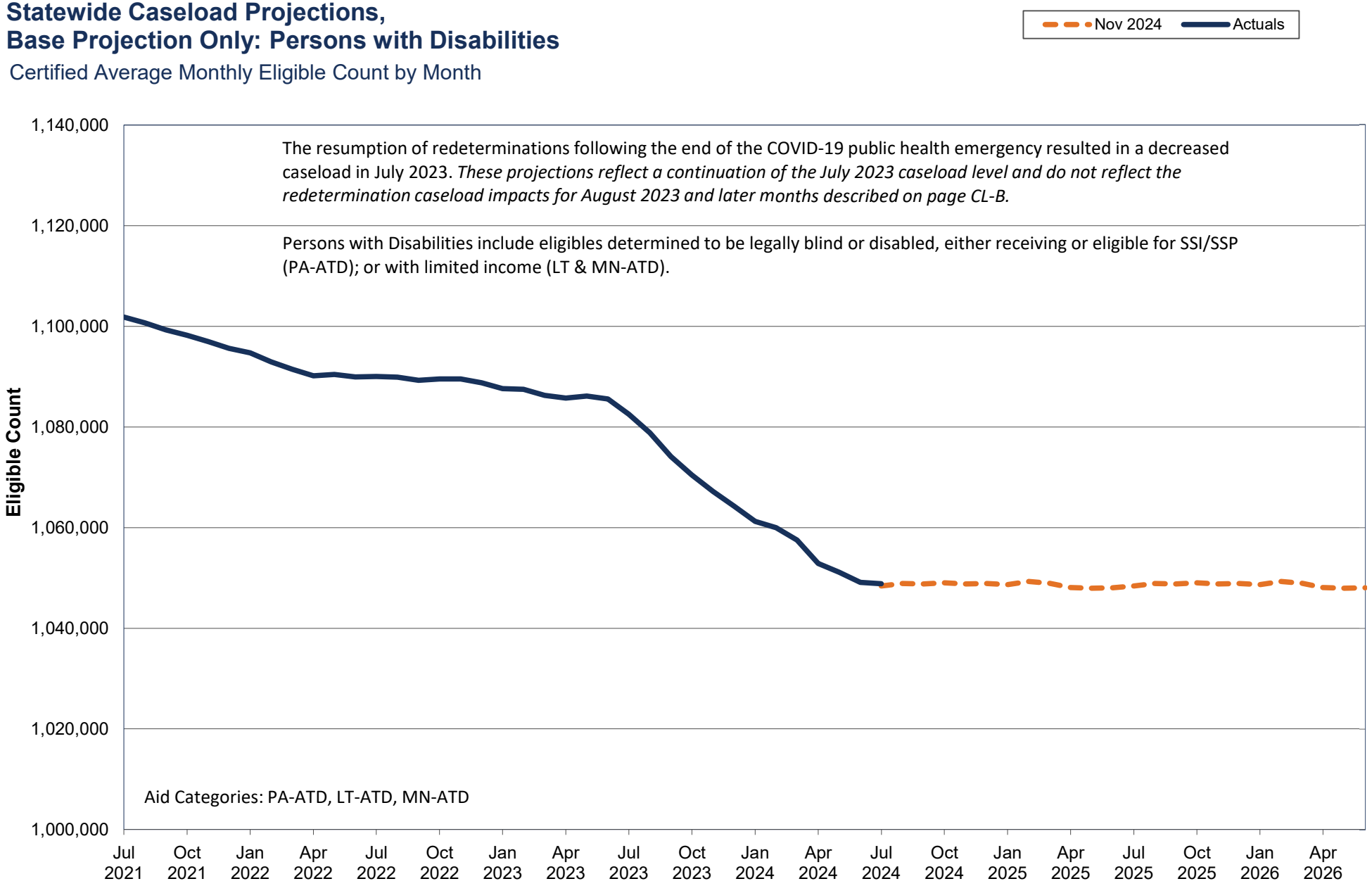
Statewide Caseload Projections, Base Projection Only: Seniors

Certified Average Monthly Eligible Count by Month



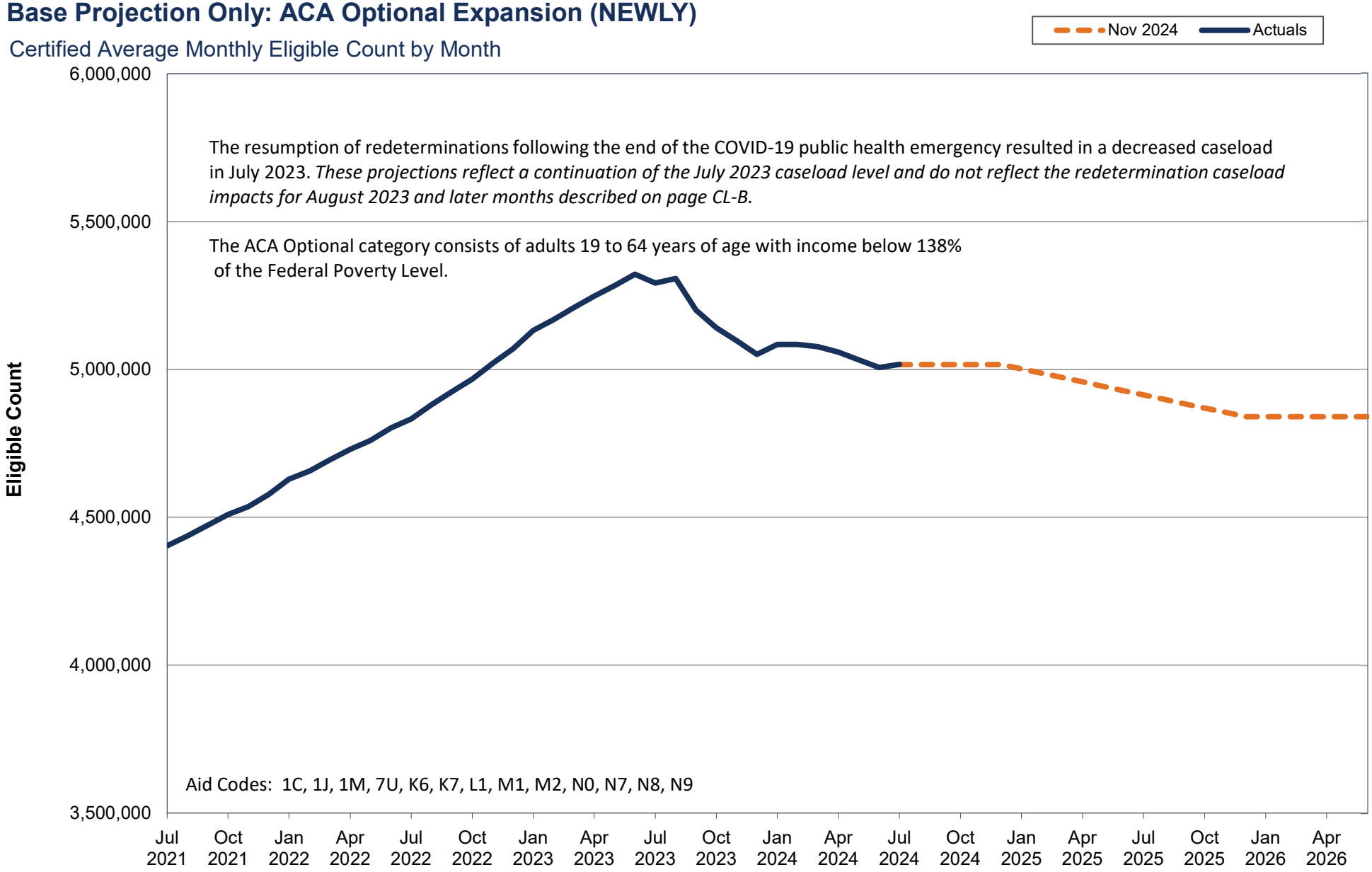
Statewide Caseload Projections, Base Projection Only: Persons with Disabilities

Certified Average Monthly Eligible Count by Month



Statewide Caseload Projections, Base Projection Only: ACA Optional Expansion (NEWLY)

Certified Average Monthly Eligible Count by Month



MEDI-CAL AID CATEGORY DEFINITIONS

Aid Category	Aid Codes
Seniors	10, 16, 1E, 13, D2, D3 J5, J6, 14, 17, 1H, 1U, 1X, 1Y, C1, C2
Disabled	20, 26, 2E, 36, 60, 66, 6A, 6C, 6E, 6N, 6P, 23, 63, D4, D5, D6, D7, J7, J8, 24, 27, 2H, 64, 67, 6G, 6H, 6S, 6U, 6V, 6W, 6X, 6Y, 8G, C3, C4, C7, C8, K8, K9, L6, L7
Families and Children (Including Pregnant Women)	2S, 2T, 2U, 30, 32, 33, 35, 38, 3A, 3C, 3E, 3F, 3G, 3H, 3L, 3M, 3P, 3R, 3U, 3W, 40, 42, 43, 49, 4F, 4G, 4H, 4N, 4S, 4T, 4W, 5L, K1, R1, 34, 37, 39, 3D, 3N, 3T, 3V, 54, 59, 5J, 5R, 5T, 5W, 6J, 6R, 7J, 7K, 7S, 7W, C5, C6, M3, M4, P5, P6, 7A, 7C, 8R, 8T, M5, M6, 72, 74, 8N, 8P, P7, P8, 44, 47, 48, 5F, 69, 76, 7F, 7G, 8U, 8V, D8, D9, M0, M7, M8, M9, P0, P9, 5C, 5D, 8X, E6, H1, H2, H3, H4, H5, T0, T1, T2, T3, T4, T5, T6, T7, T8, T9, 03, 04, 06, 07, 2A, 2P, 2R, 45, 46, 4A, 4L, 4M, 5E, 5K, 7M, 7N, 7P, 7R, 7T, 82, 83, 8E, 8W, C9, D1,G5, G6, G7, G8
Newly	1C, 1J, 1M, 7U, K6, K7, L1, M1, M2, N0, N7, N8, N9
H-PE	4E, H0, H6, H7, H8, H9, P1, P2, P3, P4, 7D
All Others	53, 81, 86, 87, 8L, F3, F4, G3, G4, J1, J2, J3, J4, 01, 02, 08, 0A, 55, 58

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FEE-FOR-SERVICE BASE

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

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 the most recent 36 months of claims paid through the Medi-Cal claims processing systems at the California Medicaid Management Information Systems (CA-MMIS) Fiscal Intermediary and beginning in January 2022, the Medi-Cal Rx Fiscal Intermediary for pharmacy claims.

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

November 2024 FFS Base Estimate

Fiscal Year		November Estimate Total Expenditure	
PY	FY 2023-24	$31,569,614,100	
CY	FY 2024-25	$33,695,870,600	6.74%
BY	FY 2025-26	$34,921,364,100	3.64%

Fiscal Year	FFS Base Expenditure		
	May-24	Nov-24	% Change
FY 2023-24	$31,186,087,600	$31,569,614,100	1.23%
FY 2024-25	$31,993,047,300	$33,695,870,600	5.32%

Overall, the November 2024 FFS Base is estimated at $33.7 billion for FY 2024-25 and $34.9 billion for FY 2025-26. The increase in the budget year is mainly from the Pharmacy service category, driven specifically by increases average cost per pharmacy claim.

Items Impacting FFS Base Estimate

Overall Changes: Compared to the M24 estimate, the N24 estimate includes (1) some of the impact of the certain populations and the long-term care benefit transitioning from FFS to managed care under CalAIM in January 2023, particularly in the ICF-DD category, and (2) increased Pharmacy and Other Medical expenditures due to the expansion of full-scope Medi-Cal to all members regardless of immigration status. These specific impacts will be described in each of the service categories.

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

Processing Days: Processing days reflect the number of days Medi-Cal adjudicates and pays providers. The number of processing days sometimes varies from year to year.

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2024 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
2022-23 *	1	4,412,550	4.49	$140.79	$632.51	$8,372,915,600
2022-23 *	2	4,275,030	4.03	$141.48	$570.00	$7,310,281,300
2022-23 *	3	4,359,490	3.83	$162.15	$621.39	$8,126,881,800
2022-23 *	4	3,944,170	3.18	$170.72	$542.44	$6,418,431,400
2022-23 *	TOTAL	4,247,810	3.90	$152.01	$593.02	$30,228,510,200
2023-24 *	1	4,411,430	3.65	$183.48	$669.37	$8,858,672,100
2023-24 *	2	4,175,310	3.30	$181.45	$598.14	$7,492,317,800
2023-24 *	3	4,382,840	3.49	$178.69	$623.72	$8,200,984,000
2023-24 *	4	4,087,600	3.20	$178.58	$572.27	$7,017,640,100
2023-24 *	TOTAL	4,264,300	3.42	$180.64	$616.94	$31,569,614,100
2024-25 **	1	4,586,140	3.67	$192.08	$705.69	$9,709,208,900
2024-25 **	2	4,455,760	3.35	$186.42	$624.01	$8,341,355,100
2024-25 **	3	4,288,980	3.45	$187.79	$647.36	$8,329,506,100
2024-25 **	4	4,066,260	3.23	$185.51	$599.72	$7,315,800,400
2024-25 **	TOTAL	4,349,280	3.43	$188.15	$645.62	$33,695,870,600
2025-26 **	1	4,568,320	3.75	$195.71	$733.45	$10,051,856,400
2025-26 **	2	4,455,760	3.35	$192.93	$646.14	$8,637,079,200
2025-26 **	3	4,288,980	3.45	$194.32	$670.64	$8,629,078,100
2025-26 **	4	4,066,220	3.25	$191.53	$623.29	$7,603,350,400
2025-26 **	TOTAL	4,344,820	3.46	$193.76	$669.79	$34,921,364,100

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

Physicians Fee-for-Service Base Estimate

Analyst: Violet Chan

Background: The Physicians category includes services billed by physicians (M.D. or D.O.) and physician groups.

FISCAL YEAR		USERS		UTILIZATION (Claims per User)		RATE (Cost per Claim)		TOTAL EXPENDITURE	
PY	2023-24	184,900	--	2.61	--	$99.46	--	$576,599,100	--
CY	2024-25	172,570	-6.7%	2.69	3.1%	$106.86	7.4%	$594,276,000	3.1%
BY	2025-26	172,270	-0.2%	2.69	0.0%	$106.92	0.1%	$594,472,600	0.0%

Users: Users are estimated to decrease by 6.7% for the CY, in part due to the redetermination impact resulting in fewer actual users. Users are estimated to remain relatively unchanged in the BY, before accounting for redetermination impacts.

Utilization: Utilization is estimated to increase by 3.1% in the CY and remain relatively unchanged in the BY.

Rate: The average rate is estimated to increase by 7.4% in the CY, partly due to the targeted rate increase effective in January 2024. The rate is estimated to remain relatively unchanged in the BY.

Total Expenditure: The CY is estimated to increase by 3.1% mainly due to an increase in rate and utilization but also offset by the decreased users. The BY is estimated to remain relatively unchanged.

Reason for Change from Prior Estimate

FISCAL YEAR	TOTAL EXPENDITURE		
	M24	N24	% Change
FY 2023-24	$588,919,200	$576,599,100	-2.1%
FY 2024-25	$575,171,000	$594,276,000	3.3%

Compared to the May 2024 Estimate, the November 2024 Estimate for FY 2023-24 decreased by 2.1% due to a decrease in users. The FY 2024-25 estimated increase of 3.3% is due to an increase in rate but offset by decrease in users.

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2024 BASE ESTIMATES)

PHYSICIANS

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2022-23 *	1	288,900	2.45	$88.79	$217.59	$188,583,500
2022-23 *	2	250,730	2.38	$88.66	$210.63	$158,432,400
2022-23 *	3	249,160	2.39	$87.93	$210.31	$157,203,600
2022-23 *	4	192,380	2.33	$94.98	$221.59	$127,886,300
2022-23 *	TOTAL	245,290	2.39	$89.72	$214.75	$632,105,800
2023-24 *	1	210,840	2.72	$97.86	$265.85	$168,156,600
2023-24 *	2	187,250	2.63	$97.68	$256.64	$144,169,700
2023-24 *	3	186,610	2.57	$98.97	$254.22	$142,319,400
2023-24 *	4	154,890	2.51	$104.68	$262.45	$121,953,400
2023-24 *	TOTAL	184,900	2.61	$99.46	$259.87	$576,599,100
2024-25 **	1	190,170	2.79	$107.61	$299.92	$171,107,600
2024-25 **	2	169,170	2.72	$106.43	$289.31	$146,824,800
2024-25 **	3	176,980	2.64	$105.85	$279.21	$148,243,400
2024-25 **	4	153,980	2.58	$107.54	$277.32	$128,100,200
2024-25 **	TOTAL	172,570	2.69	$106.86	$286.97	$594,276,000
2025-26 **	1	189,420	2.80	$107.83	$302.35	$171,811,300
2025-26 **	2	168,740	2.72	$106.44	$289.25	$146,419,600
2025-26 **	3	176,940	2.64	$105.85	$279.21	$148,212,000
2025-26 **	4	153,980	2.58	$107.52	$277.16	$128,029,600
2025-26 **	TOTAL	172,270	2.69	$106.92	$287.57	$594,472,600

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

Other Medical Fee-for-Service Base Estimate

Analyst: Violet Chan

Background: Other Medical includes clinics and specialist service providers. Payments to Federally Qualified Health Care Centers and Rural Health Centers (FQHC/RHC) are approximately 91% of expenditures in this category. A full list of the provider types is provided in the Information Only Section.

FISCAL YEAR		USERS		UTILIZATION (Claims per User)		RATE (Cost per Claim)		TOTAL EXPENDITURE	
PY	2023-24	1,448,560	--	1.57	--	$212.14	--	$5,786,148,600	--
CY	2024-25	1,557,190	7.5%	1.57	0.0%	$220.70	4.0%	$6,456,267,500	11.6%
BY	2025-26	1,554,900	-0.1%	1.57	0.0%	$220.26	-0.2%	$6,449,517,800	-0.1%

Users: Users are estimated to increase by 7.5% in the CY, due to the expansion of full scope coverage to Unsatisfactory Immigration Status (UIS) adults effective January 1, 2024. Users are estimated to remain unchanged in the BY.

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

Rate: The average rate is estimated to increase by 4.0% in the CY as rate increases previously budgeted in the Rate Increase for FQHCs/RHCs/CBRCs policy change have rolled into the base. BY is estimated to remain unchanged. Future clinic rate increases are estimated in the Rate Increase for FQHCs/RHCs/CBRCs policy change.

Total Expenditure: The CY is estimated to increase by 11.6%, primarily due to increased Users and Rates. The BY is estimated to remain unchanged.

Reason for Change from Prior Estimate

FISCAL YEAR	TOTAL EXPENDITURE		
	M24	N24	% Change
2023-24	$5,638,103,300	$5,786,148,600	2.6%
2024-25	$5,719,276,600	$6,456,247,500	12.9%

Compared to the May 2024 Estimate, the November 2024 Estimate increased by 2.6% and 12.9% for FY 2023-24 and FY 2024-25, respectively. This is primarily due to increased Users following the expansion of full scope coverage to Unsatisfactory Immigration Status (UIS) adults effective January 1, 2024.

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2024 BASE ESTIMATES)

OTHER MEDICAL

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2022-23 *	1	1,517,330	1.63	$188.52	$306.75	$1,396,305,500
2022-23 *	2	1,373,450	1.53	$195.36	$297.95	$1,227,667,100
2022-23 *	3	1,366,690	1.54	$202.49	$311.78	$1,278,315,800
2022-23 *	4	1,278,850	1.48	$198.75	$294.88	$1,131,306,600
2022-23 *	TOTAL	1,384,080	1.55	$195.89	$303.07	$5,033,595,000
2023-24 *	1	1,546,960	1.61	$203.77	$328.82	$1,526,031,100
2023-24 *	2	1,454,100	1.57	$207.39	$326.20	$1,422,976,600
2023-24 *	3	1,426,650	1.56	$218.18	$339.54	$1,453,208,100
2023-24 *	4	1,366,550	1.53	$220.91	$337.57	$1,383,932,800
2023-24 *	TOTAL	1,448,560	1.57	$212.14	$332.87	$5,786,148,600
2024-25 **	1	1,711,150	1.63	$222.66	$362.39	$1,860,320,700
2024-25 **	2	1,568,060	1.56	$218.55	$340.52	$1,601,874,500
2024-25 **	3	1,505,640	1.55	$220.35	$341.12	$1,540,811,400
2024-25 **	4	1,443,900	1.52	$221.00	$335.50	$1,453,260,900
2024-25 **	TOTAL	1,557,190	1.57	$220.70	$345.51	$6,456,267,500
2025-26 **	1	1,706,360	1.64	$221.28	$363.20	$1,859,270,800
2025-26 **	2	1,564,950	1.56	$218.55	$340.53	$1,598,763,000
2025-26 **	3	1,504,950	1.55	$220.35	$341.12	$1,540,086,100
2025-26 **	4	1,443,360	1.52	$220.75	$335.19	$1,451,397,900
2025-26 **	TOTAL	1,554,900	1.57	$220.26	$345.66	$6,449,517,800

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

County & Community Outpatient Fee-for-Service Base Estimate

Analyst: Michael Redman

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	2023-24	119,560	--	1.57	--	$242.76	--	$546,620,800	--
CY	2024-25	112,090	-6.2%	1.58	0.6%	$279.82	15.3%	$596,068,600	9.0%
BY	2025-26	112,000	-0.1%	1.59	0.6%	$278.33	-0.5%	$595,758,400	-0.1%

Users: Users are estimated to decrease by 6.2% in the CY, partly due to the resumption of eligibility redeterminations following the end of the federal COVID-19 Public Health Emergency (PHE) and due to the expansion of full scope coverage to Unsatisfactory Immigration Status (UIS) adults effective January 1, 2024.Users are estimated to remain relatively unchanged in the BY.

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

Rate: The average rate is estimated to increase by 15% in the CY, due to recent increases in Community Outpatient for families and Newborn Screening rates. The average rate is estimated to remain unchanged in the BY.

Total Expenditure: Expenditure is estimated to increase by 9% in the CY, due to recent increases in Outpatient rates for low-income families and estimated to remain unchanged in the BY.

Reason for Change from Prior Estimate

FISCAL YEAR	TOTAL EXPENDITURE		
	M24	N24	% Change
FY 2023-24	$548,541,100	$546,620,800	-0.4%
FY 2024-25	$538,194,800	$596,068,600	10.75%

Compared to the May 2024 Estimate, the November 2024 Estimate for total expenditure decreased by .4% in FY 2023-24 and increased by 10.75% in FY 2024-25, due to recent increases in Outpatient rates for low-income families.

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2024 BASE ESTIMATES)

CO. & COMM. OUTPATIENT

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2022-23 *	1	181,350	1.58	$200.17	$317.26	$172,602,400
2022-23 *	2	162,590	1.55	$185.92	$288.25	$140,602,600
2022-23 *	3	155,550	1.54	$207.84	$319.30	$148,999,900
2022-23 *	4	114,240	1.50	$231.42	$347.33	$119,033,000
2022-23 *	TOTAL	153,430	1.55	$203.96	$315.69	$581,237,900
2023-24 *	1	140,740	1.62	$229.86	$371.50	$156,851,800
2023-24 *	2	126,890	1.56	$235.63	$368.30	$140,200,700
2023-24 *	3	115,210	1.55	$257.36	$400.06	$138,268,300
2023-24 *	4	95,420	1.53	$254.67	$388.81	$111,300,000
2023-24 *	TOTAL	119,560	1.57	$242.76	$380.98	$546,620,800
2024-25 **	1	129,630	1.63	$292.58	$476.25	$185,206,700
2024-25 **	2	114,250	1.59	$269.55	$428.20	$146,769,200
2024-25 **	3	109,900	1.55	$281.00	$435.66	$143,632,200
2024-25 **	4	94,580	1.56	$272.84	$424.56	$120,460,500
2024-25 **	TOTAL	112,090	1.58	$279.82	$443.15	$596,068,600
2025-26 **	1	128,510	1.65	$285.59	$469.94	$181,178,600
2025-26 **	2	114,260	1.60	$269.86	$430.50	$147,570,900
2025-26 **	3	110,250	1.56	$281.78	$438.73	$145,108,900
2025-26 **	4	94,980	1.56	$274.38	$427.79	$121,899,900
2025-26 **	TOTAL	112,000	1.59	$278.33	$443.27	$595,758,400

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

Pharmacy Fee-for-Service Base Estimate

Analyst: Liang Xu

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

FISCAL YEAR		USERS		UTILIZATION (Claims per User)		RATE (Cost per Claim)		TOTAL EXPENDITURE	
PY	2023-24	3,324,740	--	3.14	--	$140.97	--	$17,676,722,500	--
CY	2024-25	3,414,920	2.7%	3.15	0.3%	$150.66	6.9%	$19,427,345,700	9.9%
BY	2025-26	3,413,410	0.0%	3.18	1.0%	$158.36	5.1%	$20,602,106,600	6.0%

Users: Users are estimated to increase by 2.7% in CY due to net effect of the expansion of full scope coverage to Unsatisfactory Immigration Status (UIS) adults effective January 1, 2024, and redeterminations and is projected to remain essentially unchanged in BY.

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

Rate: Rate (average cost per claim) is projected to increase by 6.9% in CY and by 5.1% in BY.

Total Expenditure: The total expenditures are estimated to increase by 9.9% from PY to CY due to the increase in users and rate (average cost per claim) and increase by 6.0% from CY to BY primarily due to projected increases in the rate (average cost per claim).

Reason for Change from Prior Estimate:

FISCAL YEAR	TOTAL EXPENDITURE		
	M24	N24	% Change
2023-24	$17,104,824,900	$17,676,722,500	3.3%
2024-25	$17,827,821,600	$19,427,345,700	9.0%

Compared to the May 2024 Estimate, the November 2024 Estimate of total expenditures for both the current year and the budget year increased is mainly due to the net effect of the expansion of full-scope coverage to UIS adults and redetermination and growth in the average cost of pharmacy claims.

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2024 BASE ESTIMATES)

PHARMACY

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2022-23 *	1	3,384,710	4.28	$93.03	$398.33	$4,044,725,800
2022-23 *	2	3,332,320	3.78	$92.62	$350.27	$3,501,619,300
2022-23 *	3	3,437,680	3.54	$119.65	$423.51	$4,367,635,200
2022-23 *	4	3,033,370	2.89	$131.46	$380.30	$3,460,724,800
2022-23 *	TOTAL	3,297,020	3.64	$106.69	$388.60	$15,374,705,100
2023-24 *	1	3,423,270	3.35	$142.14	$475.51	$4,883,391,700
2023-24 *	2	3,211,590	3.00	$138.70	$416.16	$4,009,629,300
2023-24 *	3	3,493,420	3.26	$139.62	$454.79	$4,766,333,700
2023-24 *	4	3,170,700	2.94	$143.51	$422.34	$4,017,367,700
2023-24 *	TOTAL	3,324,740	3.14	$140.97	$443.06	$17,676,722,500
2024-25 **	1	3,580,890	3.37	$152.06	$512.82	$5,509,064,400
2024-25 **	2	3,487,420	3.10	$147.86	$458.21	$4,793,917,000
2024-25 **	3	3,425,510	3.15	$151.36	$476.88	$4,900,700,100
2024-25 **	4	3,165,870	2.94	$151.26	$444.71	$4,223,664,300
2024-25 **	TOTAL	3,414,920	3.15	$150.66	$474.08	$19,427,345,700
2025-26 **	1	3,574,830	3.45	$158.55	$547.07	$5,867,044,100
2025-26 **	2	3,487,420	3.10	$156.04	$484.38	$5,067,684,600
2025-26 **	3	3,425,510	3.16	$159.60	$503.70	$5,176,310,200
2025-26 **	4	3,165,870	2.97	$159.35	$472.86	$4,491,067,800
2025-26 **	TOTAL	3,413,410	3.18	$158.36	$502.97	$20,602,106,600

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

County Inpatient Fee-for-Service Base Estimate

Analyst: Atsuko Nonoyama

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	2023-24	3,020	--	5.50	--	$3,892.62	--	$775,806,800	--
CY	2024-25	2,300	-23.8%	5.40	-1.8%	$4,067.04	4.5%	$607,898,000	-21.6%
BY	2025-26	2,320	0.9%	5.39	-0.2%	$4,149.16	2.0%	$622,992,400	2.5%

Users: Users are estimated to decrease by 23.8% from PY to CY. Due to the expansion of full scope coverage to Unsatisfactory Immigration Status (UIS) adults effective January 1, 2024, this population shifted to Managed Care plans in PY, setting a lower level for the entire CY. BY is a slight increase due to growth embedded in the projection.

Utilization: Utilization is expected to decrease by 1.8% from PY to CY. This is because in the last several months of PY were lower than earlier months, and estimates are set at that low level for CY. BY is effectively unchanged from CY.

Rate: Rate is estimated to increase by 4.5% from PY to CY, due to regular annual rate increase. A 2.0% increase is projected between CY and BY because BY's rate is projected at the highest level of CY.

Total Expenditures: Total expenditures are estimated to decrease by 21.6% from PY to CY as the decrease in users and utilization were more than offset by increased rate. Total expenditures are estimated to increase by 2.5% from CY to BY, as increases in users and rate are larger than the decrease in utilization.

Reason for Change from Prior Estimate

FISCAL YEAR	TOTAL EXPENDITURE		
	M24	N24	% Change
2023-24	$807,323,800	$775,806,800	-3.9%
2024-25	$789,428,600	$607,898,000	-23.0%

Compared to the May 2024 estimate, the November 2024 estimate is projected to be lower by 3.9% in FY 2023-24. This is mainly because of lower users than expected due to shifting in UIS population to Managed Care, not offset by higher utilization and rate. For FY 2024-25, a decrease by 23.0% is estimated because the lower users for CY are assumed for entire BY. Higher utilization and rate in BY only partially offset the lower users.

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2024 BASE ESTIMATES)

COUNTY INPATIENT

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2022-23 *	1	4,020	5.07	$3,662.40	$18,550.56	$223,534,300
2022-23 *	2	3,920	5.20	$3,783.16	$19,672.47	$231,328,600
2022-23 *	3	3,550	5.19	$3,731.28	$19,371.16	$206,186,600
2022-23 *	4	3,200	5.29	$3,866.69	$20,446.27	$196,079,700
2022-23 *	TOTAL	3,670	5.18	$3,756.85	$19,461.19	$857,129,200
2023-24 *	1	3,570	5.58	$3,768.72	$21,012.66	$224,898,500
2023-24 *	2	3,190	5.28	$3,882.75	$20,493.03	$196,405,200
2023-24 *	3	3,110	5.66	$3,988.08	$22,555.78	$210,422,900
2023-24 *	4	2,200	5.49	$3,971.34	$21,817.11	$144,080,200
2023-24 *	TOTAL	3,020	5.50	$3,892.62	$21,419.29	$775,806,800
2024-25 **	1	2,450	5.47	$3,917.35	$21,428.75	$157,798,600
2024-25 **	2	2,440	5.40	$4,167.63	$22,496.07	$164,630,800
2024-25 **	3	2,210	5.28	$4,036.87	$21,324.71	$141,080,900
2024-25 **	4	2,120	5.46	$4,156.59	$22,696.82	$144,387,700
2024-25 **	TOTAL	2,300	5.40	$4,067.04	$21,977.91	$607,898,000
2025-26 **	1	2,540	5.39	$4,144.07	$22,332.56	$169,897,400
2025-26 **	2	2,430	5.39	$4,228.55	$22,810.68	$166,156,600
2025-26 **	3	2,200	5.28	$4,055.66	$21,421.79	$141,660,300
2025-26 **	4	2,120	5.49	$4,159.31	$22,837.02	$145,278,100
2025-26 **	TOTAL	2,320	5.39	$4,149.16	$22,356.57	$622,992,400

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

Community Inpatient Fee-for-Service Base Estimate

Analyst: Atsuko Nonoyama

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 some of the Designated Public Hospitals (DPHs).

FISCAL YEAR		USERS		UTILIZATION (Days per User)		RATE (Cost per Day)		TOTAL EXPENDITURE	
PY	2023-24	15,160	--	6.38	--	$2,767.40	--	$3,212,858,900	--
CY	2024-25	14,890	-1.8%	6.41	0.5%	$2,852.99	3.1%	$3,265,495,000	1.6%
BY	2025-26	14,790	-0.7%	6.36	-0.8%	$2,942.96	3.2%	$3,322,012,700	1.7%

Users: Users are estimated to decrease by 1.8% from PY to CY. Due to the expansion of full scope coverage to Unsatisfactory Immigration Status (UIS) adults effective January 1, 2024, this population shifted to Managed Care plans in PY, setting a lower level for entire CY. A 0.7% decrease is projected between CY and BY, effectively unchanged.

Utilization: Utilization, or the number of days stayed per user, is expected to increase by 0.5% from PY to CY, effectively unchanged. A 0.8% decrease is projected between CY and BY, assuming a flat trend.

Rate: Rate, or the average cost per day, is estimated to increase by 3.1% from PY to CY, and by 3.2% again from CY to BY. This is due to normal rate growth.

Total Expenditures: Total expenditures are estimated to increase by 1.6% from PY to CY, as higher rate is assumed due to long-term growth, not fully offset by lower users. Total expenditures are estimated to increase by 1.7% from CY to BY, due to assumed growth.

Reason for Change from Prior Estimate

FISCAL YEAR	TOTAL EXPENDITURE		
	M24	N24	% Change
2023-24	$3,325,488,400	$3,212,858,900	-3.4%
2024-25	$3,432,430,700	$3,265,495,000	-4.9%

Compared to the May 2024 estimate, the November 2024 estimate is projected to decrease by 3.4% in FY 2023-24. This is mainly because of lower users observed than expected due to shifting to Managed Care among UIS population. For FY 2024-25, a decrease by 4.9% is estimated because the lower level of users observed in FY 2023-24 is assumed for entire BY.

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2024 BASE ESTIMATES)

COMMUNITY INPATIENT

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2022-23 *	1	25,960	5.13	$2,552.82	$13,089.32	$1,019,566,700
2022-23 *	2	21,560	5.18	$2,623.27	$13,577.60	$878,226,500
2022-23 *	3	21,060	5.46	$2,644.33	$14,428.78	$911,538,400
2022-23 *	4	14,640	6.14	$2,640.31	$16,201.72	$711,417,500
2022-23 *	TOTAL	20,800	5.40	$2,611.19	$14,102.18	$3,520,749,100
2023-24 *	1	18,260	6.50	$2,774.12	$18,036.74	$988,034,400
2023-24 *	2	15,980	6.14	$2,701.52	$16,595.83	$795,853,000
2023-24 *	3	14,760	6.39	$2,748.65	$17,571.11	$778,048,700
2023-24 *	4	11,630	6.51	$2,865.70	$18,661.78	$650,922,800
2023-24 *	TOTAL	15,160	6.38	$2,767.40	$17,663.36	$3,212,858,900
2024-25 **	1	17,740	6.63	$2,835.87	$18,804.95	$1,001,067,800
2024-25 **	2	15,050	6.32	$2,830.28	$17,892.30	$807,896,700
2024-25 **	3	14,450	6.40	$2,868.31	$18,343.21	$795,381,500
2024-25 **	4	12,320	6.19	$2,889.16	$17,891.90	$661,149,000
2024-25 **	TOTAL	14,890	6.41	$2,852.99	$18,273.50	$3,265,495,000
2025-26 **	1	17,350	6.47	$2,931.59	$18,974.27	$987,344,900
2025-26 **	2	15,050	6.32	$2,917.93	$18,445.19	$833,057,200
2025-26 **	3	14,450	6.40	$2,954.54	$18,894.39	$819,325,400
2025-26 **	4	12,320	6.20	$2,976.82	$18,463.40	$682,285,200
2025-26 **	TOTAL	14,790	6.36	$2,942.96	$18,713.80	$3,322,012,700

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

Nursing Facility Fee-for-Service Base Estimate

Analyst: Haixiao Hu

Background: Nursing Facilities consist 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 (Claims per User)		RATE (Cost per Claim)		TOTAL EXPENDITURE	
PY	2023-24	7,630	--	33.02	--	$327.35	--	$989,386,100	--
CY	2024-25	6,970	-8.7%	33.68	2.0%	$285.21	-12.9%	$803,101,800	-18.8%
BY	2025-26	6,980	0.1%	33.95	0.8%	$286.35	0.4%	$813,971,400	1.4%

Users: Compared to the PY, users are estimated to decrease by 8.7% in the CY, due to the CalAIM implementation in January 2023. In the BY, the number of users is expected to remain relatively unchanged compared to the CY.

Utilization: Utilization is estimated to increase by 2.0% in CY and slightly increase by 0.8% in BY, which reflects a normal fluctuation.

Rate: The rate is estimated to decrease by 12.9% in the CY and relatively unchanged in the BY. This decrease is likely primarily driven the transition of users from FFS to Managed Care.

Total Expenditure: The CY is estimated to decrease by 18.8% due to declines in both user and rate estimates, while the BY projection remains relatively unchanged compared to the CY estimate.

Reason for Change from Prior Estimate

FISCAL YEAR	TOTAL EXPENDITURE		
	M24	N24	% Change
2023-24	$1,038,787,100	$989,386,100	-4.8%
2024-25	$1,010,284,400	$803,101,800	-20.5%

Actual total expenditures for FY 2023-24 are 4.8% lower than the May 2024 Estimate. With additional observed data points showing generally lower values from February to July 2024, the November 2024 Estimate for FY 2024-25 total expenditures is 20.5% lower than the May 2024 Estimate.

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2024 BASE ESTIMATES)

NURSING FACILITIES

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2022-23 *	1	23,870	35.17	$310.97	$10,936.04	$782,976,500
2022-23 *	2	23,330	33.29	$303.04	$10,087.62	$706,052,600
2022-23 *	3	20,260	30.56	$297.90	$9,104.66	$553,481,300
2022-23 *	4	9,090	29.55	$314.56	$9,295.95	$253,546,900
2022-23 *	TOTAL	19,140	32.71	$305.67	$9,997.90	$2,296,057,400
2023-24 *	1	9,000	35.36	$328.78	$11,627.11	$313,920,300
2023-24 *	2	7,780	31.53	$342.39	$10,796.75	$252,028,600
2023-24 *	3	7,350	33.35	$344.88	$11,503.15	$253,690,400
2023-24 *	4	6,380	31.16	$284.86	$8,875.64	$169,746,700
2023-24 *	TOTAL	7,630	33.02	$327.35	$10,810.48	$989,386,100
2024-25 **	1	7,420	36.26	$288.59	$10,464.44	$232,970,700
2024-25 **	2	7,200	33.69	$287.10	$9,671.04	$208,809,000
2024-25 **	3	7,010	32.65	$284.01	$9,272.81	$194,976,000
2024-25 **	4	6,240	31.75	$279.69	$8,881.29	$166,346,000
2024-25 **	TOTAL	6,970	33.68	$285.21	$9,605.24	$803,101,800
2025-26 **	1	7,460	37.30	$292.11	$10,894.73	$243,916,000
2025-26 **	2	7,200	33.68	$287.10	$9,671.01	$208,831,600
2025-26 **	3	7,010	32.65	$284.01	$9,272.81	$194,976,800
2025-26 **	4	6,240	31.70	$280.02	$8,876.09	$166,247,000
2025-26 **	TOTAL	6,980	33.95	$286.35	$9,720.40	$813,971,400

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

ICF/DD Fee-for-Service Base Estimate

Analyst: Haixiao Hu

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 (Claims per User)		RATE (Cost per Claim)		TOTAL EXPENDITURE	
PY	2023-24	2,410	--	32.37	--	$354.33	--	$331,922,900	--
CY	2024-25	210	-91.3%	31.69	-2.1%	$349.17	-1.5%	$27,568,500	-91.7%
BY	2025-26	210	0.0%	32.46	2.4%	$349.70	0.2%	$29,095,700	5.5%

Users: Users are estimated to decrease by 91.3% in the CY mainly due to the CalAIM implementation in January 2024 which transitioned members from Fee-for-Service (FFS) to Managed Care.

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

Rate: The rate is estimated to remain relatively unchanged in both the CY and BY.

Total Expenditure: Total expenditure is estimated to decrease by 91.7% for the CY due to a decrease in users. The BY total expenditure is projected to increase by 5.5% compared to the CY.

Reason for Change from Prior Estimate:

FISCAL YEAR	TOTAL EXPENDITURE		
	M24	N24	% Change
2023-24	$473,427,200	$331,922,900	-29.9%
2024-25	$393,304,100	$27,568,500	-93.0%

Compared to the May 2024 Estimate, actual total expenditures for FY 2023-24 and the November 2024 Estimate for FY 2024-25 decreased by 29.9% and 93.0%, respectively, primarily due to the CalAIM implementation in January 2024, which transitioned members from FFS to Managed Care.

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2024 BASE ESTIMATES)

ICF-DD

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2022-23 *	1	4,190	36.22	$326.79	$11,835.98	$148,944,000
2022-23 *	2	4,100	31.07	$329.69	$10,243.48	$125,851,400
2022-23 *	3	4,050	31.18	$391.68	$12,211.30	$148,355,100
2022-23 *	4	3,880	26.99	$353.56	$9,543.45	$111,143,000
2022-23 *	TOTAL	4,060	31.45	$349.07	$10,979.01	$534,293,500
2023-24 *	1	3,970	35.81	$354.24	$12,685.17	$151,131,100
2023-24 *	2	3,950	31.16	$353.35	$11,011.53	$130,453,600
2023-24 *	3	1,580	26.12	$357.77	$9,346.47	$44,358,300
2023-24 *	4	140	39.08	$352.57	$13,778.52	$5,979,900
2023-24 *	TOTAL	2,410	32.37	$354.33	$11,468.95	$331,922,900
2024-25 **	1	200	34.96	$348.73	$12,193.32	$7,239,700
2024-25 **	2	240	31.69	$348.60	$11,048.15	$7,855,300
2024-25 **	3	220	30.16	$349.61	$10,542.55	$6,896,000
2024-25 **	4	180	29.91	$349.98	$10,468.96	$5,577,500
2024-25 **	TOTAL	210	31.69	$349.17	$11,064.46	$27,568,500
2025-26 **	1	230	37.30	$350.44	$13,072.25	$8,883,800
2025-26 **	2	230	31.73	$348.69	$11,062.87	$7,726,200
2025-26 **	3	220	30.16	$349.63	$10,543.55	$6,885,200
2025-26 **	4	180	30.05	$350.02	$10,516.48	$5,600,400
2025-26 **	TOTAL	210	32.46	$349.70	$11,349.76	$29,095,700

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

Medical Transportation Fee-for-Service Base Estimate

Analyst: Joulia Dib

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	2023-24	10,730	--	1.62	--	$358.18	--	$74,780,000	--
CY	2024-25	9,820	-8.5%	1.54	-4.9%	$355.10	-0.9%	$64,300,800	-14.0%
BY	2025-26	9,860	0.4%	1.56	1.3%	$354.59	-0.1%	$65,555,600	2.0%

Users: Users are estimated to decrease 8.5% in the CY due to CalAIM implementation in January 2023 which transitioned members from FFS to Managed Care. Declines could also be related to resumption of eligibility redeterminations starting July 2023. Users are relatively unchanged in the BY.

Utilization: Utilization is estimated to decrease by 4.9% in the CY due to a decrease in users from CalAIM implementation in January 2023. Utilization is estimated to increase 1.3% in BY reflecting normal fluctuations in the utilization trend.

Rate: The rate is estimated to decrease by 0.9% in the CY and by 0.1% in the BY reflecting normal fluctuations in rates.

Total Expenditure: Total expenditures estimated to decrease by 14.0% in the CY mainly due to a decrease in users and utilization. BY total expenditure are estimated to increase by 2.0% mainly due to higher utilization.

Reason for Change from Prior Estimate

FISCAL YEAR	TOTAL EXPENDITURE		
	M24	N24	% CHANGE
2023-24	$81,146,800	$74,780,000	-7.8%
2024-25	$81,376,700	$64,300,800	-21.0%

Compared to the May 2024 Estimate, the November 2024 Estimate total expenditures decreased by 7.8% in FY 2023-24 and by 21.0% in FY 2024-25, likely due to a decrease in users and lower utilization from CalAIM implementation in January 2023 which transitioned members from FFS to Managed Care and resumption of eligibility redeterminations starting July 2023.

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2024 BASE ESTIMATES)

MEDICAL TRANSPORTATION

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2022-23 *	1	21,000	2.73	$143.66	$392.55	$24,729,200
2022-23 *	2	19,190	2.64	$137.26	$362.71	$20,877,400
2022-23 *	3	16,660	2.26	$164.10	$370.48	$18,511,700
2022-23 *	4	10,710	1.70	$238.54	$404.50	$12,994,900
2022-23 *	TOTAL	16,890	2.43	$156.89	$380.52	$77,113,200
2023-24 *	1	12,360	1.72	$369.20	$633.47	$23,497,900
2023-24 *	2	11,490	1.61	$365.37	$588.48	$20,290,300
2023-24 *	3	11,410	1.59	$364.36	$579.32	$19,827,300
2023-24 *	4	7,670	1.53	$317.34	$485.06	$11,164,500
2023-24 *	TOTAL	10,730	1.62	$358.18	$580.52	$74,780,000
2024-25 **	1	11,320	1.54	$356.68	$550.28	$18,695,000
2024-25 **	2	10,570	1.52	$362.31	$552.38	$17,519,700
2024-25 **	3	9,650	1.54	$362.29	$557.96	$16,157,500
2024-25 **	4	7,710	1.54	$334.04	$515.48	$11,928,600
2024-25 **	TOTAL	9,820	1.54	$355.10	$545.89	$64,300,800
2025-26 **	1	11,400	1.62	$356.60	$576.58	$19,723,600
2025-26 **	2	10,550	1.53	$359.90	$550.79	$17,438,100
2025-26 **	3	9,720	1.54	$360.21	$556.40	$16,219,300
2025-26 **	4	7,790	1.54	$337.36	$521.16	$12,174,600
2025-26 **	TOTAL	9,860	1.56	$354.59	$553.78	$65,555,600

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

Other Services Fee-for-Service Base Estimate

Analyst: Joulia Dib

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

FISCAL YEAR		USERS		UTILIZATION (Claims per User)		RATE (Cost per Claim)		TOTAL EXPENDITURE	
PY	2023-24	234,740	--	2.98	--	$174.31	--	$1,463,240,500	--
CY	2024-25	237,520	1.2%	3.06	2.7%	$199.62	14.5%	$1,738,795,300	18.8%
BY	2025-26	235,090	-1.0%	3.07	0.3%	$197.72	-1.0%	$1,711,661,800	-1.6%

Users: Users are estimated to increase by 1.2% in the CY and decrease by 1.0% in the BY reflecting normal fluctuations in the user trend.

Utilization: Utilization is estimated to increase by 2.7% in CY likely due to higher utilization by the Multi-purpose Senior Care Services Program and the Assisted Living Waiver (ALW) Program, especially at Residential Care Facility for the Elderly. The BY is estimated to remain relatively unchanged.

Rate: The rate is estimated to increase 14.5% in the CY likely due to the ALW Program at Residential Care Facility for the Elderly, Certified Hospice Service and Assistive Devices. The rate is estimated to remain relatively unchanged for the BY.

Total Expenditure: Total expenditures are estimated to increase in the CY by 18.8%, primarily due to an increase in utilization and rates. The BY total expenditures are estimated to decrease 1.6% from the CY due to lower estimated users and rates.

Reason for Change from Prior Estimate:

FISCAL YEAR	TOTAL EXPENDITURE		
	M24	N24	% Change
2023-24	$1,442,769,300	$1,463,240,500	1.4%
2024-25	$1,486,992,300	$1,738,795,300	16.9%

Compared to the May 2024 Estimate, the November Estimate expenditures for FY 2023-24 remained relatively unchanged. The FY 2024-25 expenditures estimate increased by 16.9% due to higher users and rates.

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2024 BASE ESTIMATES)

OTHER SERVICES

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2022-23 *	1	216,830	2.98	$164.31	$490.03	$318,760,300
2022-23 *	2	206,810	2.79	$159.80	$446.36	$276,932,700
2022-23 *	3	224,150	3.00	$149.07	$446.51	$300,260,400
2022-23 *	4	241,480	3.03	$121.26	$367.46	$266,204,200
2022-23 *	TOTAL	222,320	2.95	$147.44	$435.62	$1,162,157,600
2023-24 *	1	231,160	3.09	$179.05	$552.65	$383,253,800
2023-24 *	2	227,530	2.81	$180.68	$506.95	$346,042,700
2023-24 *	3	231,300	2.66	$197.16	$524.30	$363,818,900
2023-24 *	4	248,960	3.34	$148.46	$495.55	$370,125,100
2023-24 *	TOTAL	234,740	2.98	$174.31	$519.46	$1,463,240,500
2024-25 **	1	250,100	3.24	$217.79	$706.50	$530,081,400
2024-25 **	2	227,070	2.82	$216.86	$610.96	$416,191,700
2024-25 **	3	228,560	2.90	$209.33	$606.30	$415,722,500
2024-25 **	4	244,370	3.23	$158.89	$513.97	$376,799,700
2024-25 **	TOTAL	237,520	3.06	$199.62	$610.04	$1,738,795,300
2025-26 **	1	243,330	3.29	$211.45	$695.39	$507,631,500
2025-26 **	2	224,870	2.82	$217.81	$614.23	$414,364,800
2025-26 **	3	228,070	2.90	$209.14	$605.64	$414,389,200
2025-26 **	4	244,090	3.24	$158.18	$512.48	$375,276,300
2025-26 **	TOTAL	235,090	3.07	$197.72	$606.73	$1,711,661,800

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

Home Health Fee-for-Service Base Estimate

Analyst: Michael Redman

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

FISCAL YEAR		USERS		UTILIZATION (Claims per User)		RATE (Cost per Claim)		TOTAL EXPENDITURE	
PY	2023-24	1,760	--	5.86	--	$1,097.27	--	$135,527,900	--
CY	2024-25	1,720	-2.3%	5.27	-10.1%	$1,057.65	-3.6%	$114,753,400	-15.3%
BY	2025-26	1,710	-0.6%	5.25	-0.4%	$1,057.46	0.0%	$114,219,200	-0.5%

Users: Users are estimated to decrease by 2% in the CY, due to the resumption of eligibility redeterminations following the end of the federal COVID-19 Public Health Emergency (PHE). Users are relatively unchanged in the BY.

Utilization: Utilization is estimated to decrease by 10% due to the resumption of eligibility redeterminations following the end of the federal COVID-19 Public Health Emergency (PHE). Utilization is relatively unchanged in the BY.

Rate: The rate is estimated to decrease by 4% in the CY and to remain relatively unchanged in the BY.

Total Expenditure: Total expenditure is estimated to decrease by 15.3% in the CY, mainly due to the decrease of users and utilization. Total expenditure is estimated to remain relatively unchanged in the BY.

Reason for Change from Prior Estimate

FISCAL YEAR	TOTAL EXPENDITURE		
	M24	N24	% Change
2023-24	$136,756,400	$135,527,900	-0.90%
2024-25	$138,766,700	$114,753,400	-17.30%

Compared to the May 2024 Estimate, the November 2024 Estimate for total expenditure decreased by .9% in FY 2023-24, due to the resumption of eligibility redeterminations following the end of the federal COVID-19 Public Health Emergency (PHE). The total expenditure is estimated to decrease by 17.3% in FY 2024-25 due to redetermination impacts.

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2024 BASE ESTIMATES)

HOME HEALTH

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2022-23 *	1	2,690	6.58	$983.76	$6,469.25	$52,187,500
2022-23 *	2	2,280	6.24	$999.36	$6,234.94	$42,690,700
2022-23 *	3	2,070	5.73	$1,021.78	$5,856.74	$36,393,800
2022-23 *	4	1,720	5.19	$1,048.03	$5,443.60	$28,094,400
2022-23 *	TOTAL	2,190	6.02	$1,007.42	$6,062.09	$159,366,400
2023-24 *	1	1,910	6.30	$1,093.29	$6,888.37	$39,504,800
2023-24 *	2	1,790	5.80	$1,103.79	$6,398.10	$34,268,200
2023-24 *	3	1,700	5.05	$1,192.92	$6,018.41	$30,687,900
2023-24 *	4	1,630	6.27	$1,014.96	$6,368.80	$31,067,000
2023-24 *	TOTAL	1,760	5.86	$1,097.27	$6,432.88	$135,527,900
2024-25 **	1	1,890	5.93	$1,061.38	$6,293.73	$35,656,200
2024-25 **	2	1,750	5.26	$1,054.62	$5,550.90	$29,066,500
2024-25 **	3	1,680	4.84	$1,062.05	$5,144.45	$25,904,600
2024-25 **	4	1,560	4.92	$1,051.13	$5,167.63	$24,126,100
2024-25 **	TOTAL	1,720	5.27	$1,057.65	$5,568.97	$114,753,400
2025-26 **	1	1,880	5.89	$1,061.33	$6,249.00	$35,154,500
2025-26 **	2	1,750	5.26	$1,054.62	$5,550.90	$29,066,500
2025-26 **	3	1,680	4.84	$1,062.05	$5,144.45	$25,904,600
2025-26 **	4	1,560	4.91	$1,050.38	$5,160.67	$24,093,600
2025-26 **	TOTAL	1,710	5.25	$1,057.46	$5,553.75	$114,219,200

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2024 BASE ESTIMATES)

PA-OAS

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2022-23 *	1	141,500	3.32	$114.39	$379.44	$161,072,400
2022-23 *	2	133,120	3.03	$120.95	$366.69	$146,440,600
2022-23 *	3	144,900	2.90	$118.62	$343.69	$149,396,900
2022-23 *	4	120,490	2.24	$112.90	$252.78	$91,373,900
2022-23 *	TOTAL	135,000	2.89	$116.97	$338.44	$548,283,700
2023-24 *	1	141,580	2.58	$110.31	$284.13	$120,678,300
2023-24 *	2	132,130	2.34	$111.98	$261.83	$103,788,700
2023-24 *	3	144,430	2.57	$98.35	$252.84	$109,558,500
2023-24 *	4	130,230	2.39	$98.55	$235.64	$92,062,500
2023-24 *	TOTAL	137,090	2.47	$104.72	$259.00	$426,087,900
2024-25 **	1	152,830	2.83	$106.59	$302.08	$138,498,100
2024-25 **	2	141,240	2.60	$102.47	$266.06	$112,732,000
2024-25 **	3	145,030	2.61	$96.11	$251.04	$109,226,000
2024-25 **	4	131,070	2.48	$95.90	$237.95	$93,562,500
2024-25 **	TOTAL	142,540	2.64	$100.63	$265.43	$454,018,600
2025-26 **	1	151,160	2.86	$104.15	$297.52	$134,920,900
2025-26 **	2	141,240	2.59	$101.61	$262.98	$111,430,400
2025-26 **	3	145,030	2.60	$95.13	$247.66	$107,756,300
2025-26 **	4	131,070	2.49	$94.04	$233.99	$92,006,700
2025-26 **	TOTAL	142,120	2.64	$99.07	$261.57	$446,114,200

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2024 BASE ESTIMATES)

NEWLY

YEAR	QUARTER	AVERAGE MONTHLY USERS	AVERAGE MONTHLY UNIT PER USER	AVERAGE MONTHLY COST PER UNIT	AVERAGE MONTHLY COST PER USER	TOTAL COST
2022-23 *	1	1,510,360	4.80	$132.63	$637.10	$2,886,751,600
2022-23 *	2	1,446,970	4.18	$137.34	$574.13	$2,492,257,800
2022-23 *	3	1,491,080	4.05	$161.97	$655.38	$2,931,659,100
2022-23 *	4	1,363,720	3.32	$176.17	$585.24	$2,394,293,500
2022-23 *	TOTAL	1,453,030	4.11	$149.50	$613.94	$10,704,962,000
2023-24 *	1	1,552,340	3.90	$184.11	$718.17	$3,344,541,200
2023-24 *	2	1,444,320	3.47	$185.54	$644.36	$2,791,988,500
2023-24 *	3	1,501,060	3.78	$187.45	$708.78	$3,191,758,200
2023-24 *	4	1,400,870	3.39	$194.79	$659.69	$2,772,391,400
2023-24 *	TOTAL	1,474,640	3.64	$187.68	$683.82	$12,100,679,300
2024-25 **	1	1,600,850	3.95	$203.88	$805.74	$3,869,598,900
2024-25 **	2	1,540,980	3.54	$201.59	$714.40	$3,302,629,200
2024-25 **	3	1,501,310	3.67	$205.00	$752.88	$3,390,920,100
2024-25 **	4	1,408,830	3.39	$207.34	$703.65	$2,973,970,800
2024-25 **	TOTAL	1,512,990	3.65	$204.35	$745.60	$13,537,119,000
2025-26 **	1	1,597,260	4.02	$214.70	$863.57	$4,138,034,400
2025-26 **	2	1,540,980	3.54	$215.26	$762.53	$3,525,113,400
2025-26 **	3	1,501,310	3.67	$218.76	$803.35	$3,618,225,300
2025-26 **	4	1,408,830	3.41	$220.72	$753.36	$3,184,086,000
2025-26 **	TOTAL	1,512,100	3.67	$217.15	$797.21	$14,465,459,100

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2024 BASE ESTIMATES)

PA-ATD

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2022-23 *	1	428,380	7.29	$162.60	$1,185.10	$1,523,013,400
2022-23 *	2	410,700	6.13	$169.32	$1,038.71	$1,279,797,900
2022-23 *	3	423,560	6.00	$187.49	$1,124.82	$1,429,277,600
2022-23 *	4	385,720	4.83	$198.67	$960.07	$1,110,940,300
2022-23 *	TOTAL	412,090	6.10	$177.27	$1,080.48	$5,343,029,200
2023-24 *	1	413,640	5.83	$210.42	$1,227.14	$1,522,759,400
2023-24 *	2	396,910	5.01	$209.51	$1,050.46	$1,250,810,000
2023-24 *	3	409,560	5.30	$203.03	$1,076.67	$1,322,896,100
2023-24 *	4	383,310	4.73	$199.11	$941.34	$1,082,488,700
2023-24 *	TOTAL	400,860	5.23	$205.85	$1,076.65	$5,178,954,300
2024-25 **	1	410,040	5.66	$212.05	$1,200.21	$1,476,397,900
2024-25 **	2	402,330	4.95	$209.85	$1,039.28	$1,254,400,700
2024-25 **	3	398,610	5.08	$207.06	$1,051.74	$1,257,698,900
2024-25 **	4	378,150	4.69	$204.35	$958.43	$1,087,292,200
2024-25 **	TOTAL	397,280	5.10	$208.58	$1,064.69	$5,075,789,600
2025-26 **	1	408,060	5.78	$211.73	$1,224.47	$1,498,983,700
2025-26 **	2	402,330	4.95	$210.54	$1,043.04	$1,258,941,900
2025-26 **	3	398,610	5.08	$207.70	$1,055.31	$1,261,974,300
2025-26 **	4	378,150	4.72	$205.01	$968.13	$1,098,300,600
2025-26 **	TOTAL	396,790	5.14	$208.97	$1,074.92	$5,118,200,500

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2024 BASE ESTIMATES)

PA-AFDC

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2022-23 *	1	299,660	3.64	$113.99	$415.44	$373,473,100
2022-23 *	2	307,450	3.46	$113.51	$392.87	$362,362,200
2022-23 *	3	309,370	3.20	$140.54	$449.62	$417,292,100
2022-23 *	4	284,240	2.74	$140.20	$383.98	$327,430,000
2022-23 *	TOTAL	300,180	3.27	$125.76	$411.02	$1,480,557,500
2023-24 *	1	311,020	3.02	$163.79	$494.16	$461,081,400
2023-24 *	2	305,740	2.83	$154.40	$436.62	$400,476,300
2023-24 *	3	315,530	2.97	$147.05	$437.02	$413,681,400
2023-24 *	4	293,110	2.83	$150.38	$426.15	$374,724,400
2023-24 *	TOTAL	306,350	2.91	$154.00	$448.82	$1,649,963,400
2024-25 **	1	313,800	3.16	$169.65	$535.68	$504,279,800
2024-25 **	2	313,730	2.97	$160.27	$475.33	$447,377,900
2024-25 **	3	288,060	3.01	$165.22	$497.67	$430,068,200
2024-25 **	4	276,950	2.92	$158.53	$463.69	$385,257,300
2024-25 **	TOTAL	298,130	3.02	$163.66	$493.90	$1,766,983,200
2025-26 **	1	311,730	3.25	$170.90	$555.76	$519,738,700
2025-26 **	2	313,730	2.97	$165.43	$490.58	$461,725,900
2025-26 **	3	288,060	3.01	$170.25	$512.81	$443,156,300
2025-26 **	4	276,950	2.94	$162.54	$477.86	$397,033,700
2025-26 **	TOTAL	297,620	3.05	$167.46	$510.07	$1,821,654,600

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2024 BASE ESTIMATES)

LT-OAS

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2022-23 *	1	16,600	25.50	$276.06	$7,040.80	$350,695,400
2022-23 *	2	16,110	23.81	$273.46	$6,511.81	$314,748,500
2022-23 *	3	15,040	19.12	$268.34	$5,130.25	$231,533,300
2022-23 *	4	9,620	12.66	$251.07	$3,177.92	$91,718,000
2022-23 *	TOTAL	14,340	21.20	$270.91	$5,743.69	$988,695,200
2023-24 *	1	10,220	14.67	$245.88	$3,606.68	$110,595,400
2023-24 *	2	9,760	12.47	$269.52	$3,359.77	$98,367,300
2023-24 *	3	10,250	11.93	$260.65	$3,108.88	$95,619,900
2023-24 *	4	9,660	10.15	$219.07	$2,222.67	$64,413,000
2023-24 *	TOTAL	9,970	12.33	$250.06	$3,083.21	$368,995,600
2024-25 **	1	10,700	12.02	$223.04	$2,681.98	$86,089,600
2024-25 **	2	9,980	11.89	$226.20	$2,689.77	$80,546,500
2024-25 **	3	10,190	11.76	$217.80	$2,561.92	$78,316,400
2024-25 **	4	9,760	9.58	$214.61	$2,056.38	$60,187,300
2024-25 **	TOTAL	10,160	11.34	$220.78	$2,503.55	$305,139,800
2025-26 **	1	10,580	12.41	$225.83	$2,803.15	$88,975,800
2025-26 **	2	9,980	11.89	$226.36	$2,690.82	$80,577,800
2025-26 **	3	10,190	11.76	$217.95	$2,563.65	$78,369,200
2025-26 **	4	9,720	9.63	$214.86	$2,068.99	$60,324,900
2025-26 **	TOTAL	10,120	11.45	$221.71	$2,538.84	$308,247,600

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2024 BASE ESTIMATES)

H-PE

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2022-23 *	1	46,480	4.32	$300.21	$1,295.82	$180,703,800
2022-23 *	2	41,060	4.14	$304.26	$1,259.52	$155,163,000
2022-23 *	3	39,970	4.21	$311.63	$1,313.14	$157,470,500
2022-23 *	4	36,710	3.80	$311.03	$1,181.21	$130,092,800
2022-23 *	TOTAL	41,060	4.13	$306.28	$1,265.34	$623,430,100
2023-24 *	1	45,880	4.32	$314.32	$1,357.13	$186,792,600
2023-24 *	2	45,820	4.15	$311.02	$1,291.96	$177,588,400
2023-24 *	3	48,770	4.26	$310.01	$1,319.77	$193,088,700
2023-24 *	4	43,560	3.70	$300.20	$1,112.16	$145,352,100
2023-24 *	TOTAL	46,010	4.12	$309.30	$1,273.01	$702,821,800
2024-25 **	1	55,630	4.29	$314.07	$1,346.38	$224,689,800
2024-25 **	2	50,150	4.23	$306.62	$1,297.32	$195,200,400
2024-25 **	3	46,970	4.43	$312.50	$1,383.58	$194,958,300
2024-25 **	4	44,410	3.96	$303.55	$1,202.68	$160,226,000
2024-25 **	TOTAL	49,290	4.23	$309.57	$1,310.40	$775,074,500
2025-26 **	1	54,430	4.32	$312.23	$1,348.86	$220,263,800
2025-26 **	2	50,150	4.23	$310.04	$1,312.20	$197,438,500
2025-26 **	3	46,970	4.43	$315.24	$1,395.82	$196,682,700
2025-26 **	4	44,410	3.96	$305.83	$1,212.25	$161,501,000
2025-26 **	TOTAL	48,990	4.24	$311.07	$1,319.78	$775,886,000

* 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 NOVEMBER 2024 BASE ESTIMATES)

LT-ATD

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2022-23 *	1	4,830	27.75	$294.04	$8,160.02	$118,263,100
2022-23 *	2	4,700	23.91	$293.77	$7,024.62	$98,955,900
2022-23 *	3	4,570	22.02	$319.45	$7,034.24	$96,404,200
2022-23 *	4	3,740	17.38	$308.18	$5,357.71	$60,118,900
2022-23 *	TOTAL	4,460	23.10	$302.40	$6,985.05	$373,742,100
2023-24 *	1	3,820	22.59	$307.93	$6,955.08	$79,739,900
2023-24 *	2	3,680	19.78	$310.28	$6,136.35	$67,684,000
2023-24 *	3	3,350	12.38	$293.54	$3,633.07	$36,483,300
2023-24 *	4	2,720	7.50	$235.55	$1,767.21	$14,446,900
2023-24 *	TOTAL	3,390	16.28	$299.31	$4,872.13	$198,354,100
2024-25 **	1	2,990	9.30	$238.48	$2,217.96	$19,873,700
2024-25 **	2	3,040	8.19	$250.88	$2,054.45	$18,759,200
2024-25 **	3	2,970	8.40	$231.81	$1,946.53	$17,328,900
2024-25 **	4	2,590	8.13	$226.36	$1,840.38	$14,281,400
2024-25 **	TOTAL	2,900	8.52	$237.35	$2,021.16	$70,243,200
2025-26 **	1	2,960	9.85	$244.50	$2,407.14	$21,402,100
2025-26 **	2	3,040	8.16	$250.58	$2,044.88	$18,671,900
2025-26 **	3	2,970	8.39	$231.74	$1,945.15	$17,316,600
2025-26 **	4	2,590	8.18	$225.25	$1,843.63	$14,306,600
2025-26 **	TOTAL	2,890	8.66	$238.76	$2,067.12	$71,697,100

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2024 BASE ESTIMATES)

POV 250

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2022-23 *	1	182,740	2.85	$122.21	$348.27	$190,932,300
2022-23 *	2	179,520	2.87	$108.13	$309.92	$166,913,900
2022-23 *	3	174,070	2.60	$133.03	$345.98	$180,667,800
2022-23 *	4	156,860	2.35	$136.20	$320.07	$150,621,300
2022-23 *	TOTAL	173,300	2.68	$123.72	$331.38	$689,135,300
2023-24 *	1	173,350	2.45	$168.64	$412.86	$214,711,800
2023-24 *	2	173,730	2.40	$147.60	$353.57	$184,280,000
2023-24 *	3	189,280	2.42	$144.81	$350.46	$199,005,700
2023-24 *	4	180,610	2.47	$134.52	$332.85	$180,346,500
2023-24 *	TOTAL	179,240	2.43	$148.64	$361.86	$778,344,000
2024-25 **	1	196,100	2.68	$161.41	$433.21	$254,857,100
2024-25 **	2	194,650	2.67	$146.19	$390.13	$227,819,100
2024-25 **	3	181,050	2.69	$144.57	$389.49	$211,550,800
2024-25 **	4	176,680	2.69	$135.37	$363.55	$192,696,400
2024-25 **	TOTAL	187,120	2.68	$147.23	$394.99	$886,923,400
2025-26 **	1	194,000	2.87	$158.53	$455.35	$265,020,600
2025-26 **	2	194,650	2.73	$146.62	$400.40	$233,813,000
2025-26 **	3	181,050	2.75	$145.10	$399.59	$217,036,000
2025-26 **	4	176,680	2.76	$135.13	$372.29	$197,330,000
2025-26 **	TOTAL	186,600	2.78	$146.76	$407.83	$913,199,600

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2024 BASE ESTIMATES)

MN-OAS

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2022-23 *	1	222,800	4.99	$132.21	$659.94	$441,097,900
2022-23 *	2	216,900	4.44	$137.10	$609.09	$396,325,200
2022-23 *	3	230,910	4.19	$144.98	$608.08	$421,232,200
2022-23 *	4	202,940	3.37	$155.33	$523.54	$318,739,300
2022-23 *	TOTAL	218,390	4.27	$141.03	$601.92	$1,577,394,600
2023-24 *	1	237,400	3.87	$160.15	$619.34	$441,091,600
2023-24 *	2	227,050	3.46	$162.85	$562.99	$383,472,000
2023-24 *	3	247,910	3.70	$162.68	$601.23	$447,144,200
2023-24 *	4	237,170	3.37	$161.57	$544.44	$387,379,700
2023-24 *	TOTAL	237,380	3.60	$161.78	$582.43	$1,659,087,500
2024-25 **	1	280,900	3.97	$169.86	$674.18	$568,129,400
2024-25 **	2	263,050	3.55	$167.74	$595.37	$469,839,700
2024-25 **	3	257,990	3.64	$161.94	$589.59	$456,333,300
2024-25 **	4	247,120	3.35	$166.49	$558.46	$414,018,300
2024-25 **	TOTAL	262,270	3.64	$166.66	$606.36	$1,908,320,600
2025-26 **	1	276,680	4.03	$169.67	$683.49	$567,323,100
2025-26 **	2	263,050	3.55	$168.15	$597.50	$471,520,200
2025-26 **	3	257,990	3.64	$162.31	$591.55	$457,847,200
2025-26 **	4	247,120	3.37	$166.55	$561.35	$416,158,500
2025-26 **	TOTAL	261,210	3.66	$166.81	$610.25	$1,912,848,900

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2024 BASE ESTIMATES)

MN-ATD

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2022-23 *	1	70,710	5.15	$160.23	$825.74	$175,158,300
2022-23 *	2	67,170	4.54	$164.53	$746.19	$150,361,500
2022-23 *	3	71,840	4.27	$172.77	$737.48	$158,938,500
2022-23 *	4	61,790	3.61	$184.77	$667.73	$123,768,200
2022-23 *	TOTAL	67,880	4.42	$169.10	$746.75	$608,226,500
2023-24 *	1	67,970	4.06	$201.13	$817.17	$166,624,600
2023-24 *	2	64,360	3.58	$198.82	$711.50	$137,379,500
2023-24 *	3	69,770	3.67	$196.59	$721.26	$150,959,700
2023-24 *	4	65,430	3.57	$184.92	$660.51	$129,655,200
2023-24 *	TOTAL	66,880	3.72	$195.63	$728.42	$584,619,000
2024-25 **	1	73,630	3.98	$203.69	$811.43	$179,231,800
2024-25 **	2	69,730	3.53	$199.56	$705.14	$147,511,800
2024-25 **	3	69,890	3.68	$191.32	$704.16	$147,642,400
2024-25 **	4	67,090	3.48	$189.52	$658.81	$132,594,200
2024-25 **	TOTAL	70,080	3.67	$196.41	$721.72	$606,980,200
2025-26 **	1	72,920	4.06	$201.92	$819.77	$179,328,000
2025-26 **	2	69,730	3.53	$200.00	$706.79	$147,856,000
2025-26 **	3	69,890	3.68	$191.69	$705.53	$147,929,300
2025-26 **	4	67,090	3.49	$189.66	$662.36	$133,308,300
2025-26 **	TOTAL	69,910	3.70	$196.14	$725.27	$608,421,500

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2024 BASE ESTIMATES)

MN-AFDC

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2022-23 *	1	1,030,810	3.63	$118.14	$428.56	$1,325,301,600
2022-23 *	2	981,790	3.34	$117.81	$393.61	$1,159,317,200
2022-23 *	3	991,350	3.18	$140.05	$445.09	$1,323,714,200
2022-23 *	4	906,890	2.73	$148.24	$404.99	$1,101,841,000
2022-23 *	TOTAL	977,710	3.23	$129.41	$418.51	$4,910,174,000
2023-24 *	1	1,012,210	3.07	$163.53	$501.43	$1,522,658,400
2023-24 *	2	944,780	2.82	$160.16	$452.38	$1,282,198,800
2023-24 *	3	1,004,210	2.99	$159.21	$476.73	$1,436,202,100
2023-24 *	4	951,060	2.79	$158.03	$440.24	$1,256,083,700
2023-24 *	TOTAL	978,060	2.92	$160.33	$468.37	$5,497,143,000
2024-25 **	1	1,052,280	3.12	$172.64	$538.96	$1,701,425,800
2024-25 **	2	1,025,850	2.92	$167.30	$488.86	$1,504,486,200
2024-25 **	3	977,740	2.98	$168.98	$504.07	$1,478,557,600
2024-25 **	4	940,690	2.83	$164.37	$464.66	$1,311,312,000
2024-25 **	TOTAL	999,140	2.97	$168.53	$500.08	$5,995,781,500
2025-26 **	1	1,049,650	3.18	$173.45	$551.53	$1,736,723,000
2025-26 **	2	1,025,850	2.92	$171.88	$501.17	$1,542,370,700
2025-26 **	3	977,740	2.98	$173.50	$517.58	$1,518,161,700
2025-26 **	4	940,690	2.84	$168.27	$478.27	$1,349,709,900
2025-26 **	TOTAL	998,480	2.98	$171.91	$513.03	$6,146,965,400

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2024 BASE ESTIMATES)

MI-C

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2022-23 *	1	61,100	3.32	$166.64	$552.93	$101,350,500
2022-23 *	2	58,490	3.15	$153.93	$484.51	$85,013,700
2022-23 *	3	57,970	3.04	$177.67	$540.33	$93,971,800
2022-23 *	4	53,040	2.66	$180.72	$480.23	$76,409,100
2022-23 *	TOTAL	57,650	3.05	$168.90	$515.69	$356,745,100
2023-24 *	1	59,350	2.99	$195.07	$584.03	$103,990,000
2023-24 *	2	61,040	2.79	$197.83	$552.25	$101,137,100
2023-24 *	3	66,060	2.87	$193.17	$554.36	$109,858,800
2023-24 *	4	60,840	2.74	$184.40	$504.84	$92,148,500
2023-24 *	TOTAL	61,820	2.85	$192.70	$548.78	$407,134,400
2024-25 **	1	69,700	2.93	$202.09	$592.36	$123,855,000
2024-25 **	2	70,590	2.61	$194.68	$507.32	$107,434,400
2024-25 **	3	66,190	2.71	$202.17	$547.26	$108,672,400
2024-25 **	4	62,350	2.60	$189.43	$493.41	$92,291,700
2024-25 **	TOTAL	67,210	2.71	$197.42	$535.98	$432,253,500
2025-26 **	1	69,020	2.95	$201.54	$594.67	$123,131,300
2025-26 **	2	70,590	2.60	$196.39	$509.97	$107,995,400
2025-26 **	3	66,190	2.70	$204.02	$550.90	$109,394,400
2025-26 **	4	62,350	2.61	$191.47	$499.35	$93,402,400
2025-26 **	TOTAL	67,040	2.72	$198.60	$539.41	$433,923,600

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2024 BASE ESTIMATES)

MI-A

YEAR	QUARTER	AVERAGE MONTHLY USERS	AVERAGE MONTHLY UNIT PER USER	AVERAGE MONTHLY COST PER UNIT	AVERAGE MONTHLY COST PER USER	TOTAL COST
2022-23 *	1	540	17.94	$286.01	$5,131.04	$8,296,900
2022-23 *	2	500	16.69	$308.24	$5,145.66	$7,754,500
2022-23 *	3	520	15.61	$284.57	$4,443.09	$6,984,500
2022-23 *	4	470	9.75	$311.92	$3,040.45	$4,311,400
2022-23 *	TOTAL	510	15.13	$295.54	$4,472.90	$27,347,300
2023-24 *	1	540	13.10	$313.15	$4,101.72	$6,677,600
2023-24 *	2	540	10.60	$298.30	$3,161.40	$5,089,900
2023-24 *	3	600	9.74	$274.17	$2,670.72	$4,839,300
2023-24 *	4	590	9.50	$220.01	$2,090.04	$3,726,500
2023-24 *	TOTAL	570	10.68	$278.63	$2,975.76	$20,333,300
2024-25 **	1	660	11.42	$239.36	$2,732.97	$5,440,500
2024-25 **	2	620	10.05	$259.08	$2,604.10	$4,811,000
2024-25 **	3	640	10.59	$260.25	$2,755.74	$5,271,500
2024-25 **	4	590	9.44	$250.92	$2,369.91	$4,228,000
2024-25 **	TOTAL	630	10.41	$251.91	$2,621.19	$19,751,000
2025-26 **	1	630	11.56	$260.36	$3,008.53	$5,682,300
2025-26 **	2	620	10.05	$263.59	$2,647.92	$4,891,900
2025-26 **	3	640	10.59	$264.46	$2,799.92	$5,356,000
2025-26 **	4	590	9.46	$256.43	$2,426.70	$4,329,300
2025-26 **	TOTAL	620	10.43	$261.35	$2,725.57	$20,259,600

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2024 BASE ESTIMATES)

REFUGEE

YEAR	QUARTER	AVERAGE MONTHLY USERS	AVERAGE MONTHLY UNIT PER USER	AVERAGE MONTHLY COST PER UNIT	AVERAGE MONTHLY COST PER USER	TOTAL COST
2022-23 *	1	830	3.83	$105.16	$403.08	$1,005,700
2022-23 *	2	1,370	3.73	$104.97	$391.73	$1,613,100
2022-23 *	3	2,040	3.55	$128.73	$457.21	$2,804,500
2022-23 *	4	1,910	3.03	$138.75	$420.36	$2,409,100
2022-23 *	TOTAL	1,540	3.47	$122.23	$423.88	$7,832,400
2023-24 *	1	1,960	3.40	$143.16	$486.40	$2,859,600
2023-24 *	2	1,590	3.16	$168.17	$532.10	$2,536,500
2023-24 *	3	1,600	3.39	$157.83	$535.66	$2,567,400
2023-24 *	4	1,380	3.12	$163.62	$510.65	$2,118,700
2023-24 *	TOTAL	1,630	3.28	$156.86	$514.71	$10,082,100
2024-25 **	1	1,590	3.46	$161.42	$558.14	$2,654,100
2024-25 **	2	1,590	2.82	$166.54	$468.86	$2,239,100
2024-25 **	3	1,500	3.11	$168.93	$525.21	$2,358,600
2024-25 **	4	1,440	2.91	$164.20	$478.57	$2,069,900
2024-25 **	TOTAL	1,530	3.08	$165.12	$508.08	$9,321,700
2025-26 **	1	1,590	3.43	$164.50	$563.54	$2,692,900
2025-26 **	2	1,590	2.82	$166.54	$468.86	$2,239,100
2025-26 **	3	1,500	3.11	$168.93	$525.21	$2,358,600
2025-26 **	4	1,440	2.93	$164.16	$481.74	$2,083,600
2025-26 **	TOTAL	1,530	3.07	$166.01	$510.30	$9,374,200

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2024 BASE ESTIMATES)

OBRA

YEAR	QUARTER	AVERAGE MONTHLY USERS	AVERAGE MONTHLY UNIT PER USER	AVERAGE MONTHLY COST PER UNIT	AVERAGE MONTHLY COST PER USER	TOTAL COST
2022-23 *	1	0	2.33	$295.45	$689.39	$2,100
2022-23 *	2	0	13.33	$333.29	$4,443.91	$13,300
2022-23 *	3	0	9.75	$346.62	$3,379.52	$13,500
2022-23 *	4	0	3.25	$131.20	$426.39	$1,700
2022-23 *	TOTAL	0	7.07	$309.33	$2,187.39	$30,600
2023-24 *	1	0	2.00	$10.76	$21.51	$100
2023-24 *	2	0	2.00	$11.63	$23.25	$100
2023-24 *	3	0	2.00	$13.73	$27.45	$0
2023-24 *	4	0				$0
2023-24 *	TOTAL	0	2.00	$11.55	$23.10	$200
2024-25 **	1	0	2.41	$14.93	$36.01	$100
2024-25 **	2	0	2.53	$15.20	$38.39	$100
2024-25 **	3	0	2.56	$14.05	$35.91	$100
2024-25 **	4	0	2.78	$14.75	$41.08	$100
2024-25 **	TOTAL	0	2.58	$14.71	$38.01	$300
2025-26 **	1	0	2.21	$14.48	$32.00	$100
2025-26 **	2	0	2.53	$15.20	$38.39	$100
2025-26 **	3	0	2.56	$14.05	$35.91	$100
2025-26 **	4	0	2.78	$14.75	$41.08	$100
2025-26 **	TOTAL	0	2.52	$14.63	$36.85	$300

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2024 BASE ESTIMATES)

POV 185

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2022-23 *	1	121,510	3.31	$240.81	$796.49	$290,340,700
2022-23 *	2	119,350	3.23	$232.56	$750.83	$268,825,300
2022-23 *	3	124,690	2.98	$263.23	$784.09	$293,293,300
2022-23 *	4	110,140	2.61	$276.28	$720.09	$237,939,300
2022-23 *	TOTAL	118,920	3.04	$251.41	$764.09	$1,090,398,500
2023-24 *	1	122,330	2.97	$297.88	$886.13	$325,191,600
2023-24 *	2	114,890	2.82	$288.48	$813.10	$280,260,500
2023-24 *	3	114,060	2.77	$280.07	$774.48	$265,011,600
2023-24 *	4	96,610	2.61	$283.48	$738.91	$214,150,500
2023-24 *	TOTAL	111,970	2.80	$288.09	$807.21	$1,084,614,200
2024-25 **	1	114,000	2.89	$290.35	$837.90	$286,554,400
2024-25 **	2	111,940	2.62	$249.75	$654.85	$219,905,600
2024-25 **	3	104,070	2.74	$246.88	$676.94	$211,353,000
2024-25 **	4	92,010	2.70	$240.96	$650.66	$179,604,500
2024-25 **	TOTAL	105,500	2.74	$258.70	$708.83	$897,417,500
2025-26 **	1	114,070	2.96	$277.43	$821.31	$281,057,100
2025-26 **	2	111,940	2.62	$254.60	$667.57	$224,178,400
2025-26 **	3	104,070	2.74	$251.20	$688.85	$215,072,600
2025-26 **	4	92,010	2.71	$246.03	$666.81	$184,064,700
2025-26 **	TOTAL	105,520	2.76	$258.55	$714.20	$904,372,800

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2024 BASE ESTIMATES)

POV 133

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2022-23 *	1	180,670	2.85	$97.77	$278.51	$150,956,600
2022-23 *	2	199,630	3.12	$76.52	$239.11	$143,196,000
2022-23 *	3	190,080	2.64	$97.13	$256.17	$146,079,600
2022-23 *	4	167,100	2.33	$107.49	$250.54	$125,593,200
2022-23 *	TOTAL	184,370	2.75	$92.94	$255.75	$565,825,300
2023-24 *	1	172,940	2.36	$124.93	$294.23	$152,651,500
2023-24 *	2	169,730	2.40	$117.31	$281.93	$143,558,300
2023-24 *	3	177,410	2.42	$109.94	$265.70	$141,415,000
2023-24 *	4	160,040	2.45	$113.95	$278.60	$133,762,500
2023-24 *	TOTAL	170,030	2.40	$116.47	$280.04	$571,387,300
2024-25 **	1	172,980	2.45	$137.42	$336.35	$174,548,900
2024-25 **	2	175,120	2.51	$124.26	$312.35	$164,098,900
2024-25 **	3	163,740	2.34	$127.62	$299.24	$146,990,600
2024-25 **	4	157,810	2.38	$123.28	$293.30	$138,860,400
2024-25 **	TOTAL	167,410	2.42	$128.26	$310.86	$624,498,800
2025-26 **	1	174,840	2.47	$133.04	$328.07	$172,079,500
2025-26 **	2	175,120	2.51	$124.66	$312.33	$164,089,100
2025-26 **	3	163,740	2.34	$128.05	$299.82	$147,272,500
2025-26 **	4	157,810	2.40	$122.93	$294.57	$139,461,300
2025-26 **	TOTAL	167,880	2.43	$127.27	$309.20	$622,902,400

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2024 BASE ESTIMATES)

POV 100

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2022-23 *	1	93,010	2.77	$122.38	$338.66	$94,500,400
2022-23 *	2	90,200	2.78	$107.82	$300.16	$81,221,600
2022-23 *	3	87,540	2.55	$128.57	$328.05	$86,148,200
2022-23 *	4	78,780	2.31	$129.76	$299.68	$70,830,400
2022-23 *	TOTAL	87,380	2.61	$121.36	$317.28	$332,700,600
2023-24 *	1	84,890	2.41	$156.72	$377.06	$96,027,300
2023-24 *	2	79,240	2.36	$145.51	$343.70	$81,702,000
2023-24 *	3	78,990	2.38	$143.23	$341.35	$80,894,100
2023-24 *	4	70,390	2.44	$140.76	$342.78	$72,389,300
2023-24 *	TOTAL	78,380	2.40	$146.90	$351.94	$331,012,700
2024-25 **	1	77,490	2.50	$159.88	$400.43	$93,083,900
2024-25 **	2	81,150	2.25	$148.59	$335.03	$81,563,500
2024-25 **	3	73,030	2.56	$146.56	$375.44	$82,259,200
2024-25 **	4	68,720	2.52	$141.35	$355.80	$73,347,600
2024-25 **	TOTAL	75,100	2.45	$149.35	$366.48	$330,254,200
2025-26 **	1	78,730	2.60	$157.35	$408.57	$96,499,400
2025-26 **	2	81,150	2.33	$148.76	$345.96	$84,225,500
2025-26 **	3	73,030	2.65	$146.63	$388.73	$85,169,000
2025-26 **	4	68,720	2.61	$140.96	$368.39	$75,942,800
2025-26 **	TOTAL	75,410	2.54	$148.68	$377.77	$341,836,600

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

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BASE POLICY CHANGES

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

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 13 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
Regional Model
PHP & Other Managed Care (Other M/C)
Dental
Mental Health
Audits/Lawsuits
Medicare Payments
State Hospital/Developmental Centers
Miscellaneous Services (Misc. Svcs.)
Recoveries
Drug Medi-Cal

SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2024-25

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	DRUG MEDI-CAL				
36	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	$1,120,157,000	$862,726,650	$169,231,350	$88,199,000
38	DRUG MEDI-CAL STATE PLAN SERVICES	$44,790,000	$26,266,400	$2,047,600	$16,476,000
	DRUG MEDI-CAL SUBTOTAL	**$1,164,947,000**	**$888,993,050**	**$171,278,950**	**$104,675,000**
	MENTAL HEALTH				
41	SMHS FOR ADULTS	$3,725,166,000	$2,511,644,400	$329,846,600	$883,675,000
42	SMHS FOR CHILDREN	$3,041,791,000	$1,659,237,200	$67,255,800	$1,315,298,000
	MENTAL HEALTH SUBTOTAL	**$6,766,957,000**	**$4,170,881,600**	**$397,102,400**	**$2,198,973,000**
	MANAGED CARE				
56	TWO PLAN MODEL	$33,977,231,000	$19,838,654,700	$14,138,576,300	$0
57	COUNTY ORGANIZED HEALTH SYSTEMS & SINGLE PLAN	$18,379,652,000	$10,995,844,100	$7,383,807,900	$0
59	GEOGRAPHIC MANAGED CARE	$6,642,878,000	$4,107,645,850	$2,535,232,150	$0
63	PACE (Other M/C)	$1,649,105,000	$821,152,900	$827,952,100	$0
66	REGIONAL MODEL	$229,310,000	$154,967,300	$74,342,700	$0
67	DENTAL MANAGED CARE (Other M/C)	$167,654,000	$96,718,200	$70,935,800	$0
69	SENIOR CARE ACTION NETWORK (Other M/C)	$98,509,000	$49,015,000	$49,494,000	$0
72	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	$36,909,000	$21,576,000	$15,333,000	$0
74	AIDS HEALTHCARE CENTERS (Other M/C)	$13,281,000	$6,640,500	$6,640,500	$0
75	COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM	$7,833,000	$5,091,450	$2,741,550	$0
76	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	$2,817,000	$1,831,050	$985,950	$0
	MANAGED CARE SUBTOTAL	**$61,205,179,000**	**$36,099,137,050**	**$25,106,041,950**	**$0**
	OTHER				
140	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$4,713,863,000	$1,948,353,000	$2,765,510,000	$0
141	MEDICARE PAYMENTS - PART D PHASED-DOWN	$3,595,832,000	$0	$3,595,832,000	$0
142	PERSONAL CARE SERVICES (Misc. Svcs.)	$3,600,022,000	$3,600,022,000	$0	$0
143	HOME & COMMUNITY-BASED SVCS.- CDDS (Misc.)	$3,431,077,000	$3,431,077,000	$0	$0
144	DENTAL SERVICES	$2,229,526,000	$1,183,003,450	$1,046,522,550	$0
145	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$437,183,000	$217,705,000	$219,478,000	$0
147	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$447,115,000	$447,115,000	$0	$0
163	MEDI-CAL TCM PROGRAM	$20,331,000	$20,331,000	$0	$0
165	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$18,440,000	$18,440,000	$0	$0
172	LAWSUITS/CLAIMS	$9,044,000	$4,522,000	$4,522,000	$0
179	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$334,000	$167,000	$167,000	$0

SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2024-25

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER				
200	BASE RECOVERIES	($892,354,000)	($532,710,650)	($359,643,350)	$0
	OTHER SUBTOTAL	**$17,610,413,000**	**$10,338,024,800**	**$7,272,388,200**	**$0**
	GRAND TOTAL	**$86,747,496,000**	**$51,497,036,500**	**$32,946,811,500**	**$2,303,648,000**

SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2025-26

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	DRUG MEDI-CAL				
36	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	$810,829,000	$619,086,000	$128,452,000	$63,291,000
38	DRUG MEDI-CAL STATE PLAN SERVICES	$44,796,000	$30,600,800	$3,137,200	$11,058,000
	DRUG MEDI-CAL SUBTOTAL	**$855,625,000**	**$649,686,800**	**$131,589,200**	**$74,349,000**
	MENTAL HEALTH				
41	SMHS FOR ADULTS	$2,937,543,000	$1,989,964,700	$296,831,300	$650,747,000
42	SMHS FOR CHILDREN	$2,231,671,000	$1,233,555,900	$52,670,100	$945,445,000
	MENTAL HEALTH SUBTOTAL	**$5,169,214,000**	**$3,223,520,600**	**$349,501,400**	**$1,596,192,000**
	MANAGED CARE				
56	TWO PLAN MODEL	$34,271,354,000	$20,002,563,250	$14,268,790,750	$0
57	COUNTY ORGANIZED HEALTH SYSTEMS & SINGLE PLAN	$18,573,489,000	$11,133,291,150	$7,440,197,850	$0
59	GEOGRAPHIC MANAGED CARE	$6,692,671,000	$4,136,814,250	$2,555,856,750	$0
63	PACE (Other M/C)	$1,968,018,000	$979,951,900	$988,066,100	$0
66	REGIONAL MODEL	$235,760,000	$160,666,200	$75,093,800	$0
67	DENTAL MANAGED CARE (Other M/C)	$167,704,000	$96,703,100	$71,000,900	$0
69	SENIOR CARE ACTION NETWORK (Other M/C)	$105,456,000	$52,472,000	$52,984,000	$0
72	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	$36,909,000	$21,576,000	$15,333,000	$0
74	AIDS HEALTHCARE CENTERS (Other M/C)	$14,578,000	$7,289,000	$7,289,000	$0
75	COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM	$7,833,000	$5,091,450	$2,741,550	$0
76	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	$2,832,000	$1,840,800	$991,200	$0
	MANAGED CARE SUBTOTAL	**$62,076,604,000**	**$36,598,259,100**	**$25,478,344,900**	**$0**
	OTHER				
140	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$4,893,986,000	$2,021,331,500	$2,872,654,500	$0
141	MEDICARE PAYMENTS - PART D PHASED-DOWN	$3,904,450,000	$0	$3,904,450,000	$0
142	PERSONAL CARE SERVICES (Misc. Svcs.)	$3,994,052,000	$3,994,052,000	$0	$0
143	HOME & COMMUNITY-BASED SVCS.- CDDS (Misc.)	$4,229,674,000	$4,229,674,000	$0	$0
144	DENTAL SERVICES	$2,310,519,000	$1,227,434,400	$1,083,084,600	$0
145	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$557,468,000	$277,604,000	$279,864,000	$0
147	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$424,275,000	$424,275,000	$0	$0
163	MEDI-CAL TCM PROGRAM	$10,885,000	$10,885,000	$0	$0
165	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$18,581,000	$18,581,000	$0	$0
172	LAWSUITS/CLAIMS	$1,350,000	$675,000	$675,000	$0
179	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$351,000	$175,500	$175,500	$0

SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2025-26

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER				
200	BASE RECOVERIES	($929,648,000)	($554,974,350)	($374,673,650)	$0
	OTHER SUBTOTAL	**$19,415,943,000**	**$11,649,713,050**	**$7,766,229,950**	**$0**
	GRAND TOTAL	**$87,517,386,000**	**$52,121,179,550**	**$33,725,665,450**	**$1,670,541,000**

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
NOVEMBER 2024 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2024-25

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2024-25 APPROPRIATION		NOV. 2024 EST. FOR 2024-25		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		DRUG MEDI-CAL						
42	36	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	$688,222,000	$92,598,750	$1,120,157,000	$169,231,350	$431,935,000	$76,632,600
45	38	DRUG MEDI-CAL STATE PLAN SERVICES	$10,251,000	$861,200	$44,790,000	$2,047,600	$34,539,000	$1,186,400
		DRUG MEDI-CAL SUBTOTAL	**$698,473,000**	**$93,459,950**	**$1,164,947,000**	**$171,278,950**	**$466,474,000**	**$77,819,000**
		MENTAL HEALTH						
47	41	SMHS FOR ADULTS	$2,237,412,000	$113,790,100	$3,725,166,000	$329,846,600	$1,487,754,000	$216,056,500
48	42	SMHS FOR CHILDREN	$2,016,635,000	$42,424,500	$3,041,791,000	$67,255,800	$1,025,156,000	$24,831,300
		MENTAL HEALTH SUBTOTAL	**$4,254,047,000**	**$156,214,600**	**$6,766,957,000**	**$397,102,400**	**$2,512,910,000**	**$240,887,800**
		MANAGED CARE						
64	56	TWO PLAN MODEL	$28,770,479,000	$11,527,032,000	$33,977,231,000	$14,138,576,300	$5,206,752,000	$2,611,544,300
65	57	COUNTY ORGANIZED HEALTH SYSTEMS & SINGLE PLAN	$16,617,667,000	$6,468,437,600	$18,379,652,000	$7,383,807,900	$1,761,985,000	$915,370,300
67	59	GEOGRAPHIC MANAGED CARE	$5,942,857,000	$2,218,273,600	$6,642,878,000	$2,535,232,150	$700,021,000	$316,958,550
72	63	PACE (Other M/C)	$1,581,710,000	$785,778,900	$1,649,105,000	$827,952,100	$67,395,000	$42,173,200
70	66	REGIONAL MODEL	$403,102,000	$110,853,100	$229,310,000	$74,342,700	($173,792,000)	($36,510,400)
76	67	DENTAL MANAGED CARE (Other M/C)	$147,426,000	$58,728,450	$167,654,000	$70,935,800	$20,228,000	$12,207,350
78	69	SENIOR CARE ACTION NETWORK (Other M/C)	$98,287,000	$49,382,000	$98,509,000	$49,494,000	$222,000	$112,000
80	72	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	$37,712,000	$16,006,000	$36,909,000	$15,333,000	($803,000)	($673,000)
82	74	AIDS HEALTHCARE CENTERS (Other M/C)	$13,007,000	$6,503,500	$13,281,000	$6,640,500	$274,000	$137,000
83	75	COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM	$9,856,000	$3,449,600	$7,833,000	$2,741,550	($2,023,000)	($708,050)
84	76	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	$4,511,000	$1,578,850	$2,817,000	$985,950	($1,694,000)	($592,900)
		MANAGED CARE SUBTOTAL	**$53,626,614,000**	**$21,246,023,600**	**$61,205,179,000**	**$25,106,041,950**	**$7,578,565,000**	**$3,860,018,350**

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
NOVEMBER 2024 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2024-25

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2024-25 APPROPRIATION		NOV. 2024 EST. FOR 2024-25		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER						
153	140	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$4,705,803,000	$2,779,866,000	$4,713,863,000	$2,765,510,000	$8,060,000	($14,356,000)
154	141	MEDICARE PAYMENTS - PART D PHASED-DOWN	$3,567,947,000	$3,567,947,000	$3,595,832,000	$3,595,832,000	$27,885,000	$27,885,000
156	142	PERSONAL CARE SERVICES (Misc. Svcs.)	$3,525,977,000	$0	$3,600,022,000	$0	$74,045,000	$0
155	143	HOME & COMMUNITY-BASED SVCS.- CDDS (Misc.)	$3,418,284,000	$0	$3,431,077,000	$0	$12,793,000	$0
157	144	DENTAL SERVICES	$2,256,227,000	$946,116,300	$2,229,526,000	$1,046,522,550	($26,701,000)	$100,406,250
--	145	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$0	$0	$437,183,000	$219,478,000	$437,183,000	$219,478,000
160	147	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$389,042,000	$0	$447,115,000	$0	$58,073,000	$0
187	163	MEDI-CAL TCM PROGRAM	$14,533,000	$0	$20,331,000	$0	$5,798,000	$0
182	165	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$17,550,000	$0	$18,440,000	$0	$890,000	$0
177	172	LAWSUITS/CLAIMS	$1,350,000	$675,000	$9,044,000	$4,522,000	$7,694,000	$3,847,000
200	179	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$367,000	$183,500	$334,000	$167,000	($33,000)	($16,500)
217	200	BASE RECOVERIES	($791,065,000)	($334,275,820)	($892,354,000)	($359,643,350)	($101,289,000)	($25,367,530)
		OTHER SUBTOTAL	**$17,106,015,000**	**$6,960,511,980**	**$17,610,413,000**	**$7,272,388,200**	**$504,398,000**	**$311,876,220**
		GRAND TOTAL	**$75,685,149,000**	**$28,456,210,130**	**$86,747,496,000**	**$32,946,811,500**	**$11,062,347,000**	**$4,490,601,370**

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2024-25 AND 2025-26

NO.	POLICY CHANGE TITLE	NOV. 2024 EST. FOR 2024-25		NOV. 2024 EST. FOR 2025-26		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	DRUG MEDI-CAL						
36	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	$1,120,157,000	$169,231,350	$810,829,000	$128,452,000	($309,328,000)	($40,779,350)
38	DRUG MEDI-CAL STATE PLAN SERVICES	$44,790,000	$2,047,600	$44,796,000	$3,137,200	$6,000	$1,089,600
	DRUG MEDI-CAL SUBTOTAL	**$1,164,947,000**	**$171,278,950**	**$855,625,000**	**$131,589,200**	**($309,322,000)**	**($39,689,750)**
	MENTAL HEALTH						
41	SMHS FOR ADULTS	$3,725,166,000	$329,846,600	$2,937,543,000	$296,831,300	($787,623,000)	($33,015,300)
42	SMHS FOR CHILDREN	$3,041,791,000	$67,255,800	$2,231,671,000	$52,670,100	($810,120,000)	($14,585,700)
	MENTAL HEALTH SUBTOTAL	**$6,766,957,000**	**$397,102,400**	**$5,169,214,000**	**$349,501,400**	**($1,597,743,000)**	**($47,601,000)**
	MANAGED CARE						
56	TWO PLAN MODEL	$33,977,231,000	$14,138,576,300	$34,271,354,000	$14,268,790,750	$294,123,000	$130,214,450
57	COUNTY ORGANIZED HEALTH SYSTEMS & SINGLE PLAN	$18,379,652,000	$7,383,807,900	$18,573,489,000	$7,440,197,850	$193,837,000	$56,389,950
59	GEOGRAPHIC MANAGED CARE	$6,642,878,000	$2,535,232,150	$6,692,671,000	$2,555,856,750	$49,793,000	$20,624,600
63	PACE (Other M/C)	$1,649,105,000	$827,952,100	$1,968,018,000	$988,066,100	$318,913,000	$160,114,000
66	REGIONAL MODEL	$229,310,000	$74,342,700	$235,760,000	$75,093,800	$6,450,000	$751,100
67	DENTAL MANAGED CARE (Other M/C)	$167,654,000	$70,935,800	$167,704,000	$71,000,900	$50,000	$65,100
69	SENIOR CARE ACTION NETWORK (Other M/C)	$98,509,000	$49,494,000	$105,456,000	$52,984,000	$6,947,000	$3,490,000
72	MEDI-CAL ACCESS PROGRAM MOTHERS 213 -322% FPL	$36,909,000	$15,333,000	$36,909,000	$15,333,000	$0	$0
74	AIDS HEALTHCARE CENTERS (Other M/C)	$13,281,000	$6,640,500	$14,578,000	$7,289,000	$1,297,000	$648,500
75	COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM	$7,833,000	$2,741,550	$7,833,000	$2,741,550	$0	$0
76	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	$2,817,000	$985,950	$2,832,000	$991,200	$15,000	$5,250
	MANAGED CARE SUBTOTAL	**$61,205,179,000**	**$25,106,041,950**	**$62,076,604,000**	**$25,478,344,900**	**$871,425,000**	**$372,302,950**
	OTHER						
140	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$4,713,863,000	$2,765,510,000	$4,893,986,000	$2,872,654,500	$180,123,000	$107,144,500

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2024-25 AND 2025-26

NO.	POLICY CHANGE TITLE	NOV. 2024 EST. FOR 2024-25		NOV. 2024 EST. FOR 2025-26		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER						
141	MEDICARE PAYMENTS - PART D PHASED-DOWN	$3,595,832,000	$3,595,832,000	$3,904,450,000	$3,904,450,000	$308,618,000	$308,618,000
142	PERSONAL CARE SERVICES (Misc. Svcs.)	$3,600,022,000	$0	$3,994,052,000	$0	$394,030,000	$0
143	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	$3,431,077,000	$0	$4,229,674,000	$0	$798,597,000	$0
144	DENTAL SERVICES	$2,229,526,000	$1,046,522,550	$2,310,519,000	$1,083,084,600	$80,993,000	$36,562,050
145	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$437,183,000	$219,478,000	$557,468,000	$279,864,000	$120,285,000	$60,386,000
147	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$447,115,000	$0	$424,275,000	$0	($22,840,000)	$0
163	MEDI-CAL TCM PROGRAM	$20,331,000	$0	$10,885,000	$0	($9,446,000)	$0
165	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$18,440,000	$0	$18,581,000	$0	$141,000	$0
172	LAWSUITS/CLAIMS	$9,044,000	$4,522,000	$1,350,000	$675,000	($7,694,000)	($3,847,000)
179	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$334,000	$167,000	$351,000	$175,500	$17,000	$8,500
200	BASE RECOVERIES	($892,354,000)	($359,643,350)	($929,648,000)	($374,673,650)	($37,294,000)	($15,030,300)
	OTHER SUBTOTAL	**$17,610,413,000**	**$7,272,388,200**	**$19,415,943,000**	**$7,766,229,950**	**$1,805,530,000**	**$493,841,750**
	GRAND TOTAL	**$86,747,496,000**	**$32,946,811,500**	**$87,517,386,000**	**$33,725,665,450**	**$769,890,000**	**$778,853,950**

MEDI-CAL PROGRAM BASE
POLICY CHANGE INDEX

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

BASE POLICY CHANGE NUMBER: 36
IMPLEMENTATION DATE: 4/2017
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2012

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$1,120,157,000	$810,829,000
- STATE FUNDS	$257,430,350	$191,743,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,120,157,000	$810,829,000
STATE FUNDS	$257,430,350	$191,743,000
FEDERAL FUNDS	$862,726,650	$619,086,000

Purpose:
This policy change estimates the cost of the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver program for opt-in counties to provide Substance Use Disorder (SUD) services.

Authority:
Drug Medi-Cal Organized Delivery System Waiver
Consolidated Appropriations Act of 2023

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 authorized originally under California's Section 1115 Bridge to Reform Demonstration Waiver and continued in the Medi-Cal 2020 Waiver. The purpose of the 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 members modeled after the American Society of Addiction Medicine (ASAM) Criteria.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER
BASE POLICY CHANGE NUMBER: 36

Additionally for opt-in counties, the following new/expanded services, not currently separately reimbursable in the four modalities, are available under the DMC-ODS waiver:

Required

- Non-perinatal RTS
- Withdrawal Management (Levels 1.0, 2.0, and 3.2)
- Recovery Services
- Case Management
- Physician Consultation
- Expanded Medication Assisted Treatment (MAT) (buprenorphine, naloxone, and disulfiram)

Optional

- Additional MAT (non-NTP Providers)
- Partial Hospitalization
- Withdrawal Management (Levels 3.7 and 4.0)

Rate Setting Methodologies

Prior to Fiscal Year 2023-24, the interim rates for the existing modalities (except NTP) were paid at the county-established rates instead of the State rates.

Under the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the Department has developed rates for DMC-ODS waiver services using new methodologies which are more specific to the provider type providing the service and/or to each county's costs. DMC-ODS rates using these methodologies were implemented on July 1, 2023. Annually, the Department will adjust the rates by the percentage change in the four-quarter average Home Health Agency Market Basket Index. This methodology will also account for the transition from the existing Healthcare Common Procedure Coding System (HCPCS) Level II coding to a combination of the Current Procedural Terminology (CPT) and HCPCS Level II coding system.

The proposed DMC-ODS rates for the following services are based on county specific, hourly, outpatient rates per provider type developed under the CalAIM initiative:

- Intensive Outpatient Treatment Services
- Outpatient Drug-Free Treatment Services
- Recovery Services
- Case Management
- Physician Consultation
- Additional MAT Services

The proposed DMC rates for the following services are based on county specific, per dose, dosing rates developed under the CalAIM initiative:

- NTP Dosing – Regular and Perinatal
- MAT Dosing – Regular and Perinatal

The proposed DMC rates for the following services are based on county specific, daily rates developed under the CalAIM initiative:

- Withdrawal Management I and II
- Withdrawal Management (WM) 3.2
- Residential ASAM Levels 3.1, 3.3 and 3.5

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER
BASE POLICY CHANGE NUMBER: 36

- Inpatient Withdrawal Management
- Partial Hospitalization

Funding for the existing treatment modalities (ODF, IOT, NTP, and Perinatal RTS) remain the same. New services under the waiver, except for non-perinatal IOT and RTS expanded services, are funded with federal funds (FF) and County Funds (CF). Consistent with prior estimates, expanded IOT and RTS services are funded with FF and General Fund (GF).

Reason for Change:
This change in FY 2024-25, from the prior estimate, is an increase due to the following:

- Updated claims data reimbursements were higher compared to the previous projection, and as a result, the overall estimate increased.
- Addition of the 100% GF for State-Only claims for full scope benefit expansion to adults 26 through 49 years of age, regardless of immigration status.
- A revised payment lag for FY 2023-24 and FY 2024-25 claims. For FY 2023-24, the proportion of claims paid within the same year decreases from 76% to 21.1%, with 78.4% paid in the second year, and 0.5% in the third year. For FY 2024-25, the payment lag is revised to 62.6% of claims paid in the same year, 37% in the second year, and 0.4% in the third year.

The change in the current estimate, from FY 2024-25 to FY 2025-26, is a net decrease due to the following:

- FY 2024-25 including a higher portion of FY 2023-24 claims to be paid due to a significant slower payment lag resulting from the implementation of the new CalAIM rates which were implemented on July 1, 2023.
- Higher estimated rates for FY 2025-26 services.
- No prior year unpaid claims assumed for FY 2025-26.

Methodology:
1. DMC-ODS waiver services for opt-in counties began in February 2017 on a phase-in basis.

2. A total of 37 counties opted-in to begin providing waiver services:

    - Four counties implemented the waiver in FY 2016-17.
    - For FY 2017-18, seven additional counties (for a total of 11 counties) began providing waiver services.
    - For FY 2018-19, 16 additional counties (for a total of 27 counties) began providing waiver services.
    - For FY 2019-20, three additional counties (for a total of 30 counties) began providing waiver services.
    - For FY 2020-21, the remaining seven opt-in counties (for a total of 37 counties) began providing waiver services under the PHP. Implementation for the seven PHP counties occurred in July 2020.

3. Effective July 1, 2023, Mariposa County opted-in to begin providing waiver services.

4. Effective July 1, 2024, Lake County opted-in to begin providing waiver services.

5. Effective December 1, 2024, Sonoma Counties will begin providing waiver services.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER
BASE POLICY CHANGE NUMBER: 36

6. A total of 18 counties have not opted-in to implement DMC-ODS waiver services.

Net DMC-ODS Waiver Costs

7. Total net cost for the DMC-ODS waiver services are:

(Dollars in Thousands)

DMC-ODS Waiver Net Cost	FY 2024-25	FY 2025-26
Required Services	$94,452	$67,778
Optional Services	$8,063	$5,787
Existing Services	$1,017,642	$737,264
Total	$1,120,157	$810,829

8. The Department implemented the CalAIM Behavioral Health Payment Reform and a new Intergovernmental Transfers (IGTs) process. For all claims with dates of service of on or after July 1, 2023, counties transfer the county portion of the submitted claims before FF can be used for payment.

9. DMC-ODS waiver costs for state-only full scope Medi-Cal services to certain immigrant populations who meet all Medi-Cal eligibility requirements except for their citizenship status, are budgeted in this policy change.

10. On a cash basis, the total for waiver services costs are estimated to be $1,120,157,000 TF and $810,829,000 TF in FY 2024-25 and FY 2025-26 respectively.

(Dollars in Thousands)

FY 2024-25	TF	GF	IGT*	FF
Regular				
Current	$328,430	$98,118	$77,425	$152,887
ACA Optional	$782,716	$70,888	$7,384	$704,444
Perinatal				
Current	$6,782	$2	$3,390	$3,390
ACA Optional	$2,229	$223	$0	$2,006
Total	**$1,120,157**	**$169,231**	**$88,199**	**$862,727**

(Dollars in Thousands)

FY 2025-26	TF	GF	IGT*	FF
Regular				
Current	$242,692	$77,421	$55,560	$109,711
ACA Optional	$561,672	$50,869	$5,299	$505,504
Perinatal				
Current	$4,866	$2	$2,432	$2,432
ACA Optional	$1,599	$160	$0	$1,439
Total	**$810,829**	**$128,452**	**$63,291**	**$619,086**

Funding:
100% GF (4260-101-0001)
100% Title XIX FF (4260-101-0890)

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

BASE POLICY CHANGE NUMBER: 36

100% Title XXI FF (4260-101-0890)
100% ACA Title XIX FF (4260-101-0890)
Medi-Cal County Behavioral Health Fund (4260-601-3420)*
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)
65% Title XXI FF / 35% GF (4260-101-0001/0890)
50% Title XIX / 50% GF (4260-101-0001/0890)

DRUG MEDI-CAL STATE PLAN SERVICES

BASE POLICY CHANGE NUMBER: 38
IMPLEMENTATION DATE: 7/2021
ANALYST: Sarah Sen
FISCAL REFERENCE NUMBER: 2320

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$44,790,000	$44,796,000
- STATE FUNDS	$18,523,600	$14,195,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$44,790,000	$44,796,000
STATE FUNDS	$18,523,600	$14,195,200
FEDERAL FUNDS	$26,266,400	$30,600,800

Purpose:
This policy change estimates the Drug Medi-Cal (DMC) expenditures to provide Substance Use Disorder (SUD) services under the State Plan.

Authority:
Title 22, California Code of Regulations 51341.1 and 51516.1

Interdependent Policy Changes:
Drug Medi-Cal Organized Delivery System Waiver
Drug Medi-Cal Annual Rate Adjustment
COVID-19 Behavioral Health

Background:
The State Plan covers SUD services provided by certified providers under contract with the counties or with the State. State Plan services are defined by treatment modality as described below.

Under the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the Department issued new DMC rates per the DMC State Plan Methodology change affective July 1, 2023, that are more specific to the provider type providing the service and/or to each county's cost. This reform created four new modalities: Mobile Crisis, Partial Hospitalization, Withdrawal Management, and 24-Hour-Day Service, which have resulted in the expansion of services available to DMC State Plan Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) members (under 21). Additionally, the reform has resulted in the elimination of ongoing services that existed under the Intensive Outpatient Treatment modality, and the transition of services that were previously held under the Residential modality to the 24-hour-Day Service modality. Lastly the Outpatient Drug Free Treatment (ODF) modality was renamed Outpatient Services, and some group and individual counseling services previously under the Narcotic Treatment Program moved into Outpatient Services.

Under the of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the Department has developed rates for DMC services using new methodologies which are more

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specific to the provider type providing the service and/or to each county's costs. DMC rates using these methodologies were implemented on July 1, 2023. Annually, the Department will adjust the DMC rates by the percentage change in the four-quarter average Home Health Agency Market Basket Index.

The Narcotic Treatment Program (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.

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

- Assessment
- Care Coordination
- Crisis Intervention
- Discharge Services
- Family Therapy
- Group Counseling
- Individual Counseling
- Medication Services
- Peer Support Specialist Services
- Recovery Services
- Supplemental Services
- Treatment Planning

24-Hour Day Service provides rehabilitation services to both EPSDT and perinatal members with substance use disorder diagnosis in a non-institutional, non-medical, residential setting. Each beneficiary lives on the premises and is supported in effort to restore, maintain, and apply interpersonal and independent living skills and access community support systems.

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

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

Perinatal services for RTS 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

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occupied by children of residents. Room and board is not reimbursable through the Medi-Cal program.

Mobile Crisis services provide a support team in collaboration between Behavioral Health and Law Enforcement to respond to emergency calls for EPSDT members experiencing a mental health crisis.

- Crisis Assessment
- Crisis Intervention
- Transportation

County Inpatient Withdrawal Management provides services withdrawal management and residential treatment services (American Society of Addiction Medicine (ASAM) levels 3.7 and 4.0 services to EPSDT members.

- Level 3.7 - Medically Monitored Intensive Inpatient Services
- Level 4.0 - Medically Managed Intensive Inpatient Services

Partial Hospitalization services are clinically intensive programs, less than 24 hours, that are designed to address the needs of EPSDT members with severe SUD requiring more intensive treatment services than can be provided at lower levels of care.

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication services
- MAT for OUD
- MAT for AUD and other non-opioid SUDs
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services

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

On August 13, 2015, the Department received approval from the Centers for Medicare and Medicaid Services to implement the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver. The DMC-ODS is an organized delivery of health care services for Medicaid eligible individuals with a substance use disorder. DMC-ODS waiver services will include the existing State Plan treatment modalities (NTP, ODF, IOT, and RTS), and additional new and expanded services.

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County participation in the DMC-ODS waiver is voluntary. State Plan service expenditures for participating counties has shifted to the Drug Medi-Cal Organized Delivery System Waiver policy change as implementation has progressed.

Reason for Change:
The change in FY 2024-25 from the prior estimate is mainly due to an increase in users, utilization, and rates, particularly from the NTP ACA category, resulting from eased regulations and improved access to methadone dosing treatments. In particular, this estimate includes additional growth due to the DMC State Plan Major Methodology change effective July 1, 2023.

Methodology:

1. As a result of the DMC State Plan rate setting methodology change and relatively limited expenditures in the program, State Plan expenditure estimates are now based on a roll-up of all six modalities instead of forecasting modalities separately. Additionally, the DMC State Plan estimate no longer separately forecasts for the perinatal population. Due to a slow ramp up expected in the mobile crisis services, DMC State Plan services related to mobile crisis services remain within the Qualifying Community-Based Mobile Crisis Services policy change.

2. Expenditures are estimated using 36 quarters of cash-basis expenditure data (July 2015-June 2024) and trending the Users, Units/User, and Rate.

	FY 2024-25				FY 2025-26			
	Average Quarterly				Average Quarterly			
Type	Users	Units/ User	Rate	Total	Users	Units/ User	Rate	Total
All Others	1,208	69.9	$97.76	$32,999,900	1,208	69.9	$65.55	$22,127,000
ACA Optional	1,213	65.9	$33.91	$10,841,800	1,213	65.9	$67.92	$21,714,700
Total				**$43,841,700**				**$43,841,700**

3. Rates include Final Rate Year (RY) 2023-24 rate increases. RY 2024-25 rate increases are partially budgeted in the Drug Medi-Cal Annual Rate Adjustment PC.

4. Funding for populations eligible prior to the implementation of the Affordable Care Act (ACA) in 2014 is 50% County Funds (CF) and 50% Title XIX Federal Funds (FF). Counties do not have a share of cost for services provided to beneficiaries as part of the Drug Medi-Cal program expansion under the ACA. Instead the non-federal share is funded through the State General Fund. Beginning January 2020, ongoing funding for ACA Optional beneficiaries is 90% FF/10% GF. Certain aid codes are eligible for Title XXI federal reimbursement at 76.5% October 2019 through September 2020, and 65% October 2020 and thereafter.

5. Funding for full-scope undocumented expansion populations is assumed to be funded with 100% state General Fund.

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6. Beginning in FY 2023-24, the Department implemented the CalAIM Behavioral Health payment reform and a new intergovernmental transfers (IGTs) process. For claims with dates of service of on or after July 1, 2023, counties transfer the county portion of the submitted claims before Federal Funds can be used for payment.

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Total estimated expenditures for DMC State Plan services are:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF	IGT*
Title XIX 100%	$32,816	$0	$16,408	$16,408
100% GF	$975	$964	$0	$11
50% Title XIX / 50% GF	$0	$0	$0	$0
ACA 90% FFP/10% GF	$10,836	$1,084	$9,752	$0
Title XXI 100%	$163	$0	$106	$57
Total	$44,790	$2,048	$26,266	$16,476

(Dollars in Thousands)

FY 2025-26	TF	GF	FF	IGT*
Title XIX 100%	$22,034	$0	$11,017	$11,017
100% GF	$980	$967	$0	$13
50% Title XIX / 50% GF	$0	$0	$0	$0
ACA 90% FFP/10% GF	$21,702	$2,170	$19,532	$0
Title XXI 100%	$80	$0	$52	$28
Total	$44,796	$3,137	$30,601	$11,058

Funding:
100% Title XIX FF (4260-101-0890)
100% GF (4260-101-0001)
Medi-Cal County Behavioral Health Fund (4260-601-3420)*
50% Title XIX / 50% GF (4260-101-0001/0980)
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)
100% Title XXI FF (4260-101-0890)

Notes: Totals may differ due to rounding. $948,000 captured in the 100% GF to account for the impact of the 26-49 Unsatisfactory Immigration Status (UIS) expansion for FY 2024-25 and FY 2025-26.

SMHS FOR ADULTS

BASE POLICY CHANGE NUMBER: 41
IMPLEMENTATION DATE: 7/2012
ANALYST: Tyler Shimizu
FISCAL REFERENCE NUMBER: 1780

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$3,725,166,000	$2,937,543,000
- STATE FUNDS	$1,213,521,600	$947,578,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,725,166,000	$2,937,543,000
STATE FUNDS	$1,213,521,600	$947,578,300
FEDERAL FUNDS	$2,511,644,400	$1,989,964,700

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
California Constitution Article XIII Section 36
Medi-Cal Specialty Mental Health Services Consolidation (CA-17) Program 1915(b4) 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 1915(b) 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 who meet criteria for specialty mental health treatment. MHPs must certify that they incurred a cost before seeking reimbursement through claims to the State. MHPs are responsible for most of the non-federal share of Medi-Cal SMHS. Mental health services for Medi-Cal members who do not meet the criteria for SMHS are provided under the Medi-Cal program through Medi-Cal managed care (MC) plans or the fee-for-service Medi-Cal (FFS/MC) program for members 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.

The following Medi-Cal SMHS are available for adults:

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- 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
- Mental Health Services
- Peer Support Services

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.

Beginning in FY 2023-24, the Department is implementing the California Advancing and Innovating Medi-Cal (CalAIM) Behavioral Health (BH) payment reform, a new intergovernmental transfers (IGTs) process, whereby counties will transfer the county portion of the fee-for-service claims to the Department, before Federal Financial Participation can be used for payment. The IGT process replaces the current Certified Public Expenditure (CPE) method, that reimbursed counties through the interim rate payment process for Short Doyle/Medi-Cal (SD/MC) claims that include Drug Medi-Cal (DMC) State Plan, Drug Medi-Cal Organized Delivery System (DMC-ODS), and SMHS.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is a net increase, due to:
- Updating projections based on additional actual SD/MC and FFS Inpatient paid claims;
- Addition of estimates for the full scope Medi-Cal benefit expansion tor adults ages 26 through 49 starting in the FY 2023-24 accrual year;
- Estimated shifts to increased utilization from the Affordable Care Act (ACA) newly population; and
- Adjusted lags based on updated data. Claiming lags for the FY 2023-24 accrual year have been updated to account for delays in county claiming with more FY 2023-24 claims being paid in FY 2024-25. In addition, it is assumed that counties will catch up on claiming and lags will return to the historical trend for FY 2024-25 and later accrual years.

The change between FY 2024-25 and FY 2025-26, in the current estimate, is due to:
- Updating projections based on additional actual SD/MC and FFS Inpatient paid claims; and
- Lags are assumed to return to historical trends in FY 2025-26.

Methodology:
1. The costs and clients are developed using 70 months of SD/MC and 70 months FFS/MC approved claims data, excluding disallowed claims. The SD/MC data is current as of June

SMHS FOR ADULTS
BASE POLICY CHANGE NUMBER: 41

30, 2024, with dates of service from June 2018 through March 2024. The FFS Inpatient data is current as of June 30, 2024, with dates of service from April 2018 through January 2024.

2. Due to the lag in reporting of claims data, the six most recent months of FFS Inpatient data and the nine most recent months of SD/MC data, are weighed (lag weights) based on observed claiming trends to create projected final claims data.

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

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

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2022-23	$2,416,433	$2,042,578	$373,855
FY 2023-24	$2,731,722	$2,324,933	$406,789
FY 2024-25	$2,950,667	$2,519,406	$431,261
FY 2025-26	$3,081,147	$2,625,414	$455,733

5. On a cash basis for FY 2024-25, the Department will be paying 0.68% of FY 2022-23 claims, 79.89% of FY 2023-24 claims, and 60.68% of FY 2024-25 SD/MC claims. For FFS Inpatient claims, the Department will be paying 2.18% of FY 2022-23 claims, 36.65% of FY 2023-24 claims, and 61.16% of FY 2024-25 claims. The cash amounts (rounded) for Adult's SMHS are:

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2022-23	$22,033	$13,868	$8,165
FY 2023-24	$2,006,488	$1,857,381	$149,107
FY 2024-25	$1,792,604	$1,528,839	$263,765
Total FY 2024-25	$3,821,125	$3,400,088	$421,037

6. On a cash basis for FY 2025-26, the Department will be paying 0.68% of FY 2023-24 claims, 38.82% of FY 2024-25 claims, and 60.68% of FY 2025-26 claims for SD/MC claims. For FFS Inpatient claims, the Department will be paying 2.18% of FY 2023-24 claims, and 36.65% of FY 2024-25 claims, and 61.16% of FY 2025-26 claims. The cash amounts (rounded) are:

SMHS FOR ADULTS
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(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2023-24	$24,670	$15,785	$8,885
FY 2024-25	$1,136,174	$978,097	$158,077
FY 2025-26	$1,871,899	$1,593,167	$278,732
Total FY 2025-26	$3,032,743	$2,587,049	$445,694

7. The FY 2024-25 and FY 2025-26 estimate includes the following funding adjustments:
   - Individuals age 19-25, 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 effective January 1, 2020, and these claims are reimbursed with 100% GF.
   - Individuals who are 50 years of age or older who meet other Medi-Cal eligibility requirements but who do not have satisfactory immigration status or are unable to verify their immigration status or citizenship became eligible for full-scope Medi-Cal benefits effective May 1, 2022. The SMHS non-emergency, non-pregnancy claims for these individuals are reimbursed with 100% GF; and non-emergency, pregnancy claims are assumed to receive federal financial participation.
   - Medi-Cal claims are eligible for 50% federal reimbursement;
   - ACA is funded by 90% FF and 10% GF beginning January 2020;
   - GF abatements from the State Controller Office's Mental Health Managed Care Deposit Fund (613-0865) transfers the county realignment funds to the Department. These amounts are displayed in this policy change;
   - IGTs are budgeted in the Medi-Cal County Behavioral Health Fund beginning July 1, 2023.
   - Adults ages 26 through 49 years of age are eligible for full scope Medi-Cal benefits beginning on January 1, 2024.

8. On a cash basis, the estimated costs for FY 2024-25 and FY 2025-26 are as follows:

(Dollars in Thousands)

Fiscal Year	TF	FF	ACA FF	GF	GF Abate from Fund 613-0865	BH IGTF	County
FY 2024-25	$3,821,125	**$980,136**	**$1,531,508**	**$329,847**	$91,848	**$883,675**	$4,111
FY 2025-26	$3,032,743	**$746,684**	**$1,243,281**	**$296,831**	$95,200	**$650,747**	$0

Funding:
100% GF (4260-101-0001)
100% Title XIX FFP (4260-101-0890)
90% Title XIX FF / 10% GF (4260-101-0001/0890)
Medi-Cal County Behavioral Health Fund* (4260-601-3420)

SMHS FOR CHILDREN

BASE POLICY CHANGE NUMBER: 42
IMPLEMENTATION DATE: 7/2012
ANALYST: Tyler Shimizu
FISCAL REFERENCE NUMBER: 1779

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$3,041,791,000	$2,231,671,000
- STATE FUNDS	$1,382,553,800	$998,115,100
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,041,791,000	$2,231,671,000
STATE FUNDS	$1,382,553,800	$998,115,100
FEDERAL FUNDS	$1,659,237,200	$1,233,555,900

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
California Constitution Article XIII Section 36
Medi-Cal Specialty Mental Health Services Consolidation (CA-17) Program 1915(b4) 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 1915(b) 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 who meet criteria for specialty mental health services. MHPs must certify that they incurred a cost before seeking reimbursement through claims to the State. MHPs are responsible for most of the non-federal share of Medi-Cal SMHS. Mental health services for Medi-Cal members 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 members not enrolled in a MC plan.

Children’s SMHS are provided under the federal requirements of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which is available to full-scope members 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

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

The following Medi-Cal SMHS are available for children:

- Adult Residential Treatment Services*
- Crisis Intervention
- Crisis Stabilization
- Crisis Residential Treatment Services*
- Day Rehabilitation
- Day Treatment Intensive
- Medication Support Services
- Psychiatric Health Facility Services
- Psychiatric Inpatient Hospital Services
- Targeted Case Management
- Therapeutic Behavioral Services
- Mental Health Services
- Therapeutic Foster Care
- Intensive Care Coordination
- Intensive Home Based Services
- Peer Support Services

*Children - Age 18 through 20

Beginning in FY 2023-24, the Department will implement the California Advancing and Innovating Medi-Cal (CalAIM) Behavioral Health (BH) payment reform, a new intergovernmental transfers (IGTs) process, whereby counties will transfer the county portion of the fee-for-service claims to the Department, before Federal Financial Participation can be used for payment. The IGT process will replace the current Certified Public Expenditure (CPE) method, that reimbursed counties through the interim rate payment process for Short Doyle/Medi-Cal (SD/MC) claims that include Drug Medi-Cal (DMC) State Plan, Drug Medi-Cal Organized Delivery System (DMC-ODS), and SMHS.

Reason for Change:
The change in FY 2024-25, in the prior estimate, is due to:
- Updating projections based on additional actual SD/MC and FFS Inpatient paid claims data and utilization; and
- Adjusted lags based on updated data. Claiming lags for the FY 2023-24 accrual year have been updated to account for delays in county claiming with more FY 2023-24 claims being paid in FY 2024-25. In addition, it is assumed that counties will catch up on claiming and lags will return to the historical trend for FY 2024-25 and later accrual years.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to:
- Increased forecasts and projections year by year based on additional actual SD/MC and FFS Inpatient paid claims data and utilization; and
- Lags are assumed to return to historical trends in FY 2025-26.

SMHS FOR CHILDREN
BASE POLICY CHANGE NUMBER: 42

Methodology:

1. The costs and clients are developed using 70 months of SD/MC and 70 months FFS/MC approved claims data, excluding disallowed claims. The SD/MC data is current as of June 30, 2024, with dates of service from June 2018 through March 2024. The FFS Inpatient data is current as of June 30, 2024, with dates of service from April 2018 through January 2024.

2. Due to the lag in reporting of claims data, the six most recent months of FFS Inpatient data and the nine most recent months of SD/MC data, are weighed (lag weights) based on observed claiming trends to create projected final claims data.

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

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

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2022-23	$2,137,783	$1,974,631	$163,152
FY 2023-24	$2,229,689	$2,054,455	$175,234
FY 2024-25	$2,283,697	$2,096,115	$187,582
FY 2025-26	$2,330,965	$2,131,034	$199,931

5. On a cash basis for FY 2024-25, the Department will be paying 0.39% of FY 2022-23 claims, 76.92% of FY 2023-24 claims, and 64.55% of FY 2024-25 SD/MC claims. For FFS Inpatient claims, the Department will be paying 0.93% of FY 2022-23 claims, 28.22% of FY 2023-24 claims, and 70.84% of FY 2024-25 claims. The cash amounts (rounded) for Children's SMHS are:

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2022-23	$9,129	$7,608	$1,521
FY 2023-24	$1,629,706	$1,580,250	$49,456
FY 2024-25	$1,485,915	$1,353,022	$132,893
Total FY 2024-25	$3,124,750	$2,940,880	$183,870

6. On a cash basis for FY 2025-26, the Department will be paying 0.39% of FY 2023-24 claims, 35.16% of FY 2024-25 claims, and 64.55% of FY 2025-26 claims for SD/MC claims. For FFS Inpatient claims, the Department will be paying 0.93% of FY 2023-24 claims, and 28.22% of FY 2024-25 claims, and 70.84% of FY 2025-26. The cash amounts (rounded) for Children's SMHS are:

SMHS FOR CHILDREN
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(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2023-24	$9,549	$7,915	$1,634
FY 2024-25	$789,962	$737,021	$52,941
FY 2025-26	$1,517,203	$1,375,562	$141,641
Total FY 2025-26	$2,316,714	$2,120,498	$196,216

7. The FY 2024-25 and FY 2025-26 estimate includes the following funding adjustments:
   - Individuals under age 19, who do not have satisfactory immigration status or are unable to verify satisfactory immigration status or citizenship, are eligible for full scope Medi-Cal benefits effective May 1, 2016, and these claims are reimbursed with 100% GF;
   - Individuals age 19-25, 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 effective January 1, 2020, and these claims are reimbursed with 100% GF;
   - Medi-Cal claims are eligible for 50% federal reimbursement;
   - MCHIP claims are eligible for 65% federal reimbursement (beginning October 1, 2020);
   - ACA is funded by 90% FF / 10% GF beginning January 1, 2020;
   - GF abatements from the State Controller Office's Mental Health Managed Care Deposit Fund (613-0865) transfers the county realignment funds to the Department. These amounts are displayed in this policy change.
   - IGTs are budgeted in the Medi-Cal County Behavioral Health Fund beginning July 1, 2023.

8. On a cash basis, the estimated costs for FY 2024-25 and FY 2025-26 are as follows:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF	MCHIP	ACA FF	GF Abatement from Fund 613-0865	BH IGTF	County
FY 2024-25	$3,124,750	**$79,263**	**$1,233,497**	**$305,673**	**$108,060**	$79,552	**$1,315,298**	$3,407
FY 2025-26	$2,316,714	**$52,670**	**$907,890**	**$227,655**	**$98,011**	$85,043	**$945,445**	$0

Funding:
100% GF (4260-101-0001)
100% Title XIX FFP (4260-101-0890)
100% Title XXI FFP (4260-101-0890)
90% Title XIX FF / 10% GF (4260-101-0001/0890)
Medi-Cal County Behavioral Health Fund* (4260-601-3420)

TWO PLAN MODEL

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

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$33,977,231,000	$34,271,354,000
- STATE FUNDS	$14,138,576,300	$14,268,790,750
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$33,977,231,000	$34,271,354,000
STATE FUNDS	$14,138,576,300	$14,268,790,750
FEDERAL FUNDS	$19,838,654,700	$20,002,563,250

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

Authority:
Welfare & Institutions Code 14087.3
AB 336 (Chapter 95, Statutes of 1991)
SB 485 (Chapter 722, Statutes of 1992)

Interdependent Policy Changes:
Capitated Rate Adjustment for FY 2025-26

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

Effective January 1, 2024, the following counties implemented an option to bring on an additional managed care plan: Fresno, Kings, Madera, Stanislaus, and Tulare. Additionally, Alameda and Contra Costa Counties opted to change managed care plan model type to Single Plan, and Alpine and El Dorado Counties opted to become Two-Plan Model counties from Regional counties.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase due to:

- The prior estimate assumed that enrollment would continue at the levels close to those observed in January 2024 (the most recent actual month at that time), with the incremental impact of further changes in enrollment due to the resumption of eligibility redeterminations accounted for in the COVID-19 Redeterminations Impact policy change. This estimate assumes that enrollment continues at levels close to those observed in July 2024 (the most recent actual month). The July 2024 caseload level is

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lower (absent the expansion of full-scope Medi-Cal to individuals with unsatisfactory immigration status (UIS) aged 26 through 49) than the January 2024 caseload level, leading to reduced costs in this policy change. The incremental impact of redeterminations on managed care costs is accounted for separately in the COVID-19 Redeterminations Impact policy change.

- Managed care costs for UIS members aged 26 through 49 that received full-scope coverage beginning January 2024 are now reflected in this policy change, leading to significantly increased costs. These costs were previously budgeted in the Undocumented Expansion Ages 26 through 49 policy change.
- Updated CY 2024 rates, including separate rates for UIS and Satisfactory Immigration Status (SIS) populations, were used for this estimate. These rates newly incorporate the impact of provider rate increases implemented January 2024 and Proposition 56 Physicians Supplemental Payments that became base rate increases in January 2024, leading to increased costs budgeted in this policy change.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to higher anticipated member months.

Methodology:

1. Capitation rates are typically rebased annually on a calendar year (CY) basis. Federal regulations and State law require that the rates be developed according to generally accepted actuarial principles and practices. Rates must be certified by an actuary as actuarially sound to ensure federal financial participation (FFP). The rebasing process includes refreshed data and updates to trends, program changes, and other adjustments.

2. On an accrual basis, the last six months of the CY 2024 rates and the first six months of the CY 2025 rates have been budgeted for FY 2024-25.

3. FY 2024-25 weighted rates have been updated from the previous estimate, and newly incorporate the impact of base rate increases that were implemented January 2024.

4. The difference from the FY 2024-25 weighted rates to the CY 2025 rates and the estimated adjustment anticipated for the CY 2026 rates, to occur in FY 2025-26 is captured in the Capitated Rate Adjustment for FY 2025-26 policy change as a percentage assumption applied to seven months of the CY 2025 rates and five months of the CY 2026 rates on a cash basis.

5. The member months in this PC are reflective of actuals through July 2024, inclusive of redetermination impacts. The COVID-19 Redeterminations Impact PC adjusts these base projections to account for incremental impacts resuming eligibility redeterminations on the Medi-Cal caseload and managed care enrollment.

6. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of $282,000,000 for FY 2024-25 and $282,000,000 for FY 2025-26 were included in the rates.

7. Indian Health Services and Maternity supplemental payments are budgeted in this PC.

TWO PLAN MODEL
BASE POLICY CHANGE NUMBER: 56

8. As of January 1, 2024, a regional rate model was implemented for certain managed care counties. Managed care plan rates in impacted counties reflect a weighted average blend of the county-specific rates. The following groupings of counties are consolidated into single rating regions:

    a. Alpine and El Dorado

9. As of January 1, 2024, Transitional Care Services are included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

10. As of January 1, 2024, Long Term Care members in Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) and Sub-Acute Facilities will transition mandatorily into managed care. The costs associated with these services are reflected in the rates.

11. As of January 1, 2024, all components of the Targeted Rate Increase are included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

12. As of July 1, 2024, Biomarker and Pharmacogenomic Testing are included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

13. The Department receives FFP of 90% for family planning services.

14. Costs for the Optional Targeted Low Income Children Program (OTLICP) are budgeted in the managed care model policy changes. An FMAP split of 65%/35% is budgeted for OTLICP.

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

TWO PLAN MODEL
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(Dollars in Thousands)

FY 2024-25	Member Months	Total
Alpine	3,293	$903
El Dorado	467,915	$149,490
Fresno	6,167,392	$1,592,615
Kern	5,481,009	$1,670,904
Kings	764,087	$188,023
Los Angeles	46,123,499	$15,876,174
Madera	951,392	$229,471
Riverside	11,625,018	$3,709,019
San Bernardino	11,098,089	$3,643,145
San Francisco	2,767,731	$1,296,305
San Joaquin	3,606,505	$1,175,112
Santa Clara	5,182,479	$1,957,183
Stanislaus	2,932,762	$891,002
Tulare	3,431,364	$769,089
Total FY 2024-25	100,602,535	$33,148,435
Maternity (events)	98,189	$881,500
Total FY 2024-25 with Maternity		**$34,029,935**

(Dollars in Thousands)

Included in the Above Dollars	FY 2024-25
Mental Health	$282,000

TWO PLAN MODEL
BASE POLICY CHANGE NUMBER: 56

(Dollars in Thousands)

FY 2025-26	Member Months	Total
Alpine	3,295	$904
El Dorado	467,912	$149,436
Fresno	6,174,517	$1,595,925
Kern	5,487,544	$1,674,133
Kings	765,167	$188,407
Los Angeles	46,230,232	$15,941,005
Madera	952,105	$229,783
Riverside	11,642,046	$3,716,485
San Bernardino	11,102,974	$3,646,177
San Francisco	2,779,199	$1,302,580
San Joaquin	3,613,711	$1,178,345
Santa Clara	5,190,571	$1,961,744
Stanislaus	2,935,247	$892,118
Tulare	3,435,573	$770,444
Total FY 2025-26	100,780,094	$33,247,484
Maternity (events)	103,096	$925,543
Total FY 2025-26 with Maternity		**$34,173,027**

(Dollars in Thousands)

Included in the Above Dollars	FY 2025-26
Mental Health	$282,000

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

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$18,431,725	$9,215,863	$9,215,863
65% Title XXI / 35% GF (4260-101-0001/0890)	$1,563,920	$547,372	$1,016,548
ACA 90% FFP/10% GF (2020 and later)	$10,569,361	$1,056,936	$9,512,425
100% State GF (4260-101-0001)	$3,311,750	$3,311,750	$0
Title XIX 100% FFP	$33,918	$0	$33,918
90% Family Planning FFP / 10% GF (4260-101-0001/0890)	$66,557	$6,656	$59,901
Total	**$33,977,231**	**$14,138,576**	**$19,838,655**

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BASE POLICY CHANGE NUMBER: 56

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$18,631,907	$9,315,954	$9,315,954
65% Title XXI / 35% GF (4260-101-0001/0890)	$1,571,865	$550,153	$1,021,712
ACA 90% FFP/10% GF (2020 and later)	$10,627,748	$1,062,775	$9,564,973
100% State GF (4260-101-0001)	$3,333,254	$3,333,254	$0
Title XIX 100% FFP	$40,023	$0	$40,023
90% Family Planning FFP / 10% GF (4260-101-0001/0890)	$66,557	$6,656	$59,901
Total	**$34,271,354**	**$14,268,791**	**$20,002,563**

COUNTY ORGANIZED HEALTH SYSTEMS & SINGLE PLAN

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

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$18,379,652,000	$18,573,489,000
- STATE FUNDS	$7,383,807,900	$7,440,197,850
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$18,379,652,000	$18,573,489,000
STATE FUNDS	$7,383,807,900	$7,440,197,850
FEDERAL FUNDS	$10,995,844,100	$11,133,291,150

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

Authority:
Welfare & Institutions Code 14087.3

Interdependent Policy Changes:
Capitated Rate Adjustment for FY 2025-26

Background:
A COHS is a local agency created by a county board of supervisors to contract with the Medi-Cal program. Through December 2023, there were 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.

Beginning January 2024, a new Single Plan model is available, in which the Department contracts with a managed care plan that operates under the authorization and sponsorship of a county or local authority.

Effective January 2024, the following counties opted to become COHS and Single Plan model counties: Alameda, Butte, Colusa, Contra Costa, Glenn, Imperial, Mariposa, Nevada, Placer, Plumas, San Benito, Sierra, Sutter, Tehama, and Yuba.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase due to:

- The prior estimate assumed that enrollment would continue at the levels close to those observed in January 2024 (the most recent actual month at that time), with the incremental impact of further changes in enrollment due to the resumption of eligibility redeterminations accounted for in the COVID-19 Redetermination Impact policy change. This estimate assumes that enrollment continues at levels close to those observed in

COUNTY ORGANIZED HEALTH SYSTEMS & SINGLE PLAN
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July 2024 (the most recent actual month). The July 2024 caseload level is lower (absent the expansion of full-scope Medi-Cal to individuals with unsatisfactory immigration status (UIS) aged 26 through 49) than the January 2024 caseload level, leading to reduced costs in this policy change. The incremental impact of redeterminations on managed care costs is accounted for separately in the COVID-19 Redeterminations Impact policy change.

- Managed care costs for UIS members aged 26 through 49 that received full-scope coverage beginning January 2024 are now reflected in this policy change, leading to significantly increased costs. These costs were previously budgeted in the Undocumented Expansion Ages 26 through 49 policy change.
- Updated CY 2024 rates, including separate rates for UIS and Satisfactory Immigration Status (SIS) populations, were used for this estimate. These rates newly incorporate the impact of provider rate increases implemented January 2024 and Proposition 56 Physicians Supplemental Payments that became base rate increases in January 2024, leading to increased costs budgeted in this policy change.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to higher anticipated member months.

Methodology:

1. Capitation rates are typically rebased annually on a calendar year (CY) basis. Federal regulations and State law require that the rates be developed according to generally accepted actuarial principles and practices. Rates must be certified by an actuary as actuarially sound to ensure federal financial participation (FFP). The rebasing process includes refreshed data and updates to trends, program changes, and other adjustments.

2. On an accrual basis, the last six months of the CY 2024 rates and the first six months of the CY 2025 rates have been budgeted for FY 2024-25.

3. FY 2024-25 weighted rates have been updated from the previous estimate, and newly incorporate the impact of base rate increases that were implemented January 2024.

4. The difference from the FY 2024-25 weighted rates to the CY 2025 rates and the estimated rate adjustment anticipated for the CY 2026 rates to occur in FY 2025-26 is captured in the Capitated Rate Adjustment for FY 2025-26 policy change as a percentage assumption applied to seven months of the CY 2025 rates and five months of the CY 2026 rates on a cash basis.

5. Currently, all COHS and Single Plan managed care plans (MCPs) have assumed risk for long term care services.

6. The member months in this PC are reflective of actuals through July 2024, inclusive of redetermination impacts. The COVID-19 Redeterminations Impact PC adjusts these base projections to account for incremental impacts resuming eligibility redeterminations on the Medi-Cal caseload and managed care enrollment.

7. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of $157,600,000 for FY 2024-25 and $157,600,000 for FY 2025-26 were included in the rates.

COUNTY ORGANIZED HEALTH SYSTEMS & SINGLE PLAN
BASE POLICY CHANGE NUMBER: 57

8. Indian Health Services and Maternity supplemental payments are reflected in this PC.

9. As of January 1, 2024, Transitional Care Services are included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

10. As of January 1, 2024, Long Term Care Beneficiaries in Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) and Sub-Acute Facilities will transition mandatorily into Managed Care. The costs associated with these services are reflected in the rates.

11. As of January 1, 2024, all components of the Targeted Rate Increase are included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

12. As of July 1, 2024, Biomarker and Pharmacogenomic Testing are included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

13. The Department receives 90% FFP for family planning services.

14. Costs for the Optional Targeted Low Income Children Program (OTLICP) are budgeted in the managed care model policy changes. An FMAP split of 65%/35% is budgeted for OTLICP.

15. COHS and Single Plan dollars on an accrual basis are shown below, which excludes both WCM dollars and members:

COUNTY ORGANIZED HEALTH SYSTEMS & SINGLE PLAN

BASE POLICY CHANGE NUMBER: 57

(Dollars in Thousands)

FY 2024-25	Member Months	Total
San Luis Obispo	807,560	$278,435
Santa Barbara	2,079,328	$655,301
San Mateo	1,728,599	$724,210
Solano	1,223,297	$531,507
Santa Cruz	948,328	$347,909
Orange	10,734,412	$3,642,434
Napa	323,148	$139,168
Monterey	2,342,311	$802,760
Yolo	637,628	$273,046
Marin	555,703	$239,653
Lake	413,957	$161,726
Mendocino	497,307	$186,470
Sonoma	1,327,864	$551,672
Merced	1,800,829	$609,649
Ventura	2,984,429	$1,045,631
Humboldt	703,889	$272,802
Lassen	105,066	$39,570
Modoc	47,220	$18,860
Shasta	811,209	$318,763
Siskiyou	217,758	$87,099
Trinity	66,619	$26,247
Del Norte	147,726	$60,712
Alameda	4,807,917	$1,893,975
Contra Costa	3,099,888	$1,128,075
Imperial	1,159,328	$260,724
Partnership HP of California	3,752,499	$1,319,097
San Benito	246,879	$86,722
Mariposa	67,429	$23,840
Kaiser Foundation HP	3,772,128	$1,251,177
Total FY 2024-25	47,410,256	$16,977,235
Maternity (events)	57,514	$647,699
Total FY 2024-25 with Maternity		**$17,624,934**

COUNTY ORGANIZED HEALTH SYSTEMS & SINGLE PLAN

BASE POLICY CHANGE NUMBER: 57

(Dollars in Thousands)

Included in Above Dollars	FY 2024-25
Mental Health	$157,600

(Dollars in Thousands)

FY 2025-26	Member Months	Total
San Luis Obispo	809,652	$280,030
Santa Barbara	2,084,812	$659,516
San Mateo	1,728,533	$724,233
Solano	1,228,079	$535,670
Santa Cruz	951,789	$349,998
Orange	10,754,090	$3,654,504
Napa	324,899	$140,716
Monterey	2,347,065	$805,486
Yolo	638,682	$273,916
Marin	556,853	$240,550
Lake	414,519	$162,052
Mendocino	498,210	$187,066
Sonoma	1,329,947	$553,477
Merced	1,804,180	$611,630
Ventura	2,989,061	$1,049,012
Humboldt	705,251	$273,667
Lassen	105,144	$39,619
Modoc	47,201	$18,855
Shasta	812,216	$319,358
Siskiyou	218,107	$87,301
Trinity	66,608	$26,245
Del Norte	147,703	$60,710
Alameda	4,808,167	$1,894,101
Contra Costa	3,099,867	$1,128,019
Imperial	1,159,391	$260,750
Partnership HP of California	3,753,385	$1,319,331
San Benito	246,827	$86,724
Mariposa	67,424	$23,839
Kaiser Foundation HP	3,772,497	$1,251,288
Total FY 2025-26	47,470,162	$17,017,664
Maternity (events)	60,364	$679,786
Total FY 2025-26 with Maternity		**$17,697,450**

COUNTY ORGANIZED HEALTH SYSTEMS & SINGLE PLAN
BASE POLICY CHANGE NUMBER: 57

(Dollars in Thousands)

Included in Above Dollars	FY 2025-26
Mental Health	$157,600

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

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$9,635,769	$4,817,885	$4,817,885
65% Title XXI / 35% GF (4260-101-0001/0890)	$972,982	$340,544	$632,438
ACA 90% FFP/10% GF (2020 and later)	$5,888,929	$588,893	$5,300,036
100% State GF (4260-101-0001)	$1,633,078	$1,633,078	$0
Title XIX 100% FFP	$214,806	$0	$214,806
90% Family Planning FFP / 10% GF (4260-101-0001/0890)	$34,088	$3,409	$30,679
Total	**$18,379,652**	**$7,383,808**	**$10,995,844**

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$9,721,136	$4,860,568	$4,860,568
65% Title XXI / 35% GF (4260-101-0001/0890)	$976,673	$341,836	$634,837
ACA 90% FFP/10% GF (2020 and later)	$5,948,595	$594,860	$5,353,736
100% State GF (4260-101-0001)	$1,639,526	$1,639,526	$0
Title XIX 100% FFP	$253,471	$0	$253,471
90% Family Planning FFP / 10% GF (4260-101-0001/0890)	$34,088	$3,409	$30,679
Total	**$18,573,489**	**$7,440,198**	**$11,133,291**

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 59
IMPLEMENTATION DATE: 4/1994
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 58

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$6,642,878,000	$6,692,671,000
- STATE FUNDS	$2,535,232,150	$2,555,856,750
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$6,642,878,000	$6,692,671,000
STATE FUNDS	$2,535,232,150	$2,555,856,750
FEDERAL FUNDS	$4,107,645,850	$4,136,814,250

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

Authority:
Welfare & Institutions Code 14087.3
AB 336 (Chapter 95, Statutes of 1991)
SB 485 (Chapter 722, Statutes of 1992)

Interdependent Policy Changes:
Capitated Rate Adjustment for FY 2025-26

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 members.

Effective January 2024, Aetna Better Health of California will no longer provide services in Sacramento and San Diego counties. Health Net and United Healthcare Community Plan of California will no longer provide services in San Diego County.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase due to:

- The prior estimate assumed that enrollment would continue at the levels close to those observed in January 2024 (the most recent actual month at that time), with the incremental impact of further changes in enrollment due to the resumption of eligibility redeterminations accounted for in the COVID-19 Redeterminations Impact policy change. This estimate assumes that enrollment continues at levels close to those observed in July 2024 (the most recent actual month). The July 2024 caseload level is lower (absent the expansion of full-scope Medi-Cal to individuals with unsatisfactory immigration status (UIS) aged 26 through 49) than the January 2024 caseload level, leading to reduced costs in this policy change. The incremental impact of

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BASE POLICY CHANGE NUMBER: 59

redeterminations on managed care costs is accounted for separately in the COVID-19 Redeterminations Impact policy change.
- Managed care costs for UIS members aged 26 through 49 that received full-scope coverage beginning January 2024 are now reflected in this policy change, leading to significantly increased costs. These costs were previously budgeted in the Undocumented Expansion Ages 26 through 49 policy change.
- Updated CY 2024 rates, including separate rates for UIS and Satisfactory Immigration Status (SIS) populations, were used for this estimate. These rates newly incorporate the impact of provider rate increases implemented January 2024 and Proposition 56 Physicians Supplemental Payments that became base rate increases in January 2024, leading to increased costs budgeted in this policy change.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to higher anticipated member months.

Methodology:
1. Capitation rates are typically rebased annually on a calendar year (CY) basis. Federal regulations and State law require that the rates be developed according to generally accepted actuarial principles and practices. Rates must be certified by an actuary as actuarially sound to ensure federal financial participation (FFP). The rebasing process includes refreshed data and updates to trends, program changes, and other adjustments.

2. On an accrual basis, the last six months of the CY 2024 rates and the first six months of the CY 2025 rates have been budgeted for FY 2024-25.

3. FY 2024-25 weighted rates have been updated from the previous estimate, and newly incorporate the impact of base rate increases that were implemented January 2024.

4. The difference from the FY 2024-25 weighted rates to the CY 2025 rates and the estimated adjustment anticipated for the CY 2026 rates, to occur in FY 2025-26 is captured in the Capitated Rate Adjustment for FY 2025-26 policy change as a percentage assumption applied to seven months of the CY 2025 rates and five months of the CY 2026 rates on a cash basis.

5. The member months in this PC are reflective of actuals through July 2024, inclusive of redetermination impacts. The COVID-19 Redeterminations Impact PC adjusts these base projections to account for incremental impacts resuming eligibility redeterminations on the Medi-Cal caseload and managed care enrollment.

6. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of $62,800,000 for FY 2024-25 and $62,800,000 for FY 2025-26 were included in the rates.

7. Indian Health Services and Maternity supplemental payments are budgeted in this PC.

8. As of January 1, 2024, Transitional Care Services are included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

GEOGRAPHIC MANAGED CARE
BASE POLICY CHANGE NUMBER: 59

9. As of January 1, 2024, Long Term Care members in Intermediate Care Facilities for the Developmentally Disabled and Sub-Acute Facilities will transition mandatorily into managed care. The costs associated with these services are reflected in the rates.

10. As of January 1, 2024, all components of the Targeted Rate Increase are included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

11. As of July 1, 2024, Biomarker and Pharmacogenomic Testing are included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

12. The Department receives 90% FFP for family planning services.

13. Costs for the Optional Targeted Low Income Children Program (OTLICP) are budgeted in the managed care model policy changes. An FMAP split of 65%/35% is budgeted for OTLICP.

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

FY 2024-25	Member Months	Total
Sacramento	7,268,764	$2,262,038
San Diego	11,764,653	$4,225,713
Total FY 2024-25	19,033,417	$6,487,750
Maternity (events)	18,041	$168,675
Total FY 2024-25 with Maternity		**$6,656,425**

(Dollars in Thousands)

Included in Dollars Above	FY 2024-25
Mental Health	$62,800

(Dollars in Thousands)

FY 2025-26	Member Months	Total
Sacramento	7,276,463	$2,265,827
San Diego	11,779,241	$4,234,098
Total FY 2025-26	19,055,703	$6,499,925
Maternity (events)	18,943	$177,108
Total FY 2025-26 with Maternity		**$6,677,033**

(Dollars in Thousands)

Included in Dollars Above	FY 2025-26
Mental Health	$62,800

GEOGRAPHIC MANAGED CARE
BASE POLICY CHANGE NUMBER: 59

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

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$3,623,760	$1,811,880	$1,811,880
65% Title XXI / 35% GF (4260-101-0001/0890)	$328,923	$115,123	$213,800
ACA 90% FFP/10% GF (2020 and later)	$2,296,854	$229,685	$2,067,169
100% State GF (4260-101-0001)	$377,241	$377,241	$0
Title XIX 100% FFP	$3,073	$0	$3,073
90% Family Planning FFP / 10% GF (4260-101-0001/0890)	$13,027	$1,303	$11,724
Total	**$6,642,878**	**$2,535,232**	**$4,107,646**

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$3,657,025	$1,828,513	$1,828,513
65% Title XXI / 35% GF (4260-101-0001/0890)	$330,463	$115,662	$214,801
ACA 90% FFP/10% GF (2020 and later)	$2,309,056	$230,906	$2,078,150
100% State GF (4260-101-0001)	$379,474	$379,474	$0
Title XIX 100% FFP	$3,627	$0	$3,627
90% Family Planning FFP / 10% GF (4260-101-0001/0890)	$13,026	$1,303	$11,723
Total	**$6,692,671**	**$2,555,857**	**$4,136,814**

PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 63
IMPLEMENTATION DATE: 7/1992
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 62

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$1,649,105,000	$1,968,018,000
- STATE FUNDS	$827,952,100	$988,066,100
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,649,105,000	$1,968,018,000
STATE FUNDS	$827,952,100	$988,066,100
FEDERAL FUNDS	$821,152,900	$979,951,900

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

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

Interdependent Policy Changes:
Not Applicable

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

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

PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 63

Below is a list of new PACE organizations:

New PACE Organizations	County	Operational
Valley PACE	Fresno	July 1, 2024
	Madera	July 1, 2024
Seen Health PACE	Los Angeles	January 1, 2025
Family Health care Network	Kings	July 1, 2024
	Tulare	July 1, 2024
High Desert PACE	San Bernardino	July 1, 2024
	Los Angeles	July 1, 2024
WelbeHealth Inland Empire	Riverside	July 1, 2024
	San Bernardino	July 1, 2024
Roze Room PACE	Los Angeles	July 1, 2025
Chinatown Services Center	Los Angeles	January 1, 2025
WelbeHealth Sierra PACE (Stockton PACE)	Sacramento	July 1, 2025
Innercare	Imperial	July 1, 2025
MyPlace Health South LA PACE	Los Angeles	January 1, 2025
WelbeHealth San Bernardino PACE	Riverside	July 1, 2025
	San Bernardino	July 1, 2025
K-Day PACE	Los Angeles	January 1, 2025
Central Valley	Merced	July 1, 2024
360 of OC	Orange	July 1, 2025
Complete Care PACE Program	Los Angeles	July 1, 2025
Tungsten Health	Sacramento	January 1, 2025
	Placer	January 1, 2025
	Sutter	January 1, 2025
	Los Angeles	July 1, 2025
Innovative Integrated Health	San Joaquin	July 1, 2025
North East Medical Services	Santa Clara	July 1, 2025
AltaMed	Riverside	July 1, 2025
	Sacramento	July 1, 2025
PACE of Sacramento	Sacramento	July 1, 2025
Asian Heritage Services (1818 Western LLC)	Los Angeles	January 1, 2025
Camarena Health	Los Angeles	July 1, 2025
Asian Health Services	Alameda	July 1, 2025
Clinica Sierra Vista	Kern	January 1, 2026
	Tulare	January 1, 2026

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase due to higher estimated member enrollments based on additional actuals data and the inclusion of three additional plans to the estimate. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a net increase due to a projected increase in enrollment and higher rates.

PACE (Other M/C)
BASE POLICY CHANGE NUMBER: 63

Methodology:
1. Assume the calendar year (CY) 2024, CY 2025, and CY 2026 rates will be calculated using plan specific experienced-based data to build actuarially sound prospective rates.

2. FY 2024-25 and FY 2025-26 estimated funding is based on CY 2024 rates and projected CY 2025 and CY 2026 rates.

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

4. Health care plans that began January 2024 or later are not in the total fund (TF) or general fund (GF) due to costs being recognized in other fee-for-service Medi-Cal plans or managed care plans. The new health care plans estimated costs are $140,518,000 TF in FY 2024-25 and $405,355,000 TF in FY 2025-26.

PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 63

FY 2024-25	TF Cost (Rounded)	Eligible Months	Avg. Mo. Enrollment
Centers for Elders' Independence (Alameda & Contra Costa)	$91,798,000	13,940	1,162
Sutter Senior Care	$39,273,000	6,209	517
AltaMed Senior Care (Los Angeles & Orange)	$303,926,000	57,675	4,806
OnLok (San Francisco, Alameda, & Santa Clara)	$195,873,000	23,565	1,964
St. Paul's PACE	$79,741,000	17,004	1,417
Los Angeles Jewish Homes (DBA Brandman Center for Senior Care)	$24,386,000	4,324	360
CalOptima PACE	$38,107,000	6,272	523
InnovAge (San Bernardino & Riverside)	$69,927,000	13,884	1,157
Redwood Coast (Humboldt)	$22,494,000	3,845	320
Innovative Integrated Health (Fresno, Kern, Tulare, & Orange)	$118,486,000	23,253	1,938
San Ysidro San Diego	$192,251,000	34,926	2,911
Stockton Sierra PACE (San Joaquin & Stanislaus)	$82,462,000	12,800	1,067
Gary & Mary West (San Diego)	$26,675,000	5,012	418
Family Health Centers of San Diego	$25,217,000	4,356	363
Central Valley (San Joaquin & Stanislaus)	$38,751,000	5,418	452
LA Coast (Los Angeles)	$45,943,000	6,981	582
Pacific PACE (Los Angeles)	$91,433,000	13,126	1,094
Sequoia (Fresno)	$62,410,000	10,580	882
InnovAge (Sacramento, Placer, El Dorado, Sutter, San Joaquin, & Yuba)	$28,990,000	4,718	393
North East Medical Services (San Francisco)	$17,653,000	1,957	163
Neighborhood Health (Riverside & San Bernardino)	$15,890,000	2,972	248
AgeWell PACE (Sonoma & Marin)	$15,447,000	2,430	203
Providence PACE (Napa, Solano, & Sonoma)	$8,120,000	1,332	111
ConcertoHealth PACE (Los Angeles)	$13,852,000	2,107	176
Total FY 2024-25	**$1,649,105,000**	**278,686**	**23,227**

*Totals may differ due to rounding.

PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 63

FY 2025-26	TF Cost (Rounded)	Eligible Months	Avg. Mo. Enrollment
Centers for Elders' Independence (Alameda & Contra Costa)	$98,708,000	14,352	1,196
Sutter Senior Care	$44,894,000	6,720	560
AltaMed Senior Care (Los Angeles & Orange)	$339,230,000	61,404	5,117
OnLok (San Francisco, Alameda, & Santa Clara)	$215,766,000	24,828	2,069
St. Paul's PACE	$84,180,000	17,004	1,417
Los Angeles Jewish Homes (DBA Brandman Center for Senior Care)	$27,666,000	4,656	388
CalOptima PACE	$46,256,000	7,176	598
InnovAge (San Bernardino & Riverside)	$68,844,000	12,900	1,075
Redwood Coast (Humboldt)	$26,493,000	4,344	362
Innovative Integrated Health (Fresno, Kern, Tulare, & Orange)	$134,963,000	25,267	2,106
San Ysidro San Diego	$216,461,000	37,920	3,160
Stockton Sierra PACE (San Joaquin & Stanislaus)	$102,274,000	15,180	1,265
Gary & Mary West (San Diego)	$31,210,000	5,640	470
Family Health Centers of San Diego	$28,979,000	4,764	397
Central Valley (San Joaquin & Stanislaus)	$53,274,000	7,044	587
LA Coast (Los Angeles)	$55,236,000	8,040	670
Pacific PACE (Los Angeles)	$131,040,000	17,964	1,497
Sequoia (Fresno)	$74,685,000	12,180	1,015
InnovAge (Sacramento, Placer, El Dorado, Sutter, San Joaquin, & Yuba)	$43,224,000	6,715	560
North East Medical Services (San Francisco)	$22,293,000	2,364	394
Neighborhood Health (Riverside & San Bernardino)	$19,998,000	3,504	319
AgeWell PACE (Sonoma & Marin)	$41,596,000	6,318	574
Providence PACE (Napa, Solano, & Sonoma)	$21,690,000	3,406	310
ConcertoHealth PACE (Los Angeles)	$39,058,000	5,719	520
Total FY 2025-26	**$1,968,018,000**	**315,409**	**26,626**

*Totals may differ due to rounding.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2024-25	**$1,649,105**	**$827,952**	**$821,153**
FY 2025-26	**$1,968,018**	**$988,066**	**$979,952**

*Totals may differ due to rounding.

PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 63

Funding:
50% Title XIX / 50% GF (4260-101-0890/0001)
100% GF (4260-101-0001)
90% Title XIX ACA FF / 10% GF (4260-101-0890/0001)

REGIONAL MODEL

BASE POLICY CHANGE NUMBER: 66
IMPLEMENTATION DATE: 11/2013
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1842

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$229,310,000	$235,760,000
- STATE FUNDS	$74,342,700	$75,093,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$229,310,000	$235,760,000
STATE FUNDS	$74,342,700	$75,093,800
FEDERAL FUNDS	$154,967,300	$160,666,200

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:
Capitated Rate Adjustment for FY 2025-26

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 members throughout the state receive health care through an organized delivery system that coordinates their care and leads to better health outcomes and lower costs.

Through December 2023, there were 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.

Effective January 1, 2024, the following 15 counties opted to change managed care plan model type and are no longer participating in the Regional Model: Alpine, Butte, Colusa, El Dorado, Glenn, Imperial, Mariposa, Nevada, Placer, Plumas, San Benito, Sierra, Sutter, Tehama, and Yuba.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a decrease due to:

- The prior estimate assumed that enrollment would continue at the levels close to those observed in January 2024 (the most recent actual month at that time), with the incremental impact of further changes in enrollment due to the resumption of eligibility redeterminations accounted for in the COVID-19 Redeterminations Impact and policy change. This estimate assumes that enrollment continues at levels close to those observed in July 2024 (the most recent actual month). The July 2024 caseload level is

REGIONAL MODEL
BASE POLICY CHANGE NUMBER: 66

lower than the January 2024 caseload level, leading to decreased costs in this policy change. The incremental impact of redeterminations on managed care costs is accounted for separately in the COVID-19 Redeterminations Impact policy change.
- Certain counties requested a change to their managed care model. This change, which was implemented in January 2024, resulted in a shift of costs from this policy change into the Two-Plan Model and the COHS and Single Plan policy changes. The cost shift is based on the transition of members associated with this change.
- Managed care costs for Unsatisfactory Immigration Status (UIS) members aged 26 through 49 that received full-scope coverage beginning January 2024 are now reflected in this policy change, leading to increased costs. These costs were previously budgeted in the Undocumented Expansion Ages 26 through 49 policy change.
- Updated CY 2024 rates, including separate rates for UIS and Satisfactory Immigration Status (SIS) populations, were used for this estimate. These rates newly incorporate the impact of provider rate increases implemented January 2024 and Proposition 56 Physicians Supplemental Payments that became base rate increases in January 2024, leading to increased costs budgeted in this policy change.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to higher member months in FY 2024-25.

Methodology:
1. Capitation rates are typically rebased annually on a calendar year (CY) basis. Federal regulations and State law require that the rates be developed according to generally accepted actuarial principles and practices. Rates must be certified by an actuary as actuarially sound in order to ensure federal financial participation (FFP). The rebasing process includes refreshed data and updates to trends, program changes, and other adjustments.

2. On an accrual basis, the last six months of the CY 2024 rates and the first six months of the CY 2025 rates have been budgeted for FY 2024-25.

3. FY 2024-25 weighted rates have been updated from the previous estimate, and newly incorporate the impact of base rate increases that were implemented January 2024.

4. The difference from the FY 2024-25 weighted rates to the CY 2025 rates and the estimated adjustment anticipated for the CY 2026 rates, to occur in FY 2025-26 is captured in the Capitated Rate Adjustment for FY 2025-26 policy change as a percentage assumption applied to seven months of the CY 2025 rates and five months of the CY 2026 rates on a cash basis.

5. The member months in this PC are reflective of actuals through July 2024, inclusive of redetermination impacts. The COVID-19 Redeterminations Impact PC adjusts these base projections to account for incremental impacts resuming eligibility redeterminations on the Medi-Cal caseload and managed care enrollment.

6. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of $29,800,000 for FY 2024-25 and $29,800,000 for FY 2025-26 were included in the rates.

7. Indian Health Services and Maternity supplemental payments are reflected in this PC.

REGIONAL MODEL
BASE POLICY CHANGE NUMBER: 66

8. As of January 1, 2024, Transitional Care Services are included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

9. As of January 1, 2024, Long Term Care members in Intermediate Care Facilities for the Developmentally Disabled and Sub-Acute Facilities will transition mandatorily into managed care. The costs associated with these services are reflected in the rates.

10. As of January 1, 2024, all components of the Targeted Rate Increase are included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

11. As of July 1, 2024, Biomarker and Pharmacogenomic Testing are included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

12. The Department receives 90% FFP for family planning services.

13. Costs for the Optional Targeted Low Income Children Program (OTLICP) are budgeted in the managed care model policy changes. An FMAP split of 65%/35% is budgeted for OTLICP.

14. Regional Model dollars on an accrual basis are:

(Dollars in Thousands)

FY 2024-25	Member Months	Total
Amador	102,361	$34,161
Calaveras	152,940	$49,655
Inyo	58,498	$21,976
Mono	34,894	$9,730
Tuolumne	172,001	$66,096
Total FY 2024-25	520,694	$181,618
Maternity (events)	1,892	$24,451
Total FY 2024-25 with Maternity		$206,070

(Dollars in Thousands)

Included in Dollars Above	FY 2024-25
Mental Health	$29,800

REGIONAL MODEL
BASE POLICY CHANGE NUMBER: 66

(Dollars in Thousands)

FY 2025-26	Member Months	Total
Amador	102,345	$34,146
Calaveras	153,157	$49,774
Inyo	58,506	$21,965
Mono	34,907	$9,733
Tuolumne	172,131	$66,145
Total FY 2025-26	521,046	$181,764
Maternity (events)	1,986	$25,674
Total FY 2025-26 with Maternity		$207,438

(Dollars in Thousands)

Included in Dollars Above	FY 2025-26
Mental Health	$29,800

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

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$120,235	$60,118	$60,118
65% Title XXI / 35% GF (4260-101-0001/0890)	$7,340	$2,569	$4,771
ACA 90% FFP/10% GF (2020 and later)	$73,387	$7,339	$66,048
100% State GF (4260-101-0001)	$4,281	$4,281	$0
Title XIX 100% FFP	$23,702	$0	$23,702
90% Family Planning FFP / 10% GF (4260-101-0001/0890)	$365	$37	$329
Total	**$229,310**	**$74,343**	**$154,967**

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$121,485	$60,743	$60,743
65% Title XXI / 35% GF (4260-101-0001/0890)	$7,374	$2,581	$4,793
ACA 90% FFP/10% GF (2020 and later)	$74,259	$7,426	$66,833
100% State GF (4260-101-0001)	$4,308	$4,308	$0
Title XIX 100% FFP	$27,969	$0	$27,969
90% Family Planning FFP / 10% GF (4260-101-0001/0890)	$365	$37	$329
Total	**$235,760**	**$75,094**	**$160,666**

DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER: 67
IMPLEMENTATION DATE: 7/2004
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1029

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$167,654,000	$167,704,000
- STATE FUNDS	$70,935,800	$71,000,900
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$167,654,000	$167,704,000
STATE FUNDS	$70,935,800	$71,000,900
FEDERAL FUNDS	$96,718,200	$96,703,100

Purpose:
The policy change estimates the cost of dental capitation rates for the Dental Managed Care (DMC) program.

Authority:
Social Security Act, Title XIX
AB 82 (2013, Chapter 23), Section 14131.10 of the Welfare & Institutions Code
Access Dental Plan Contract #12-89341
Access Dental Plan Contract #13-90115
Access Dental Plan Contract #22-20508
Access Dental Plan Contract #22-20509
Health Net of California Contract #12-89342
Health Net of California Contract #13-90116
Health Net of California Contract #22-20510
Health Net of California Contract #22-20511
Liberty Dental Plan of California, Inc. Contract #12-89343
Liberty Dental Plan of California, Inc. Contract #13-90117
Liberty Dental Plan of California, Inc. Contract #22-20512
Liberty Dental Plan of California, Inc. Contract #22-20513

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 members in Sacramento and Los Angeles counties.

DENTAL MANAGED CARE (Other M/C)
BASE POLICY CHANGE NUMBER: 67

Each dental plan receives a 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 members, including Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), is limited to the adult optional benefits restored May 1, 2014, in addition to the adult dental benefits which include services for pregnant women, emergency services, Federally Required Adult Dental Services (FRADs), services provided at an Intermediate Care Facility/Skilled Nursing Facility, and services for Department of Developmental Services consumers. Effective January 1, 2018, the full restoration of adult dental benefits includes the remaining services which were not restored in 2014, such as restorative services (crowns), prosthodontic services (partial dentures), and endodontic services (root canals). The impact of the restoration of adult dental benefits is included in the capitation rates.

The Medi-Cal DMC plan contracts establish a single-sided risk corridor in the form of a minimum Medical Loss Ratio (MLR) of 85% beginning with FY 2019-20 rating period. The Department will require DMC plans to remit necessary funds that do not meet the 85% threshold. These recoupments are budgeted in a separate policy change.

New contracts were procured and awarded to three DMC Plans for FY 2025-26: Liberty Dental Plan of California, California Dental Network, Inc., and Health Net Community Solutions, Inc. Each of the plans will assume operations on July 1, 2025, in both Sacramento and Los Angeles County.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase due to updated member counts and rates. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a slight increase due to updated 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. Any portion of the rate attributable to Proposition 56 Supplemental Payments is captured in their respective policy changes.

3. A 3% compliance withhold is held back every month per the contract with the DMC plans. The withhold amount is returned no sooner than April of the following fiscal year if performance measures in the contract are met.

4. Effective January 1, 2023, a new 3% performance withhold will be held back every month per the contract with the health plans. The withhold amount is returned no sooner than April of the following fiscal year if the plans are in compliance with the contract.

DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER: 67

FY 2024-25	Total Member Months	Average Monthly Eligibles	Total Costs
Adult - GMC	4,125,288	343,774	$46,521,072
Child - GMC	2,746,524	228,877	$55,614,168
Adult - PHP	3,921,264	326,772	$41,315,964
Child - PHP	1,421,652	118,471	$19,729,037

FY 2025-26	Total Member Months	Average Monthly Eligibles	Total Costs
Adult - GMC	4,125,288	343,774	$49,063,575
Child - GMC	2,746,524	228,877	$58,638,460
Adult - PHP	3,921,264	326,772	$43,599,362
Child - PHP	1,421,652	118,471	$20,803,965

Funding:

FY 2024-25	TF	GF	FF
Regular FMAP T19	$95,670,000	$47,835,000	$47,835,000
ACA 90% FFP/10% GF (2020)	$47,000,000	$4,700,000	$42,300,000
Title 21 65% FFP/35% GF	$10,128,000	$3,545,000	$6,583,000
UIS 100% State GF	$14,856,000	$14,856,000	$0
Total	**$167,654,000**	**$70,936,000**	**$96,718,000**

FY 2025-26	TF	GF	FF
Regular FMAP T19	$95,655,000	$47,828,000	$47,827,000
ACA 90% FFP/10% GF (2020)	$46,993,000	$4,699,000	$42,294,000
Title 21 65% FFP/35% GF	$10,126,000	$3,544,000	$6,582,000
UIS 100% State GF	$14,930,000	$14,930,000	$0
Total	**$167,704,000**	**$71,001,000**	**$96,703,000**

*Totals may differ due to rounding.

Funding:
50% Title XIX / 50% GF (4260-101-0890/0001)
90% ACA Title XIX FF / 10% GF (4260-101-0890/0001)
65% Title XXI / 35% GF (4260-101-0890/0001)
100% State GF (4260-101-0001)

SENIOR CARE ACTION NETWORK (Other M/C)

BASE POLICY CHANGE NUMBER: 69
IMPLEMENTATION DATE: 2/1985
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 61

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$98,509,000	$105,456,000
- STATE FUNDS	$49,494,000	$52,984,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$98,509,000	$105,456,000
STATE FUNDS	$49,494,000	$52,984,000
FEDERAL FUNDS	$49,015,000	$52,472,000

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

Authority:
Welfare & Institutions Code 14200

Interdependent Policy Changes:
Not Applicable

Background:
SCAN is a Medicare Advantage Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) that contracts with the Department to coordinate and provide health care services on a capitated basis for persons aged 65 and older with both Medicare and Medi-Cal coverage in Los Angeles, San Bernardino, and Riverside Counties. Expansion to San Diego County occurred January 1, 2023. Enrollees who are certified for Skilled Nursing Facility (SNF) and Intermediate Care Facility (ICF) levels of care are eligible for additional Home and Community Based Services (HCBS) through the SCAN Health Plan Independent Living Power program.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase due to updated Calendar Year (CY) 2025 rate and enrollment projections. The change from FY 2024-25 to FY 2025-26 in the current estimate, is an increase due to updated CY 2026 cost projections.

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

2. Assume average monthly members of 21,640 in FY 2024-25 and 22,398 in FY 2025-26.

3. The CY 2024 rates are final rates.

SENIOR CARE ACTION NETWORK (Other M/C)
BASE POLICY CHANGE NUMBER: 69

4. CY 2025 and CY 2026 rates were projected by trending forward the CY 2024 final rates.

5. Assume seven months of CY 2024 rating period payments and five months of CY 2025 rating period payments are paid in FY 2024-25.

6. Assume seven months of CY 2025 rating period payments and five months of CY 2026 rating period payments are paid in FY 2025-26.

7. Anticipated costs by county on a cash basis are:

(Dollars in Thousands)

FY 2024-25	Costs	Member Months	Avg. Monthly Members
Los Angeles	$63,172	162,630	13,552
Riverside	$16,450	41,228	3,436
San Bernardino	$11,515	31,746	2,645
San Diego	$7,372	24,081	2,007
Total FY 2024-25	$98,509	259,685	21,640

(Dollars in Thousands)

FY 2025-26	Costs	Member Months	Avg. Monthly Members
Los Angeles	$67,627	168,322	14,027
Riverside	$17,610	42,671	3,556
San Bernardino	$12,327	32,857	2,738
San Diego	$7,892	24,924	2,077
Total FY 2025-26	$105,456	268,774	22,398

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
50% Title XIX FF / 50% GF	$98,030	$49,015	$49,015
100% GF Title XIX	$479	$479	$0
Total FY 2024-25	**$98,509**	**$49,494**	**$49,015**

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
50% Title XIX FF / 50% GF	$104,944	$52,472	$52,472
100% GF Title XIX	$512	$512	$0
Total FY 2025-26	**$105,456**	**$52,984**	**$52,472**

Funding:
50% Title XIX / 50% GF (4260-101-0890/0001)
100% GF Title XIX (4620-101-0001)

MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL

BASE POLICY CHANGE NUMBER: 72
IMPLEMENTATION DATE: 7/2014
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 1837

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$36,909,000	$36,909,000
- STATE FUNDS	$15,333,000	$15,333,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$36,909,000	$36,909,000
STATE FUNDS	$15,333,000	$15,333,000
FEDERAL FUNDS	$21,576,000	$21,576,000

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

Authority:
AB 99 (Chapter 278, Statutes of 1991)
SB 800 (Chapter 448, Statutes of 2013)
SPA 17-0043
SPA 17-0044
SPA 18-0028
SPA 22-0041

Interdependent Policy Changes:
Not Applicable

Background:
MCAP covers pregnant women in families with incomes between 213-322% of the FPL. Effective July 1, 2022, premium contribution amounts were reduced to $0.00. The Department integrated eligibility rules for MCAP into the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) in October 2015. The Department maintained a health plan delivery system for MCAP that was separate from the Medi-Cal delivery system until September 30, 2016. The Department made final reconciliation payments to health plans under the erstwhile delivery system in FY 2018-19.

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

MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL

BASE POLICY CHANGE NUMBER: 72

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a decrease due to projecting reduced enrollment because of caseload redeterminations. There is no change from FY 2024-25 to FY 2025-26 in the current estimate.

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

Program Forecast	FY 2024-25	FY 2025-26
Average Monthly Caseload	5,492	5,492
Average Expected Deliveries	270	270
Per Member Per Month (PMPM)	$254.33	$254.33

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

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

4. The total estimated costs for MCAP mothers in FY 2024-25 and FY 2025-26 are:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
65% Title XXI FFP / 35% GF	$33,194	$11,618	$21,576
100% GF Title XXI	$3,715	$3,715	$0
Total	**$36,909**	**$15,333**	**$21,576**

FY 2025-26	TF	GF	FF
65% Title XXI FFP / 35% GF	$33,194	$11,618	$21,576
100% GF Title XXI	$3,715	$3,715	$0
Total	**$36,909**	**$15,333**	**$21,576**

*Totals differ due to rounding.

Funding:
Title XXI FFP (4260-101-0890)
Title XXI GF (4260-101-0001)

AIDS HEALTHCARE CENTERS (Other M/C)

BASE POLICY CHANGE NUMBER: 74
IMPLEMENTATION DATE: 5/1985
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 63

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$13,281,000	$14,578,000
- STATE FUNDS	$6,640,500	$7,289,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$13,281,000	$14,578,000
STATE FUNDS	$6,640,500	$7,289,000
FEDERAL FUNDS	$6,640,500	$7,289,000

Purpose:
This policy change estimates the cost of capitation rates for Positive Healthcare, which is the Medi-Cal managed care plan operated by AIDS Healthcare Foundation (AHF), as well as other health plan(s) participating in the transition of current AHF members.

Authority:
Welfare & Institutions Code 14088.85

Interdependent Policy Changes:
Not Applicable

Background:
The HIV/AIDS capitated case management project in Los Angeles became operational in April 1995.

The Department held a contract with AHF as a Primary Care Case Management (PCCM) plan through June 30, 2019. Effective July 1, 2019, AHF transitioned to a full risk-managed care plan as approved by the Department. The Department developed a full-risk amendment that added inpatient services as a benefit and changed plan pharmacy coverage.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase due to updated Calendar Year (CY) 2025 enrollment. The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to higher cost projections for CY 2025 and CY 2026.

Methodology:
1. Assume the following member months on an accrual basis:

AIDS HEALTHCARE CENTERS (Other M/C)
BASE POLICY CHANGE NUMBER: 74

Member Months	Dual	Medi-Cal Only
CY 2024	3,659	7,507
CY 2025	3,790	8,071
CY 2026	3,913	8,625

2. Assume the following paid rates:

Paid Rates	Dual	Medi-Cal Only
CY 2024	$163.37	$1,617.80
CY 2025	$168.27	$1,666.33
CY 2026	$173.33	$1,716.32

An annual three percent growth factor is assumed to calculate CY 2025 draft rates.

3. The following amounts are estimated for this policy change on a cash basis and based on the updated member months and rates:

FY 2024-25	Paid Rate	MM	TF
Dual	$165.41	3,714	$614,000
Medi-Cal Only	$1,638.02	7,742	$12,667,000
Total	N/A	N/A	$13,281,000

FY 2025-26	Paid Rate	MM	TF
Dual	$170.37	3,841	$654,000
Medi-Cal Only	$1,687.16	8,302	$13,924,000
Total	N/A	N/A	$14,578,000

4. The following chart shows the funding split of dollars on a cash basis:

FY 2024-25	**TF**	**GF**	**FF**
Positive Healthcare	$13,281,000	$6,640,000	$6,641,000
Total FY 2024-25	**$13,281,000**	**$6,640,000**	**$6,641,000**

FY 2025-26	**TF**	**GF**	**FF**
Positive Healthcare	$14,578,000	$7,289,000	$7,289,000
Total FY 2025-26	**$14,578,000**	**$7,289,000**	**$7,289,000**

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

COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM

BASE POLICY CHANGE NUMBER: 75
IMPLEMENTATION DATE: 7/2014
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 1823

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$7,833,000	$7,833,000
- STATE FUNDS	$2,741,550	$2,741,550
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$7,833,000	$7,833,000
STATE FUNDS	$2,741,550	$2,741,550
FEDERAL FUNDS	$5,091,450	$5,091,450

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

Authority:
AB 495 (Chapter 648, Statutes of 2001)
SB 800 (Chapter 448, Statutes of 2013)
SB 857 (Chapter 31, Statutes of 2014)
SPA 17-0043
SPA 17-0044
SPA 22-0041
SB 184 (Chapter 47, Statutes of 2022)

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.

Effective July 1, 2014, SB 857 eliminated the Managed Risk Medical Insurance Board 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 required 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, elected to cease funding the non-federal share of program expenditures during the maintenance effort timeframe, the bill required the Department to provide funding from the General Fund (GF) in amounts equal to the total non-federal share of incurred expenditures.

COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM
BASE POLICY CHANGE NUMBER: 75

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

Effective October 1, 2019, the Department transitioned CCHIP members into the Medi-Cal Managed Care (MCMC) delivery system and also transitioned all administrative functions, such as premium collection and case management, for CCHIP to MAXIMUS. MAXIMUS is the current administrator vendor for the Medi-Cal Access Program (MCAP) and the Optional Targeted Low Income Program (OTLICP). The OTLICP, MCAP, Special Populations Admin Costs policy change contains costs for MAXIMUS' administrative functions and contract transition responsibilities. CCHIP premium collections and benefit costs for CCHIP eligible members are still reflected in this policy change. Effective July 1, 2022, premium contribution amounts were reduced to $0.00.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a decrease due to projecting a decrease in enrolled members. There is no change from FY 2024-25 to FY 2025-26 in the current estimate.

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

2. Effective July 1, 2022, premium contribution amounts were reduced to $0.00.

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

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

5. Assume there will be approximately 5,381 CCHIP members in FY 2024-25 and FY 2025-26.

FY 2024-25	**TF**	**GF**	**FF**
Benefits Title XXI 65 FF/35 GF	$7,833,000	$2,742,000	$5,091,000
Total FY 2024-25	**$7,833,000**	**$2,742,000**	**$5,091,000**
FY 2025-26	**TF**	**GF**	**FF**
Benefits Title XXI 65 FF/35 GF	$7,833,000	$2,742,000	$5,091,000
Total FY 2025-26	**$7,833,000**	**$2,742,000**	**$5,091,000**

*Totals may differ due to rounding.

Funding:
65% Title XXI FF / 35% GF (4260-101-0890/0001)

MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL

BASE POLICY CHANGE NUMBER: 76
IMPLEMENTATION DATE: 11/2013
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 1797

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$2,817,000	$2,832,000
- STATE FUNDS	$985,950	$991,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,817,000	$2,832,000
STATE FUNDS	$985,950	$991,200
FEDERAL FUNDS	$1,831,050	$1,840,800

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

Authority:
AB 82 (Chapter 23, Statutes of 2013)
SPA 17-0043
SPA 17-0044
SPA 22-0041

Interdependent Policy Changes:
Not Applicable

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

The Department integrated eligibility rules for MCAIP into the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) in October 2015, with additional updates that occurred in 2020. Similar to subscribers enrolled in the Optional Targeted Low Income Children's Program (OTLICP) with family incomes at or above 160% of the FPL, subscribers enrolled in MCAIP are subject to premiums. Effective July 1, 2022, premium contribution amounts were reduced to $0.00.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a decrease due to projecting reduced enrollment because of caseload redeterminations.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is a slight increase due to a projected growth in weighted average PMPM costs for Medi-Cal Managed Care.

MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL

BASE POLICY CHANGE NUMBER: 76

Methodology:

1. The Department estimates the average monthly FFS enrollment will be 230 in FY 2024-25 and 230 in FY 2025-26, and the average monthly Medi-Cal Managed Care enrollment will be 546 in FY 2024-25 and 546 in FY 2025-26.

2. The Department estimates the weighted average PMPM cost will be $389.47 in FY 2024-25 and $389.47 in FY 2025-26 for FFS infants, and $265.95 in FY 2024-25 and $268.20 in FY 2025-26 for Medi-Cal Managed Care infants.

3. The total estimated costs for MCAIP infants in FY 2024-25 and FY 2025-26 are:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
Benefits	$2,817	$986	$1,831
Net Total	**$2,817**	**$986**	**$1,831**

FY 2025-26	TF	GF	FF
Benefits	$2,832	$991	$1,841
Net Total	**$2,832**	**$991**	**$1,841**

*Totals may differ due to rounding.

Funding:

65% Title XXI FFP/35% GF (4260-101-0890/0001)

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

BASE POLICY CHANGE NUMBER: 140
IMPLEMENTATION DATE: 7/1988
ANALYST: Allison Tamai
FISCAL REFERENCE NUMBER: 76

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$4,713,863,000	$4,893,986,000
- STATE FUNDS	$2,765,510,000	$2,872,654,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$4,713,863,000	$4,893,986,000
STATE FUNDS	$2,765,510,000	$2,872,654,500
FEDERAL FUNDS	$1,948,353,000	$2,021,331,500

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

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

Interdependent Policy Changes:
Not Applicable

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

Reason for Change:
Expenditures for FY 2024-25 were revised up 0.17% from the prior estimate:

- Actual caseload is higher than previously projected by 0.84% due to CMS corrections to Medicare buy-in enrollment.
- Partly offset by lower 2025 Part A premiums of $26.00.

Expenditures are projected to grow 3.82% between FY 2024-25 and FY 2025-26 due to an estimated increase in the Part A premium of $20.00 and Part B premium of $1.90 between 2025 and 2026.

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

BASE POLICY CHANGE NUMBER: 140

Premiums:

Calendar Year	2024	2025		2026
	Actual	May 2024 Estimate	Nov 2024 Estimate	Nov 2024 Estimate
Part A	$505.00	$536.00	$510.00	$530.00
Part B	$174.70	$185.00	$185.00	$186.90

Average Monthly Beneficiaries:

FY	2023-24	2024-25		2025-26
	Actual	May 2024 Estimate	Nov 2024 Estimate	Nov 2024 Estimate
Part A	157,984	155,672	159,378	159,333
Part B	1,661,125	1,662,217	1,673,706	1,693,268

Methodology:

1. The Centers for Medicare and Medicaid set the following premiums for 2024.

Calendar Year	Part A	Part B
2024	$505.00	$174.70

2. For 2025 and 2026, the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance is projecting 1.0% and 3.9% respective growth in the Medicare Part A premium. Applying this growth to the prior year Part A premium calculates as $505.00 x 1.01 = $510.00 and $510.00 X 1.039 = $530 (rounded).

3. For 2025 and 2026, the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance is projecting 5.84% and 1.0% respective growth in the Medicare Part B premium. Applying this growth to the prior year Part B premium calculates as $174.80 x 1.0584 = $185.00 and $185 X 1.01 = $186.90. (rounded).

FY 2024-25	Part A	Part B
Average Monthly Members	159,378	1,673,706
Rate 07/2024-12/2024	$505.00	$174.70
Rate 01/2025-06/2025	$510.00	$185.00

FY 2025-26	Part A	Part B
Average Monthly Members	159,333	1,693,268
Rate 07/2025-12/2025	$510.00	$185.00
Rate 01/2026-06/2026	$530.00	$186.90

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

BASE POLICY CHANGE NUMBER: 140

Funding:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
Title XIX 50/50	$3,869,626	$1,934,813	$1,934,813
State GF 100%	$830,697	$830,697	$0
Title XIX 100% FFP	$13,540	$0	$13,540
Total	**$4,713,863**	**$2,765,510**	**$1,948,353**

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
Title XIX 50/50	$4,014,452	$2,007,226	$2,007,226
State GF 100%	$865,429	$865,429	$0
Title XIX 100% FFP	$14,106	$0	$14,106
Total	**$4,893,987**	**$2,872,655**	**$2,021,332**

MEDICARE PAYMENTS - PART D PHASED-DOWN

BASE POLICY CHANGE NUMBER: 141
IMPLEMENTATION DATE: 1/2006
ANALYST: Kathleen Dong
FISCAL REFERENCE NUMBER: 1019

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$3,595,832,000	$3,904,450,000
- STATE FUNDS	$3,595,832,000	$3,904,450,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,595,832,000	$3,904,450,000
STATE FUNDS	$3,595,832,000	$3,904,450,000
FEDERAL FUNDS	$0	$0

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 members and other Medicare eligible members that enroll in Part D. Dual eligible members 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 members. 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.

MEDICARE PAYMENTS - PART D PHASED-DOWN

BASE POLICY CHANGE NUMBER: 141

Medi-Cal's Part D Per Member Per Month (PMPM) rate:

Calendar Year	PMPM rate
2022	$147.83
2023	$155.08
2024	$167.50
2025	$181.87
2026	$192.14 (estimated)

Medi-Cal's total payments on a cash basis and average monthly eligible members by fiscal year:

Fiscal Year	Total Payment	Ave. Monthly Members
FY 2021-22	$2,350,153,376	1,584,095
FY 2022-23	$2,622,797,792	1,656,292
FY 2023-24	$3,144,217,563	1,707,569

Reason for Change:

Expenditure projections for FY 2024-25 were revised up by 0.78% from the prior estimate:

- Actual caseload is higher than projected due to CMS corrections for Medicare buy-in enrollment resulting in additional Part D members. Caseload projections continue at this higher level based on the historical growth trend absent enrollment growth during the FFCRA continuous coverage requirement period.

Expenditures are projected to increase 8.58% between FY 2024-25 and FY 2025-26 in the current estimate because:

- An estimated increase in the PMPM rate of $10.27, a 5.65% year over year increase, for 2026, and
- Historical caseload growth, absent enrollment growth during the FFCRA continuous coverage requirement period.

Methodology:

1. The 2024 growth increased 8.01% over 2023 amounts per the *Centers for Medicare & Medicaid Services*. Medi-Cal's PMPM rate for 2024 is $167.50.

2. The 2025 growth increased 8.58% over 2024 amounts per the *Centers for Medicare & Medicaid Services*. Medi-Cal's estimated PMPM rate for 2025 is $181.87.

3. The 2026 growth is estimated to increase 5.65% over 2025 amounts based on an average of the annual percentage increase for the prior three years provided by the *Centers for Medicare & Medicaid Services*. Medi-Cal's estimated PMPM rate for 2026 is $192.14.

MEDICARE PAYMENTS - PART D PHASED-DOWN

BASE POLICY CHANGE NUMBER: 141

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 members are estimated using the growth trend in the monthly Part D enrollment data from May 2018 to July 2024.

	Payment Months	Est. Ave. Monthly Members	Est. Ave. Monthly Cost	Total Cost
FY 2024-25	12	1,739,197	$299,653,000	**$3,595,832,000**
FY 2025-26	12	1,755,885	$325,371,000	**$3,904,450,000**

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

PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 142
IMPLEMENTATION DATE: 4/1993
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 22

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$3,600,022,000	$3,994,052,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,600,022,000	$3,994,052,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$3,600,022,000	$3,994,052,000

Purpose:
This policy change provides Title XIX federal financial participation (FFP) to the California Department of Social Services (CDSS) for Medi-Cal members participating in the In-Home Supportive Services (IHSS) programs: the Personal Care Services Program (PCSP) and the IHSS Plus Option (IPO) program administered by CDSS.

Authority:
Social Security Act (42 U.S.C., Section 1396, et. seq.)
PCSP Interagency Agreements (IA) 03-75676
IPO IA 09-86307
SB 1036 (Chapter 45, Statutes of 2012)
SB 1008 (Chapter 33, Statutes of 2012)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
Eligible services are authorized under Title XIX of the federal Social Security Act (42 U.S.C., Section 1396, et. seq.). The Department draws down and provides FFP to CDSS through IAs for the IHSS PCSP and the IPO program.

SB 1008 enacted the Coordinated Care Initiative (CCI) which required, in part, mandatory enrollment for dual eligible members into managed care for their Medi-Cal benefits. Those benefits included IHSS. Beginning April 1, 2014, some IHSS costs were paid through managed care capitation due to IHSS recipients transitioning into managed care. Effective January 1, 2018, IHSS are no longer included in the managed care capitation, thus all costs for IHSS eligible services are captured in this policy change.

FFP for the county cost of administering the PCSP is in the Personal Care Services policy change located in the Other Administration section of the Estimate.

PERSONAL CARE SERVICES (Misc. Svcs.)
BASE POLICY CHANGE NUMBER: 142

The Governor's Budget estimated the CCI project would no longer be cost-effective. Therefore, pursuant to the provisions of current law, the program was discontinued in FY 2017-18. Based on the lessons learned from the CCI demonstration project, the Budget proposed the extension of the Cal MediConnect program and the mandatory enrollment of dual eligible members and integrating of long-term services and supports, except IHSS, into managed care. IHSS were removed from capitation rate payments effective January 1, 2018.

As a result of the COVID-19 national public health emergency, increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

Reason for Change:
There is an increase from the prior estimate for FY 2024-25, due to updated expenditure data provided by CDSS. There is an increase in the current estimate from FY 2024-25 to FY 2025-26 due to updated expenditure data provided by CDSS.

Methodology:
1. The following estimates were provided by CDSS on an accrual basis.

(Dollars in Thousands)

FY 2024-25	**TF**	**FF**	**CDSS GF/ County Share**
Title XIX 100% FFP	$7,695,250	$3,847,625	$3,847,625
COVID-19 Title XIX Increased FMAP	$0	$0	$0
Total	$7,695,250	$3,847,625	$3,847,625
FY 2025-26	**TF**	**FF**	**CDSS GF/ County Share**
Title XIX 100% FFP	$8,428,910	$4,214,455	$4,214,455
COVID-19 Title XIX Increased FMAP	$0	$0	$0
Total	$8,428,910	$4,214,455	$4,214,455

*Totals may differ due to rounding.

2. The following estimates were provided by CDSS on a cash basis.

(Dollars in Thousands)

FY 2024-25	**TF**	**FF**	**CDSS GF/ County Share**
Title XIX 100% FFP	$7,200,551	$3,600,275	$3,600,276
COVID-19 Title XIX Increased FMAP	$0	($254)	$254
Total	$7,200,551	**$3,600,021**	$3,600,530

PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 142

FY 2025-26	TF	FF	CDSS GF/ County Share
Title XIX 100% FFP	$7,988,103	$3,994,052	$3,994,051
COVID-19 Title XIX Increased FMAP	$0	$0	$0
Total	$7,988,103	**$3,994,052**	$3,994,051

*Totals may differ due to rounding.

Funding:
Title XIX 100% FFP (4260-101-0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)

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

BASE POLICY CHANGE NUMBER: 143
IMPLEMENTATION DATE: 7/1990
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 23

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$3,431,077,000	$4,229,674,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,431,077,000	$4,229,674,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$3,431,077,000	$4,229,674,000

Purpose:
This policy change estimates the federal match for the California Department of Developmental Services (CDDS) for the Home & Community Based Services (HCBS) program.

Authority:
Interagency Agreement 01-15834

Interdependent Policy Changes:
Not Applicable

Background:
CDDS, under a federal HCBS waiver, offers and arranges for non-State Plan Medicaid services via the Regional Center system. The HCBS waiver allows the State to offer these services to individuals who would otherwise require the level of care provided in a hospital, nursing facility (NF), or in an intermediate care facility for the developmentally disabled (ICF/DD). Services covered under this waiver include but are not limited to: home health aide services, habilitation, transportation, communication aides, family training, homemaker/chore services, nutritional consultation, specialized medical equipment/supplies, respite care, personal emergency response system, crisis intervention, supported employment and living services, home and vehicle modifications, prevocational services, skilled nursing, residential services, and transition/set-up expenses.

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

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

BASE POLICY CHANGE NUMBER: 143

As a result of the COVID-19 national public health emergency, increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to a net increase in paid expenditures and a slight decrease in prior year expenditures in FY 2024-25.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to an increase in program utilization, caseload growth, and prior year expenditures expected in FY 2025-26.

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

2. The negative COVID-19 enhanced FMAP is due to refunding invoices under this program and billing the Department through the HCBS Spending Plan (HCBS SP) under the American Rescue Plan Act (ARPA). The federal fund minus the COVID-19 enhanced FMAP comes up to the General Fund amount. The funds that were identified as ARPA expenditures were refunded to the program then billed under the HCBS Spending Plan. See the HCBS SP CDDS policy change for the estimated HCBS Spending Plan expenditures.

3. Negative COVID-19 FF and ARPA invoices went out for this program in September 2024.

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	DHCS FFP	COVID-19 FF
FY 2024-25	$6,862,154	$3,431,077	**$3,434,289**	**($3,212)**
FY 2025-26	$8,459,348	$4,229,674	**$4,229,674**	**$0**

Funding:
Title XIX 100% FFP (4260-101-0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)

DENTAL SERVICES

BASE POLICY CHANGE NUMBER: 144
IMPLEMENTATION DATE: 7/1988
ANALYST: Sarah Sen
FISCAL REFERENCE NUMBER: 135

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$2,229,526,000	$2,310,519,000
- STATE FUNDS	$1,046,522,550	$1,083,084,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,229,526,000	$2,310,519,000
STATE FUNDS	$1,046,522,550	$1,083,084,600
FEDERAL FUNDS	$1,183,003,450	$1,227,434,400

Purpose:
This 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:
COVID-19 Redetermination Impact

Background:

These dental costs are for fee-for-service (FFS) Medi-Cal members. Dental costs for members with dental managed care plans are shown in the Dental Managed Care Policy Change. PACE, SCAN, and Health Plan of San Mateo plans which also provide dental benefits are captured in other Policy Change Documents.

Gainwell Technologies LLC (GWT) was awarded a multi-year Fiscal Intermediary-Dental Business Operations (FI-DBO) contract in 2022, and replaced Delta Dental of California (Delta) contract on May 13, 2024. The FI-DBO contractor is responsible for duties including claims processing, provider enrollment, and outreach for the Medi-Cal Dental FFS Program. GWT was awarded a multi-year Fiscal Intermediary (FI) contract in 2016. The FI contractor is responsible for duties to operate and maintain the California Medicaid Management Information System (CD-MMIS).

The Medi-Cal Dental program covers a broad range of dental services for both children (0-20) and adults (21 and older) including, but not limited to the following dental service categories: diagnostic, preventive, restorative, endodontic, prosthodontic, and oral maxillofacial surgery services.

DENTAL SERVICES
BASE POLICY CHANGE NUMBER: 144

Reason for Change:
The change from the prior estimate for FY 2024-25 and FY 2025-26 is primarily due to a decrease in users as a result of the redeterminations impact that began on July 1, 2023. This decrease is offset by an increase in General Fund costs due to the growth in the 26-49 Unsatisfactory Immigration Status (UIS) population due to the expansion of the full-scope Medi-Cal services to this population effective January 1, 2024.

There is no significant change from FY 2024-25 to FY 2025-26 in the current estimate.

DENTAL SERVICES
BASE POLICY CHANGE NUMBER: 144

Methodology:
1. Dental expenditures are estimated using 36 months of cash-basis expenditure data (July 2021 - June 2024) and trending Users, Units/User, and Rate.

2. A portion of Proposition 56 Supplemental Payments, CalAIM - Dental Initiatives, and Evidence-Based Dental Practices estimates are included in this policy change.

3. Dental services estimates for the Breast and Cervical Cancer Treatment Program (BCCTP) are included in the BCCTP policy change.

4. The Families First Coronavirus Response Act (FFCRA) required the department suspend eligibility redeterminations during the national public health emergency, with the first impacts of resuming redeterminations that began in July 2023. Projections include decreases in user counts and costs related to the redeterminations impact through June 2024. Further changes in spending related to redeterminations are included in the Redeterminations Impact policy change.

Funding:
(Dollars in Thousands)

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF	$1,275,013	$637,507	$637,507
ACA 90% FFP/10% GF (2020)	$418,361	$41,836	$376,524
65% Title XXI/35% GF (10/2020)	$259,837	$90,943	$168,894
100% GF	$276,237	$276,237	$0
Title XIX 100% FFP	$78	$0	$78
Total	**$2,229,526**	**$1,046,522**	**$1,183,003**

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF	$1,339,192	$669,596	$669,596
ACA 90% FFP/10% GF (2020)	$424,066	$42,407	$381,659
65% Title XXI/35% GF (10/2020)	$270,920	$94,822	$176,098
100% GF	$276,260	$276,260	$0
Title XIX 100% FFP	$81	$0	$81
Total	**$2,310,519**	**$1,083,085**	**$1,227,434**

Note: Totals may differ due to rounding.

WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 145
IMPLEMENTATION DATE: 4/2000
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 32

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$437,183,000	$557,468,000
- STATE FUNDS	$219,478,000	$279,864,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$437,183,000	$557,468,000
STATE FUNDS	$219,478,000	$279,864,000
FEDERAL FUNDS	$217,705,000	$277,604,000

Purpose:
This policy change estimates the costs of waiver personal care services (WPCS) under the Home and Community-Based Alternatives (HCBA) Waiver.

Authority:
AB 668 (Chapter 896, Statutes of 1998)
Interagency Agreement (IA) 19-96360
AB 1811 (Chapter 35, Statutes of 2018)
SB 214 (Chapter 300, Statutes of 2020)

Interdependent Policy Changes:
Not Applicable

Background:
The HCBA Waiver provides Home and Community-Based Services (HCBS) to Medi-Cal eligible waiver members using specific Level of Care (LOC) criteria. AB 668 added section 14132.97 to the Welfare and Institutions Code and authorized WPCS, which provides personal care services for Medi-Cal members that are eligible for the Medi-Cal Skilled Nursing Facility (NF) LOC HCBS Waiver program. WPCS include personal care services, in addition to, and that differ from those in the State Plan In-Home Supportive Services (IHSS) program, and which allow members to remain at home. Although there is no longer a requirement that waiver members receive a maximum of 283 hours of IHSS prior to receiving WPCS, waiver members must be eligible to receive State Plan IHSS hours prior to accessing this waiver service. WPCS are provided by the counties' IHSS program providers and paid via an IA with the California Department of Social Services (CDSS). The Department leverages CDSS' Case Management, Information, and Payrolling System to enroll and manage WPCS providers, and to process claims and payments.

Beginning FY 2018-19, the county, or the public authority or nonprofit consortium, as defined, deems to be the employer to meet and confer in good faith regarding wages, benefits, and other terms and conditions of employment of individuals providing WPCS. For service dates on or after the effective date of federal approval obtained by the Department, wages, benefits, and all other terms and conditions of employment for individuals providing WPCS are required to be

WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)
BASE POLICY CHANGE NUMBER: 145

equal to the wages, benefits, and other terms and conditions of employment in the respective county for the individual provider mode of services in the IHSS program. Prospective minimum wage increases for WPCS providers are budgeted in the Minimum Wage Increase for HCBS Waivers policy change. If eligibility for benefits requires a provider to work a threshold number of hours, eligibility would be required to be determined based on the aggregate number of monthly hours worked between IHSS and WPCS. Beginning FY 2019-20, WPCS care providers can access sick leave time.

Reason for Change:
This is a new policy change. The policy change costs were previously budgeted in the Home & Community-Based Alternatives Waiver policy change.

Methodology:
1. The chart below is on a cash basis.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2024-25	$437,183	$219,478	$217,705
FY 2025-26	$557,468	$279,864	$277,604

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

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

BASE POLICY CHANGE NUMBER: 147
IMPLEMENTATION DATE: 7/1991
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 26

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$447,115,000	$424,275,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$447,115,000	$424,275,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$447,115,000	$424,275,000

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.

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

BASE POLICY CHANGE NUMBER: 147

Reason for Change:
The change in FY 2024-25, from the prior estimate, is an increase due to changes in the caseload growth estimate, offset by higher than expected prior year expenditures. Rates for FY 2023-24 were higher and invoices paid in FY 2024-25 increased.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to continuing caseload growth with higher prior year expenditures in FY 2025-26.

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

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	DHCS FFP
FY 2024-25	$894,231	$447,116	**$447,115**
FY 2025-26	$848,551	$424,276	**$424,275**

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

MEDI-CAL TCM PROGRAM

BASE POLICY CHANGE NUMBER: 163
IMPLEMENTATION DATE: 6/1995
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 27

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$20,331,000	$10,885,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$20,331,000	$10,885,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$20,331,000	$10,885,000

Purpose:
This policy change estimates the federal match provided to Local Government Agencies (LGAs) for the Targeted Case Management (TCM) program.

Authority:
Welfare & Institutions Code 14132.44
SB 910 (Chapter 1179, Statutes of 1991)

Interdependent Policy Changes:
Not Applicable

Background:
The TCM program provides funding to LGAs based on certified public expenditures incurred for assisting Medi-Cal members in gaining access to needed medical, social, educational, and other services. TCM services include needs assessment, individualized service plans, referral, and monitoring/follow-up. Through rates established in the annual cost reports, LGAs submit invoices to the Department to claim federal financial participation (FFP) and receive interim payments. Counties are then required to submit annual cost reports that are audited by the Department and are used to reconcile those interim payments with a county's audited costs. Counties either receive additional funding if costs exceeded the interim payments or counties are required to reimburse the federal funds if interim payments exceeded their costs.

Additionally, effective FY 2024-25, the majority of qualifying TCM beneficiaries will be referred to California Advancing and Innovating Medi-Cal's (CalAIM) Enhanced Care Management (ECM) program. TCM providers will no longer serve Medi-Cal members who qualify for ECM, except for a few exceptions for a set limited period of time. The Department is intentionally pursuing this strategy to This will avoid duplication of services between TCM and ECM, while promoting comprehensive care management through a broader network of providers.

As a result of the COVID-19 national public health emergency, increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the

MEDI-CAL TCM PROGRAM
BASE POLICY CHANGE NUMBER: 163

increased FMAP was only available through the end of Calendar Year 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to the following reasons:

- Base payments are estimated to decrease based on updated FY 2023-24 expenditure data.
- FFCRA FMAP payments are estimated to increase based on updated data.
- Programmatic reimbursements are estimated to decrease based on updated data.
- Increased reconciliation payments are now estimated in FY 2024-25 compared to previously estimated reconciliation recoupments.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to the following reasons:

- The base payments are projected to decrease in FY 2025-26 due to the implementation of ECM related policy and transitions as of July 2024.
- No payments are estimated for FFCRA FMAP or programmatic reimbursements in FY 2025-26.
- More reconciliations recoupments are expected in FY 2025-26

Methodology:

1. SPA 10-010, approved on December 19, 2013, and effective October 16, 2010, included interim and final reconciliations of LGAs costs for providing TCM.

2. The projected base payment amounts of $15,140,000 (Regular invoices) and $3,205,000 (Affordable Care Act (ACA) invoices) for FY 2024-25 are based on the average of actual payments made in FY 2021-22, FY 2022-23, and FY 2023-24.

3. The projected base payment amounts of $10,598,000 (Regular invoices) and $2,244,000 (ACA invoices) for FY 2025-26 are based on the average of actual payments made in FY 2021-22, FY 2022-23, and FY 2023-24 reduced by 30% for the expected ECM reductions.

4. On a cash basis, the FFCRA increased FMAP of $1,119,000 is expected to be paid in FY 2024-25, and $0 in FY 2025-26.

5. Programmatic reimbursements from internal audits are estimated to be ($104,000) in FY 2024-25 and $0 in FY 2025-26.

6. In FY 2024-25 and FY 2025-26, the Department will complete reconciliations for FY 2020-21 through FY 2023-24. The Department expects to pay a net amount of $971,000 for actual/estimated audit reports during FY 2024-25. Additionally, the Department expects to receive a net amount of $1,957,000 for estimated audit reports during FY 2025-26. The Department anticipates the recoupment/payment of these amounts based on previous invoice history, reimbursement history, and history of reconciliation payments.

MEDI-CAL TCM PROGRAM
BASE POLICY CHANGE NUMBER: 163

FY 2024-25	TF	FF	COVID-19 FF
Base (Regular Expenditures)	$15,140,000	$15,140,000	$0
Base (ACA Expenditures)	$3,205,000	$3,205,000	$0
FFCRA FMAP Increase	$1,119,000	$0	$1,119,000
Programmatic Reimbursements			
Regular Claims	($104,000)	($104,000)	$0
Reconciliation			
FFCRA Claims	$2,199,000	$0	$2,199,000
Regular Claims	($1,952,000)	($1,952,000)	$0
ACA Claims	$724,000	$724,000	$0
Total FY 2024-25	**$20,331,000**	**$17,013,000**	**$3,318,000**

FY 2025-26	TF	FF	COVID-19 FF
Base (Regular Expenditures) with ECM Impact	$10,598,000	$10,598,000	$0
Base (ACA Expenditures)	$2,244,000	$2,244,000	$0
Reconciliation			
FFCRA Claims	($1,095,000)	$0	($1,095,000)
Regular Claims	($1,000,000)	($1,000,000)	$0
ACA Claims	$138,000	$138,000	$0
Total FY 2025-26	**$10,885,000**	**$11,980,000**	**($1,095,000)**

Funding:
100% Title XIX FFP (4260-101-0890)
100% Title XIX ACA (4260-101-0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)

DEVELOPMENTAL CENTERS/STATE OP SMALL FAC

BASE POLICY CHANGE NUMBER: 165
IMPLEMENTATION DATE: 7/1997
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 77

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$18,440,000	$18,581,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$18,440,000	$18,581,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$18,440,000	$18,581,000

Purpose:
This policy change estimates the federal match provided to the California Department of Developmental Services (CDDS) for Developmental Centers (DCs) and State Operated Facilities (SOFs).

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 SOFs. There are two DCs and one SOF 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 SOFs are licensed as intermediate care facilities. This policy change also includes reimbursement for the federal share of the QA fee.

The General Fund (GF) is included in the CDDS budget on an accrual basis and the federal funds in the Department's budget are on a cash basis.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to increased billing rates for the fiscal year resulting in higher monthly invoicing.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is a slight increase in billing rates and number of consumers expected in FY 2025-26.

DEVELOPMENTAL CENTERS/STATE OP SMALL FAC

BASE POLICY CHANGE NUMBER: 165

Methodology:

1. The following estimates, on a cash basis, have been provided by CDDS.

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	FFP
FY 2024-25	$36,880	$18,440	**$18,440**
FY 2025-26	$37,162	$18,581	**$18,581**

Funding:

100% Title XIX (4260-101-0890)

LAWSUITS/CLAIMS

BASE POLICY CHANGE NUMBER: 172
IMPLEMENTATION DATE: 7/2017
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2080

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$9,044,000	$1,350,000
- STATE FUNDS	$4,522,000	$675,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$9,044,000	$1,350,000
STATE FUNDS	$4,522,000	$675,000
FEDERAL FUNDS	$4,522,000	$675,000

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:
The State Legislature appropriates funds to pay the costs related to Medi-Cal lawsuits and claims. Larger lawsuit settlement amounts require both State Legislature and the Governor's approval for payment. Federal financial participation is claimed for all eligible lawsuit settlements approved by the Legislature and the Governor.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase due to additional lawsuit settlement payments expected to be made. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due to fewer lawsuit settlement payments expected to be made.

LAWSUITS/CLAIMS

BASE POLICY CHANGE NUMBER: 172

Methodology:

FY 2024-25 (rounded)	Total Amount
Other Attorney Fees	
Hinkle, et al. v. Kent, et al.	$1,550,000
American Medical Response West v. DHCS	$215,000
Leighkendall v. DHCS	$100,000
Total	**$1,865,000**
Other Provider Settlements	
Blue Cross of CA dba Anthem Blue Cross (rate settlement)	$360,000
The Pill Club Pharmacy Holdings LLC. (bankruptcy clawback)	$6,169,000
Angel Care dba Cole Homes	$650,000
Total	**$7,179,000**
FY 2024-25 Total (rounded)	**$9,044,000**

FY 2024-25			
	Committed	**Balance**	**Budgeted**
Attorney Fees <$30,000	$0	$200,000	$200,000
Provider Settlements <$100,000	$0	$1,000,000	$1,000,000
Member Settlements <$10,000	$0	$150,000	$150,000
Small Claims Court	$0	$0	$0
Other Attorney Fees	$1,865,000	N/A	$1,865,000
Other Provider Settlements	$7,179,000	N/A	$7,179,000
Other Member Settlements	$0	N/A	$0
Interest Paid	$0	$0	$0
Totals (rounded)	**$9,044,000**	**$1,350,000**	**$10,394,000**

LAWSUITS/CLAIMS

BASE POLICY CHANGE NUMBER: 172

FY 2025-26	
	Budgeted
Attorney Fees<$30,000;Provider Settlements<$100,000; Member Settlements<$10,000	$1,350,000
Other Attorney Fees	$0
Other Provider Settlements	$0
Other Member Settlements	$0
Interest Paid	$0
Totals (rounded)	**$1,350,000**

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

HIPP PREMIUM PAYOUTS (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 179
IMPLEMENTATION DATE: 1/1993
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 91

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$334,000	$351,000
- STATE FUNDS	$167,000	$175,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$334,000	$351,000
STATE FUNDS	$167,000	$175,500
FEDERAL FUNDS	$167,000	$175,500

Purpose:
This policy change estimates the cost of the payouts for the Department's Health Insurance Premium Payment (HIPP) program.

Authority:
Welfare & Institutions Code 14124.91
Social Security Act 1905(a), 1906(a)(3), 1906A(e), and 1916(e)
Title 22 California Code of Regulations 50778 (Chapter 2, Article 15)
State Plan Amendment 21-0057

Interdependent Policy Changes:
Not Applicable

Background:
The HIPP program is a voluntary program for full-scope Medi-Cal members who have a high-cost medical condition. Under the HIPP program, the Department pays for premiums, coinsurance, deductibles, and other cost sharing obligations when it is cost effective. HIPP program costs are budgeted separately from other Medi-Cal benefits since these are paid outside of the regular Medi-Cal claims payment procedures. The California Advancing and Innovating Medi-Cal (CalAIM) initiatives have required some HIPP members to enroll into managed care as of January 1, 2022. A portion of the remaining HIPP population transitioned to managed care enrollment starting January 1, 2023. Those with managed care are restricted from the HIPP program, which in turn has decreased HIPP enrollment members. Members may apply for a medical exemption from managed care enrollment. If the exemption is approved, they may remain in the HIPP program if all eligibility criteria are still met. The Department does not expect a significant change in HIPP enrollment members going forward since the HIPP population that was required to transition to managed care has done so already.

HIPP PREMIUM PAYOUTS (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 179

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to a decrease based on the FY 2023-24 actuals, which shows a steady decrease in program enrollment.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to an increase based on actual costs and the assumption that premiums and cost sharing obligations increase which is typically 5% each fiscal year based on historical trends.

Methodology:
1. HIPP premium costs are determined by:
   - Actual premium and cost share obligation expenses for July 2023 through June 2024 for the current HIPP members,
   - Using the actual amounts from FY 2023-24 to project premium and cost share obligation expenses for FY 2024-25.
     - The assumption that approximately 28 of the remaining HIPP members will continue their HIPP program eligibility.
   - To project FY 2025-26 costs, the projection is based upon the assumption that:
     - Premium costs and cost share obligation expenses will increase by 5% each fiscal year based on historical trends,
     - The population will remain stable as aforementioned.

2. The average Per Member Per Month (PMPM) cost including ancillary costs is estimated to be $995 in FY 2024-25 and $1,045 in FY 2025-26.

3. The average monthly HIPP enrollment is estimated to be 28 in both FY 2024-25 and FY 2025-26.

4. Costs for FY 2024-25 and FY 2025-26 are estimated to be:
   FY 2024-25: $995 (average PMPM cost) x 28 (estimated member count) x 12 months = $334,000 TF (rounded).

   FY 2025-26: $1,045 (average PMPM premium cost) x 28 (estimated member count) x 12 months = $351,000 TF (rounded).

Fiscal Year	TF	GF	FF
FY 2024-25	$334,000	$167,000	$167,000
FY 2025-26	$351,000	$176,000	$175,000

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

BASE RECOVERIES

BASE POLICY CHANGE NUMBER: 200
IMPLEMENTATION DATE: 7/1987
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 127

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	-$892,354,000	-$929,648,000
- STATE FUNDS	-$359,643,350	-$374,673,650
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$892,354,000	-$929,648,000
STATE FUNDS	-$359,643,350	-$374,673,650
FEDERAL FUNDS	-$532,710,650	-$554,974,350

Purpose:
This policy change estimates estate, personal injury, workers' compensation, provider/beneficiary overpayments, and other insurance recoveries used to offset the cost of Medi-Cal services.

Authority:
- Welfare & Institutions Code 10022, 14009, 14009.5, 14024, 14124.70 – 14124.795, 14124.81-14124.86, 14124.90-14124.94, 14172, 14172.5, 14173, 14176, and 14177
- Probate Code Sections 215, 9202, 19202, 3600-3605, and 3610-3613
- Title 22, California Code of Regulations Chapter 2.5 and Sections 50489.9, 50781-50791, 51045, 51047, and 51458.1
- United States Code 42, 1396a(25)

Interdependent Policy Changes:
Not Applicable

Background:
Recoveries are credited to the Health Care Deposit Fund and used to finance current obligations of the Medi-Cal program. These recoveries result from collections from personal injury or workers' compensation settlements, judgements or awards; special needs trusts; estates; provider/beneficiary overpayments; and other health insurance to offset the cost of services to Medi-Cal members in specified circumstances.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA established the increased FMAP effective January 1, 2020, and extended its availability through the last day of the calendar quarter of the national public health emergency (PHE).

BASE RECOVERIES
BASE POLICY CHANGE NUMBER: 200

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
Recovery collections vary greatly from month to month, depending on the number of provider audits completed, the financial circumstance of beneficiaries, and fluctuations in settlements, judgements, and awards.

The change in FY 2024-25, from the prior estimate, is a net increase due to:

- Health insurance collections are projected to increase due to:
    - Actual recoveries have exceeded projections for dental managed care plans, medical, and pharmacy, increasing FY 2024-25 projection levels;
    - Home health recoveries are anticipated to begin in FY 2024-25;
    - These increases are slightly offset by newborn initiative recoveries now being projected to occur in FY 2025-26.
- Provider overpayments are higher based on the historical trend absent anomalous low recovery months.
- Personal injury collections are lower due to a decrease in settlement amounts awarded and court judgements obtained starting in March 2024, which lowered the overall trend projection.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to:

- Health insurance collections are anticipated to increase due to the start of the newborn initiative recoveries, run out collections during the contract turn over period, and the resumption of collections under the new contract in FY 2025-26. This estimate assumes that recoveries will remain stable with the new contract beginning December 1, 2025.
- Provider overpayments are higher based on the historical trend absent anomalous low recovery months.

BASE RECOVERIES
BASE POLICY CHANGE NUMBER: 200

Methodology:

1. The Title XIX COVID-19 increased FMAP is assumed for recoveries through December 31, 2023 for this policy change.

2. The recoveries estimate uses the trend in monthly recoveries for July 2021 – July 2024.

(Dollars in Thousands)

Recovery Type	FY 2024-25	FY 2025-26
Personal Injury Collections	($147,399)	($147,405)
Workers' Comp. Collections	($3,923)	($3,926)
Health Insurance Collections	($356,000)	($384,800)
General Collections	($385,032)	($393,517)
TOTAL	**($892,354)**	**($929,648)**

Funding:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	($683,294)	($341,647)	($341,647)
Title XIX 65 FF / 35 GF (4260-101-0890/0001)	($16,871)	($5,905)	($10,966)
Title XIX FFP (4260-101-0890)	($21,294)	$0	($21,294)
90% Title XIX ACA FF / 10% GF (4260-101-0890/0001)	($170,895)	($17,090)	($153,806)
COVID-19 Title XIX Increased FFP (4260-101-0890)	($4,333)	$0	($4,333)
COVID-19 Title XIX GF (4260-101-0001)	$4,333	$4,333	$0
COVID-19 BCCTP Title XIX Increase FFP (4260-101-0890)	($665)	$0	($665)
COVID-19 BCCTP Title XIX GF (4260-101-0001)	$665	$665	$0
TOTAL	**($892,354)**	**($359,643)**	**($532,711)**

BASE RECOVERIES
BASE POLICY CHANGE NUMBER: 200

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	($711,850)	($355,925)	($355,925)
Title XIX 65 FF / 35 GF (4260-101-0890/0001)	($17,577)	($6,152)	($11,425)
Title XIX FFP (4260-101-0890)	($22,184)	$0	($22,184)
90% Title XIX ACA FF / 10% GF (4260-101-0890/0001)	($178,037)	($17,804)	($160,233)
COVID-19 Title XIX Increased FFP (4260-101-0890)	($4,514)	$0	($4,514)
COVID-19 Title XIX GF (4260-101-0001)	$4,514	$4,514	$0
COVID-19 BCCTP Title XIX Increase FFP (4260-101-0890)	($693)	$0	($693)
COVID-19 BCCTP Title XIX GF (4260-101-0001)	$693	$693	$0
TOTAL	**($929,648)**	**($374,673)**	**($554,975)**

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REGULAR POLICY CHANGES

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

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CALAIM - INMATE PRE-RELEASE PROGRAM

REGULAR POLICY CHANGE NUMBER: 1
IMPLEMENTATION DATE: 10/2024
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2332

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$48,758,000	$146,073,000
- STATE FUNDS	$16,578,000	$35,937,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$48,758,000	$146,073,000
STATE FUNDS	$16,578,000	$35,937,000
FEDERAL FUNDS	$32,180,000	$110,136,000

Purpose:
This policy change estimates the cost for the development, implementation, ongoing maintenance, and operation, of certain California Advancing & Innovating Medi-Cal (CalAIM) initiatives involving justice-involved populations.

Authority:
Penal Code Section 4011.11
Welfare & Institutions Code Sections 14011.10, 14132.275, 14184.800, and 14186
AB 133 (Chapter 143, Statutes of 2021)

Interdependent Policy Change:
Not Applicable

Background:
California is requesting federal authority necessary to implement CalAIM, a framework that encompasses broad-based delivery system, program and payment reform across the Medi-Cal program. CalAIM recognizes the opportunity to move California's whole-person care approach – first authorized by the Medi-Cal 2020 Section 1115 demonstration – to a statewide level, with a clear focus on improving health and reducing health disparities and inequities. Collectively, the Section 1115 CalAIM demonstration and Section 1915(b) waiver, along with related contractual and Medi-Cal State Plan changes, will enable California to fully execute the CalAIM initiative, providing benefits to certain high needs, hard-to-reach populations, with the objective of improving health outcomes for Medi-Cal members and other low-income people in the state.

Inmates leaving correctional facilities are at extremely high risk of poor outcomes due to high rates of mental illness, substance use disorders, complex medical conditions, and unmet social needs such as housing insecurity, unemployment, and inadequate social connections. CalAIM proposes to improve outcomes for this population by mandating county inmate pre-release application processes, allowing Medi-Cal reimbursement for services in the 90-day time period prior to release, and to ensure a facilitated referral and linkage ("warm hand-off") to behavioral health services, both to providers in managed care networks and to county behavioral health departments.

CALAIM - INMATE PRE-RELEASE PROGRAM

REGULAR POLICY CHANGE NUMBER: 1

This policy change estimates costs for CalAIM Pre-Release Services up-to-90 days prior to release:

- To provide targeted Medi-Cal services to eligible justice-involved populations up to 90-days pre-release no sooner than October 1, 2024, which includes: care management/care coordination; community-based physical and behavioral health clinical consultation services provided via telehealth or, optionally, in-person as needed, including behavioral health referrals/linkages; medications for addiction treatment (also known as medication-assisted treatment or MAT), medications for mental health diagnoses; and other medications to stabilize chronic and significant conditions, associated laboratory/radiology services; and for use post-release into the community a supply of medication (according to the applicable Medi-Cal policy duration for individual medications) and necessary Durable Medical Equipment.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a slight increase due to updated payment timing assumptions. The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to more months of costs and additional ramp up in FY 2025-26 as the program implements on October 1, 2024.

Methodology:
1. Assume Pre-Release Services up-to-90 days prior to release (including Behavioral Health Referrals/Linkages) policies implement no sooner than October 1, 2024.

2. Total estimated costs for FY 2024-25 and FY 2025-26 are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2024-25	$48,758	$16,578	$32,180
FY 2025-26	$146,073	$35,937	$110,136

Funding:
100% GF (4260-101-0001)
100% Title XIX FF (4260-101-0890)

MEDI-CAL STATE INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 2
IMPLEMENTATION DATE: 12/2016
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 1569

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$38,066,000	$38,037,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$38,066,000	$38,037,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$38,066,000	$38,037,000

Purpose:
This policy change estimates the federal financial participation (FFP) provided to the California Department of Corrections and Rehabilitation (CDCR)/California Correctional Health Care Services (CCHCS) for the costs of providing inpatient services for adult inmates who are enrolled in 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)
SB 184 (Chapter 47, Statutes of 2022)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
AB 1628 (Chapter 729, Statutes of 2010) authorizes the Department and the CDCR to:

- Claim FFP for inpatient hospital services to Medi-Cal enrolled adult inmates in State correctional facilities when these services are provided off the grounds of the facility. Previously these services were paid by the CDCR with 100% General Fund (GF). Effective April 1, 2011, the Department began accepting Medi-Cal applications from the CCHCS for eligibility determinations for State inmates, retroactive to November 1, 2010. The Department will budget the FFP for services and CCHCS administrative costs and the CCHCS will continue to budget the GF.

SB 1399 (Chapter 405, Statutes of 2010) authorizes the Board of Parole Hearings to:

- Grant medical parole to permanently medically incapacitated State inmates. State inmates granted medical parole are potentially eligible for Medi-Cal. When a State inmate is granted medical parole, the CCHCS submits a Medi-Cal application to the

MEDI-CAL STATE INMATE PROGRAMS
REGULAR POLICY CHANGE NUMBER: 2

Department to determine eligibility. Previously this service was funded through the CDCR with 100% GF.

SB 184 (Chapter 47, Statutes of 2022) requires County Welfare Departments to suspend Medi-Cal benefits for all inmates of a public institution for the duration of their incarceration. State law requires the suspension of Medi-Cal benefits for any individual, regardless of age, who is a Medi-Cal member at the time of their incarceration. This amendment allows counties to activate suspended Medi-Cal benefits upon release from the public institution without requiring a new application, as long as they remain otherwise eligible for Medi-Cal throughout their incarceration.

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

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

As a result of the Coronavirus Disease 2019 (COVID-19) national public health emergency, increased Federal Medical Assistance Percentage (FMAP) was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is a decrease due to updated actuals based on current invoices from FY 2023-24. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a slight decrease due to increased FMAP as a result of COVID-19 ending in FY 2024-25.

Methodology:
1. The adult State inmate program began in November 2010. Eligibility began in April 2011 with claiming beginning in April 2012. The Medical Parole program began in June 2011 with claiming beginning in April 2013.

2. Estimated costs for FY 2024-25 and FY 2025-26 are annualized projections primarily based on actual claims data for FY 2023-24. An average of the highest two quarters was used as the basis for the projection.

3. Assume a six-month lag in ongoing payments.

4. The Non-Federal share for this policy change is budgeted in the CDCR's budget. Included below is the total estimated FFP for the Medi-Cal Inpatient Hospital Costs for all eligible (Non-ACA and ACA) adult inmates in FY 2024-25 and FY 2025-26.

MEDI-CAL STATE INMATE PROGRAMS
REGULAR POLICY CHANGE NUMBER: 2

FY 2024-25	TF	FF
Adults - Non-ACA	$14,039,000	$7,020,000
Adults - ACA	$34,073,000	$30,975,000
Medical Parole – Non-ACA	$85,000	$42,000
Medical Parole – ACA	$0	$0
COVID-19 Tile XXI Increased FMAP	$29,000	$29,000
Total FY 2024-25	$48,226,000	**$38,066,000**
FY 2025-26	**TF**	**FF**
Adults - Non-ACA	$14,039,000	$7,020,000
Adults - ACA	$34,073,000	$30,975,000
Medical Parole – Non-ACA	$85,000	$42,000
Medical Parole – ACA	$0	$0
Total FY 2025-26	**$48,197,000**	**$38,037,000**

*Totals may differ due to rounding.

Funding:
100% Title XIX FFP (4260-101-0890)
100% Title XIX ACA FF (4260-101-0890)
COVID-19 Title XIX Increased FMAP (4260-101-0890)

BREAST AND CERVICAL CANCER TREATMENT

REGULAR POLICY CHANGE NUMBER: 3
IMPLEMENTATION DATE: 1/2002
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 3

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$19,736,000	$15,862,000
- STATE FUNDS	$9,491,400	$8,138,350
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$19,736,000	$15,862,000
STATE FUNDS	$9,491,400	$8,138,350
FEDERAL FUNDS	$10,244,600	$7,723,650

Purpose:
This policy change estimates the fee-for-service (FFS) and Managed Care costs of the Breast and Cervical Cancer Treatment Program (BCCTP).

Authority:
AB 430 (Chapter 171, Statutes of 2001)
AB 1810 (Chapter 34, Statutes of 2018)
AB 133 (Chapter 143, Statutes of 2021)
Senate Bill (SB) 184 (Chapter 47, Statutes of 2022)

Interdependent Policy Changes:
Not Applicable

Background:
AB 430 authorized the BCCTP effective January 1, 2002, for individuals at or below 200% of the federal poverty level. Enhanced Title XIX Medicaid funds (65% FF / 35% GF) may be claimed under the federal Medicaid Breast and Cervical Cancer Treatment Act of 2000 (P.L. 106-354) for cancer treatment and full scope Medi-Cal benefits for individuals under 65 years of age who are citizens or legal immigrants with no other health coverage. Every Woman Counts and Family Planning, Access, Care, and Treatment (Family PACT) providers screen members.

A State-Only program covers individuals 65 years of age or older regardless of immigration status, individuals who are underinsured, undocumented women, and males for breast cancer treatment only. In FY 2017-18 the coverage term was 18 months for breast cancer and 24 months for cervical cancer, however, coverage limits were removed through AB 1810 beginning in FY 2018-19. Estimated State-Only costs include undocumented individuals' non-emergency services during cancer treatment. With the implementation of the Affordable Care Act (ACA) in January 2014, some BCCTP members now have other coverage options available through Covered California and the Individual Insurance Market.

BREAST AND CERVICAL CANCER TREATMENT
REGULAR POLICY CHANGE NUMBER: 3

Effective July 1, 2018, Health Omnibus Trailer Bill, AB 1810 (Chapter 34, Statutes of 2018) signed June 27, 2018, appropriated funding to the General Fund for the elimination of the 18 and 24-month treatment limitations.

Effective May 1, 2022, AB 133, (Chapter 143, Statutes of 2021) granted full-scope Medi-Cal to adults who are 50 years of age and older. AB 133 also eliminated the asset limits for all non-Modified Adjusted Gross Income (MAGI) Medi-Cal programs, including Medicare Savings Programs and Long-Term Care effective January 1, 2024. Effective January 1, 2024, SB 184, Chapter 47, granted full-scope Medi-Cal to adults who are 26-49 years of age.

Reason for Change:
There is a decrease from the prior estimate for FY 2024-25, and from FY 2024-25 to FY 2025-26 in the current estimate, due to decreased enrollment resulting from full scope Medi-Cal expansions, the continuous coverage requirements unwinding, and the asset limit repeal for all non-MAGI programs.

Methodology:
1. Assume a total of 1,100 members, of which 80 were in FFS and 1,020 were in managed care. Additionally, approximately two of the FFS members and three of the managed care members were eligible for State-Only services.

2. Due to SB 184, of the 1,100 individuals currently in BCCTP coverage, 100 individuals will transfer to county Medi-Cal from BCCTP. Project a total of 1,000 active individuals in BCCTP coverage effective January 1, 2025, with 75 individuals in FFS and 925 individuals in managed care. Additionally, approximately one of the FFS individuals and two of the managed care individuals are eligible for State-Only services.

3. Assume none of the members were in accelerated enrollment.

4. Assume the State will pay Medicare and other health coverage premiums for an average of 170 members monthly in FY 2024-25 and in FY 2025-26. Assume an average monthly premium cost per members of $86.49.

5. Assume 45% of members will require a third year of treatment, and 20% of those members will require a fourth year of treatment.

6. Assume Managed Care costs associated with the BCCTP are budgeted in this policy change. Assume an average, weighted monthly costs of $849.88 in FY 2024-25 and $893.31 in FY 2025-26 for Managed Care members.

7. FFS and Managed Care costs are estimated as follows:

BREAST AND CERVICAL CANCER TREATMENT

REGULAR POLICY CHANGE NUMBER: 3

FY 2024-25	TF	GF	FF
Full Scope FFS Costs	$9,056,000	$3,270,000	$5,787,000
FFS State-Only Services	$569,000	$569,000	$0
FFS State-Only Premiums	$177,000	$177,000	$0
Full Scope Managed Care Costs	$8,719,000	$4,261,000	$4,458,000
Managed Care State-Only Services	$1,215,000	$1,215,000	$0
Total	**$19,736,000**	**$9,492,000**	**$10,245,000**
FY 2025-26	**TF**	**GF**	**FF**
Full Scope FFS Costs	$5,286,000	$1,956,000	$3,330,000
FFS State-Only Services	$607,000	$607,000	$0
FFS State-Only Premiums	$177,000	$177,000	$0
Full Scope Managed Care Costs	$8,595,000	$4,201,000	$4,394,000
Managed Care State-Only Services	$1,197,000	$1,197,000	$0
Total	**$15,862,000**	**$8,138,000**	**$7,724,000**

* Totals differ due to rounding.

Funding:

FY 2024-25	TF	GF	FF
100% General Fund (4260-101-0001)	$1,960,000	$1,960,000	$0
50% Title XIX FFP / 50% GF (4260-101-0890/0001)	$8,732,000	$4,366,000	$4,366,000
65% Title XIX FFP/ 35% GF (4260-101-0890/0001)	$9,044,000	$3,166,000	$5,878,000
Total	**$19,736,000**	**$9,492,000**	**$10,245,000**
FY 2025-26	**TF**	**GF**	**FF**
100% General Fund (4260-101-0001)	$1,981,000	$1,981,000	$0
50% Title XIX FFP / 50% GF (4260-101-0890/0001)	$8,660,000	$4,330,000	$4,330,000
65% Title XIX FFP/ 35% GF (4260-101-0890/0001)	$5,221,000	$1,827,000	$3,394,000
Total	**$15,862,000**	**$8,138,000**	**$7,724,000**

* Totals differ due to rounding.

HEALTH ENROLLMENT NAVIGATORS FOR CLINICS

REGULAR POLICY CHANGE NUMBER: 4
IMPLEMENTATION DATE: 12/2023
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2422

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$7,490,000	$7,510,000
- STATE FUNDS	$3,745,000	$3,755,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$7,490,000	$7,510,000
STATE FUNDS	$3,745,000	$3,755,000
FEDERAL FUNDS	$3,745,000	$3,755,000

Purpose:
This policy change estimates the funding provided specifically to Community Health Centers (CHCs) and Regional Clinic Associations (RCAs) for providing culturally and linguistically appropriate health navigation tied to the COVID-19 Public Health Emergency Unwinding efforts to ensure Medi-Cal eligible individuals enroll or retain coverage.

Authority:
AB 102 (Chapter 38, Statutes of 2023)

Interdependent Policy Changes:
Not Applicable

Background:
CHCs and RCAs play a vital role in assisting counties to reach out to marginalized populations and help eligible individuals apply and successfully complete the health coverage enrollment process, retain coverage, navigate the health care system, and gain timely access to medical care through community-based care management.

This funding for outreach, enrollment, retention, and community-based assistance with utilization and care management will help Medi-Cal eligible individuals enroll or maintain enrollment in health care coverage and have access to the care they need.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a decrease due to some claims shifting from FY 2024-25 into FY 2025-26 for payment. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a slight increase due to projecting more claims to be processed in FY 2025-26.

Methodology:
1. A prime contractor implementation occurred on October 1, 2023.

HEALTH ENROLLMENT NAVIGATORS FOR CLINICS
REGULAR POLICY CHANGE NUMBER: 4

2. Assume local CHCs and RCAs will conduct outreach, enrollment, and retention activities in their applicable area and will receive supplemental funding.

3. Implementation started in December 2023, and will continue through June 2025. Close-out will occur through June 2026.

4. The Budget Act for FY 2023-24 provided $20 million TF ($10 million GF). The table below displays the estimated spending and remaining funds by Appropriation Year:

(Dollars in Thousands)

Appropriation Year 2023-24	**TF**	**GF**	**FF***
Prior Years	$5,000	$2,500	$2,500
Estimated in FY 2024-25	$7,490	$3,745	$3,745
Estimated in FY 2025-26	$7,510	$3,755	$3,755
Total Estimated Remaining	$0	$0	$0

*Federal funds authority is newly requested for the fiscal year in which funds are anticipated to be expended.

5. Total estimated costs for FY 2024-25 and FY 2025-26 are:

(Dollars in Thousands)

FY 2024-25	**TF**	**GF**	**FF***
Appropriation Year 2023-24	$7,490	$3,745	$3,745
Total FY 2024-25	**$7,490**	**$3,745**	**$3,745**

FY 2025-26	**TF**	**GF**	**FF***
Appropriation Year 2023-24	$7,510	$3,755	$3,755
Total FY 2025-26	**$7,510**	**$3,755**	**$3,755**

*Federal funds authority is newly requested for the fiscal year in which funds are anticipated to be expended.

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

NON-OTLICP CHIP

REGULAR POLICY CHANGE NUMBER: 6
IMPLEMENTATION DATE: 12/1998
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 13

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$106,656,300	-$107,574,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$106,656,300	-$107,574,600
FEDERAL FUNDS	$106,656,300	$107,574,600

Purpose:
This policy change estimates the technical adjustment in funding for the Non-Optional Targeted Low Income Children's Program (OTLICP) population of the Children's Health Insurance Program (CHIP) as described below. Expenditures are adjusted from Title XIX 50% federal financial participation (FFP) to enhanced Title XXI FFP.

Authority:
SB 903 (Chapter 624, Statutes of 1997)
42 CFR 435.907(e)

Interdependent Policy Changes:
Not Applicable

Background:
Medi-Cal has multiple CHIP eligibility categories. The largest is OTLICP which is budgeted throughout the Estimate. The other CHIP eligibility categories are budgeted in this policy change.

- Resource Disregard Program: Prior to the implementation of the Affordable Care Act (ACA), Medi-Cal had asset limitations where families that exceeded it were eligible through the CHIP Resource Disregard Program. However, the ACA requires that states raise the minimum income level to at least 133 percent of the federal poverty level (FPL) and remove the Medicaid asset test for children, effective January 1, 2014. These changes allow certain children who would not have been eligible for Medicaid under the State Plan in effect on March 31, 1997, to now be eligible for Medicaid. Until these children transition out of the associated aid codes, the Department continues to budget the adjustment in this policy change (aid codes 8N, 8P, 8R, 8T).

- Medicaid Expansion: This CHIP population exceeds the Medicaid FPL limit and are below the OTLICP FPL (aid codes M5, M6).

NON-OTLICP CHIP
REGULAR POLICY CHANGE NUMBER: 6

- Hospital Presumptive Eligibility (HPE): Effective January 1, 2016, the ACA requires the Department to give hospitals the option to determine HPE for Medicaid. The HPE Program offers qualified individuals immediate access to temporary Medi-Cal while applying for permanent Medi-Cal coverage or other health coverage. CHIP coverage extends to a portion of HPE (aid codes H0, H6, H9).

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a General Fund (GF) savings decrease due to a decrease in estimated expenditures. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a slight GF savings increase due to an increase in estimated expenditures.

Methodology:
1. It is assumed the estimated costs of the HPE, Medicaid Expansion, and Resource Disregard aid codes will be $711,042,000 TF in FY 2024-25 and $717,164,000 TF in FY 2025-26.

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. Beginning October 1, 2020, estimated costs are eligible for Title XXI 65/35 FMAP.

3. Total estimated costs for FY 2024-25 and FY 2025-26 are:

FY 2024-25	**TF**	**GF**
Resource Disregard	$27,000	($4,000)
HPE	$5,334,000	($800,000)
Medicaid Expansion	$705,681,000	($105,852,000)
Total Cost	**$711,042,000**	**($106,656,000)**

FY 2025-26	**TF**	**GF**
Resource Disregard	$27,000	($5,000)
HPE	$5,043,000	($756,000)
Medicaid Expansion	$712,094,000	($106,814,000)
Total Cost	**$717,164,000**	**($107,575,000)**

Funding:

FY 2024-25	**TF**	**GF**	**FF**
50% Title XIX FF/50% GF (4260-101-0890/0001)	($711,042,000)	($355,521,000)	($355,521,000)
65% Title XXI FF/35% GF (4260-101-0890/0001)	$711,042,000	$248,865,000	$462,177,000
Net Impact (rounded)	**$0**	**($106,656,000)**	**$106,656,000**

NON-OTLICP CHIP
REGULAR POLICY CHANGE NUMBER: 6

FY 2025-26	TF	GF	FF
50% Title XIX FF / 50% GF (4260-101-0890/0001)	($717,164,000)	($358,582,000)	($358,582,000)
65% Title XXI FF / 35% GF (4260-101-0890/0001)	$717,164,000	$251,007,000	$466,157,000
Net Impact (rounded)	**$0**	**($107,575,000)**	**$107,575,000**

NON-EMERGENCY FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 7
IMPLEMENTATION DATE: 12/1997
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 15

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$3,054,378,750	$3,054,378,750
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$3,054,378,750	$3,054,378,750
FEDERAL FUNDS	-$3,054,378,750	-$3,054,378,750

Purpose:
This policy change is a technical adjustment to shift funds from Title XIX and Title XXI federal financial participation (FFP) to 100% General Fund (GF) because the Department cannot claim FFP for non-emergency health care expenditures for nonexempt New Qualified Immigrants (NQI) subject to the five-year bar, Permanent Residence Under the Color of Law (PRUCOL), undocumented children and adults.

Authority:
HR 3734 (1996), Personal Responsibility and Work Opportunity Act (PRWORA)
Welfare & Institutions Code 14007.5
SB 75 (Chapter 18, Statutes of 2015)
SB 104 (Chapter 67, Statutes of 2019)
AB 184, (Chapter 47, Statutes of 2022)

Interdependent Policy Changes:
Not Applicable

Background:
HR 3734 (1996), PRWORA, specifies that FFP is not available for full-scope Medi-Cal services for qualified, nonexempt immigrants who have resided in the United States for less than five years. Currently, FFP is only available for emergency and pregnancy services. California provides full scope Medi-Cal services to eligible, nonexempt, qualified immigrants; however, non-emergency services that are not pregnancy related are 100% State funded.

Previously, California provided restricted-scope Medi-Cal coverage (emergency and pregnancy related services only) to many low-income undocumented children and young adults. FFP was available, regardless of immigration status, for emergency and pregnancy related services. Full scope Medi-Cal benefits became available for individuals who did not have satisfactory immigration status or were unable to verify satisfactory immigration status or citizenship effective:

- May 16, 2016, for individuals under the age of 19.
- January 1, 2020, for individuals 19 through 25 years of age.
- May 1, 2022, for individuals over 50 years of age or older.

NON-EMERGENCY FUNDING ADJUSTMENT
REGULAR POLICY CHANGE NUMBER: 7

- January 1, 2024, for individuals 26 through 49 years of age.

California will continue to receive FFP for the emergency and pregnancy related services; however, any non-emergency services provided will be ineligible for FFP and funded solely by the State's GF.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase due a projected increase in costs. There is no change from FY 2024-25 to FY 2025-26 in the current estimate.

Methodology:
1. Based on updated January 2024 through June 2024 FFS expenditure reports of non-emergency services provided to this population, the Department estimates the following non-emergency FFS costs will be $4,595,743,000 TF in FY 2024-25 and FY 2025-26.

2. Managed care costs shifted into the managed care base policy changes beginning FY 2023-24.

3. The impact of the State Children's Health Insurance Program (SCHIP) funding for prenatal care for new qualified immigrants is included in the SCHIP Funding for the Prenatal Care policy change.

4. The estimated FFP Repayment in FY 2024-25 and FY 2025-26:

(Dollars in Thousands)

FFS Costs	FY 2024-25		FY 2025-26	
	TF	FF Repayment	TF	FF Repayment
All Others (50% FF / 50% GF)	$2,629,323	$1,314,661	$2,629,323	$1,314,661
All Others (65% FF / 35% GF)	$11,246	$7,310	$11,246	$7,310
All Others (Title XXI)	$108,997	$70,848	$108,997	$70,848
ACA	$1,846,177	$1,661,559	$1,846,177	$1,661,559
Total	$4,595,743	**$3,054,378**	$4,595,743	**$3,054,378**

Funding:
50% Title XIX FF / 50% GF (4260-101-0890/0001)
65% Title XIX FF / 35% GF (4260-101-0890/0001)
100% GF (4260-101-0001)
90% Title XIX ACA / 10% GF (4260-101-0890/0001)

SCHIP FUNDING FOR PRENATAL CARE

REGULAR POLICY CHANGE NUMBER: 8
IMPLEMENTATION DATE: 7/2005
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 1007

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$70,822,050	-$70,822,050
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$70,822,050	-$70,822,050
FEDERAL FUNDS	$70,822,050	$70,822,050

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

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

Interdependent Policy Changes:
Not Applicable

Background:
AB 131 required the Department to submit a State Plan Amendment to claim CHIP federal funding for prenatal care for women with unsatisfactory immigration status and legal immigrants through the Medi-Cal Program and the Medi-Cal Access Infants Program. Previously, these costs for prenatal care were funded with 100% General Fund for the Medi-Cal Program. California draws down federal CHIP funding through the Title XXI unborn option for both programs.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a decrease in General Fund savings due to a decrease in prenatal costs. There is no change from FY 2024-25 to FY 2025-26 in the current estimate.

Methodology:
1. Assume the FMAP for Title XXI is 65% FF and 35% GF beginning October 1, 2020.

2. The total fund cost of prenatal care for undocumented and legal immigrant women is estimated to be:

SCHIP FUNDING FOR PRENATAL CARE

REGULAR POLICY CHANGE NUMBER: 8

(Dollars in Thousands)

FY 2024-25	**$108,957**
FY 2025-26	**$108,957**

Funding:
(Dollars in Thousands)

FY 2024-25	**Fund Number**	**TF**	**GF**	**FF**
100% State GF	4260-101-0001	($108,957)	($108,957)	$0
Title XXI 65% FF / 35% GF	4260-101-0890/0001	$108,957	$38,135	$70,822
Net Impact		**$0**	**($70,822)**	**$70,822**
FY 2025-26	**Fund Number**	**TF**	**GF**	**FF**
100% State GF	4260-101-0001	($108,957)	($108,957)	$0
Title XXI 65% FF / 35% GF	4260-101-0890/0001	$108,957	$38,135	$70,822
Net Impact		**$0**	**($70,822)**	**$70,822**

MEDI-CAL COUNTY INMATE REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 9
IMPLEMENTATION DATE: 2/2018
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2029

	FY 2024-25	FY 2025-26
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

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)
AB 80 (Chapter 12, Statutes of 2020)
SB 184 (Chapter 47, Statutes of 2022)

Interdependent Policy Changes:
Not Applicable

Background:
AB 1628 (Chapter 729, Statutes of 2010) authorizes the Department and counties to:

- Claim FFP for inpatient hospital services for Medi-Cal enrolled adult inmates in county correctional facilities when these services are provided off the grounds of the facility. Previously these services were paid by the county.

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

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

SB 1462 (Chapter 837, Statutes of 2012) authorizes a county sheriff, or his/her designee, to:

- Release certain prisoners (compassionate release) from a county correctional facility and request that a court grant medical probation, or resentencing in lieu of jail time, to certain county inmates. Counties are responsible for paying the non-federal share of costs associated with providing care to inmates compassionately released or granted

MEDI-CAL COUNTY INMATE REIMBURSEMENT
REGULAR POLICY CHANGE NUMBER: 9

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.

AB 80 (Chapter 12, Statutes of 2020) conforms the suspension of benefits for juveniles, as defined under state law, with the existing federal law, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act). The definition of juvenile has changed (both State and County) to include individuals under the age of 21 or individuals enrolled in the former foster youth group under the age of 26. “Eligible Juveniles”, as defined by the SUPPORT Act, only impacts Medi-Cal suspension of benefits policies and does not impact eligibility age restrictions or age requirements for general Medi-Cal programs.

SB 184 (Chapter 47, Statutes of 2022) requires County Welfare Departments to suspend Medi-Cal benefits for all inmates of a public institution for the duration of their incarceration. State law requires the suspension of Medi-Cal benefits for any individual, regardless of age, who is a Medi-Cal member at the time of their incarceration. This amendment allows counties to activate suspended Medi-Cal benefits upon release from the public institution without requiring a new application, as long as they remain otherwise eligible for Medi-Cal throughout their incarceration.

For county inmates, counties may participate in the MCIP that will allow coverage for specified services to Medi-Cal enrolled 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 enrolled inmates.

Claims processed by the FI are paid with GF and federal funds (FF). The Department will invoice counties for the GF share of the medical costs associated with the county Medi-Cal eligible inmate on a quarterly basis. The fourth quarter reimbursement will be received the following fiscal year; therefore, a GF impact will occur each year.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase due to capturing more recent paid claims data. The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to updated claims data projecting an increase for FY 2025-26.

Methodology:
1. Claims with dates of services beginning April 1, 2017, will be processed by the FI.

2. The Department will invoice the counties on a quarterly basis for the GF share of the medical costs; therefore, the fourth quarter reimbursement will be received the following fiscal year, and as a result the GF impact and reimbursement per FY will not match.

MEDI-CAL COUNTY INMATE REIMBURSEMENT
REGULAR POLICY CHANGE NUMBER: 9

3. The GF column represents the amount of GF spent and the reimbursement column represents the amount recouped from the counties for the GF amount.

4. The Department makes federal fund payments to all hospital types including Designated Public Hospitals (DPH), Non-Designated Public Hospitals (NDPH), and private hospitals, however GF is only paid out to the NDPH and private hospitals, therefore no GF recoupment takes place for the DPHs as payments to DPHs are only federal funds.

5. The total estimated GF reimbursement in FY 2024-25 and FY 2025-26 will be:

FY 2024-25	GF	Reimbursement
Non ACA	$659,000	$646,000
ACA	$1,007,000	$1,002,000
Juvenile	$1,000	$2,000
Compassionate Release – Non ACA	$67,000	$51,000
Compassionate Release - ACA	$1,000	$2,000
Total	$1,735,000	**$1,703,000**

FY 2025-26	GF	Reimbursement
Non ACA	$692,000	$684,000
ACA	$1,057,000	$1,045,000
Juvenile	$1,000	$1,000
Compassionate Release – Non ACA	$70,000	$70,000
Compassionate Release - ACA	$2,000	$2,000
Total	$1,822,000	**$1,802,000**

*Totals may differ due to rounding.

Funding:
100% GF (4260-101-0001)
Reimbursement GF (4260-610-0995)

CS3 PROXY ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 10
IMPLEMENTATION DATE: 4/2017
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2155

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$67,383,500	-$67,428,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$67,383,500	-$67,428,500
FEDERAL FUNDS	$67,383,500	$67,428,500

Purpose:
This policy change estimates the technical adjustment in funding for the Non-Optional Targeted Low Income Children's Program (OTLICP) population of the Children's Health Insurance Program (CHIP) as described below. Expenditures are adjusted from Title XIX 50% federal financial participation (FFP) to enhanced Title XXI FFP.

Authority:
SB 903 (Chapter 624, Statutes of 1997)
42 CFR 435.907(e)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
Medi-Cal has multiple CHIP eligibility categories. The largest is OTLICP which is budgeted throughout the Estimate.

California was granted a proxy methodology (CS3-Proxy) to claim enhanced federal medical assistance percentage (FMAP) for children formerly eligible for CHIP who are now eligible for Medicaid. Due to the ACA and pursuant to 42 CFR 435.907(e), California may not collect information concerning asset eligibility. Due to the modified asset test rules, the State cannot determine which children are only eligible for Medicaid and would have received CHIP funding. The CS3-Proxy aims to provide the same level of CHIP funding as before this change.

As a result of the Coronavirus Disease 2019 (COVID-19) national public health emergency, increased FMAP was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

CS3 PROXY ADJUSTMENT
REGULAR POLICY CHANGE NUMBER: 10

Reason for Change:
The change for FY 2024-25, from the prior estimate, is a General Fund (GF) savings increase due to updated actuals based on recent adjustment memos. The change from FY 2024-25 to FY 2025-26, in the current estimate, is negligible due to the COVID-19 increased FMAP being captured in FY 2024-25.

Methodology:
1. Effective FY 2020-21, assume a two-quarter adjustment lag.

2. This adjustment shifts funding from Title XIX federal funds with a 50% GF match to Title XXI federal funds with a 35% GF match for claims after October 1, 2020.

3. Assume increased FMAP due to the COVID-19 public health emergency is available in FY 2024-25 for one quarter of Fee-for-Service claims.

4. Total estimated costs for FY 2024-25 and FY 2025-26 are:

(Dollars in Thousands)

Fiscal Years	TF	GF	FF
FY 2024-25	**$0**	**($67,383)**	**$67,383**
FY 2025-26	**$0**	**($67,428)**	**$67,428**

Funding:
(Dollars in Thousands)

FY 2024-25	Fund Number	TF	GF	FF
50% Title XIX / 50% GF	4260-101-0890/0001	($304,270)	($152,135)	($152,135)
65% Title XXI / 35% GF	4260-101-0890/0001	$304,270	$106,495	$197,775
Title XIX FF	4260-101-0890	($72,628)	$0	($72,628)
Title XIX GF	4260-101-0001	$72,628	$72,628	$0
Title XXI FF	4260-101-0890	$94,416	$0	$94,416
Title XXI GF	4260-101-0001	($94,416)	($94,416)	$0
COVID-19 Title XIX Increased FMAP	4260-101-0890/0001	$0	$149	($149)
COVID-19 Title XXI Increased FMAP	4260-113-0890/0001	$0	($104)	$104
Net Impact (rounded)		**$0**	**($67,383)**	**$67,383**

* Totals may differ due to rounding

CS3 PROXY ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 10

(Dollars in Thousands)

FY 2025-26	Fund Number	TF	GF	FF
50% Title XIX / 50% GF	4260-101-0890/0001	($304,270)	($152,135)	($152,135)
65% Title XXI / 35% GF	4260-101-0890/0001	$304,270	$106,495	$197,775
Title XIX FF	4260-101-0890	($72,628)	$0	($72,628)
Title XIX GF	4260-101-0001	$72,628	$72,628	$0
Title XXI FF	4260-101-0890	$94,416	$0	$94,416
Title XXI GF	4260-101-0001	($94,416)	($94,416)	$0
Net Impact (rounded)		**$0**	**($67,428)**	**$67,428**

* Totals may differ due to rounding

REFUGEE MEDICAL ASSISTANCE

REGULAR POLICY CHANGE NUMBER: 11
IMPLEMENTATION DATE: 11/2020
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2237

	FY 2024-25	FY 2025-26
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

Purpose:
This policy change estimates the refugees' medical expenditures to be reimbursed by the California Department of Public Health (CDPH).

Authority:
Interagency Agreement (IA) 22-20415

Interdependent Policy Changes:
Not Applicable

Background:
Full federal funding is available through the Refugee Resettlement Program (RRP) for medical services provided to refugees in Refugee Medical Assistance (aid code 02) during their first 12 months in the United States. The RRP federal grant is administered by CDPH, which has program responsibility through the Refugee Health Assessment Program. The federal Office of Refugee Resettlement allows only one grant award for refugee health services in the state. The Department invoices the CDPH through an IA for refugee expenditure reimbursement, which is originally paid with General Fund (GF) dollars. There is a $600,000 annual reimbursement cap under the grant for these services.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase due to reimbursement of claims being higher than previously estimated and the addition of a one-time system change cost. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due to a one-time system change cost occurring in FY 2024-25 and not FY 2025-26.

Methodology:
1. The Department provides CDPH with the number of RMA individuals in aid code 02 and the associated medical expenditures for each Federal Fiscal Year.

REFUGEE MEDICAL ASSISTANCE
REGULAR POLICY CHANGE NUMBER: 11

2. The total reimbursable amounts are estimated to be:

Fiscal Year	TF	GF	GF Reimbursement
FY 2024-25	$0	($346,000)	$346,000
FY 2025-26	$0	($312,000)	$312,000

Funding:
100% GF (4260-101-0001)
Reimbursement GF (4260-601-0995)

COMMUNITY FIRST CHOICE OPTION

REGULAR POLICY CHANGE NUMBER: 12
IMPLEMENTATION DATE: 12/2012
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 1595

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$9,133,032,000	$10,038,990,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$9,133,032,000	$10,038,990,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$9,133,032,000	$10,038,990,000

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
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
The ACA established a new State Plan option, which became available to states on October 1, 2010, to provide home and community-based attendant services and supports through CFCO. CFCO allows States to receive a 6% increase in federal match for expenditures related to this option. The state submitted a State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) which proposed moving federally eligible Personal Care Services Program (PCSP) and In-Home Supportive Services (IHSS) Plus Option program participants into CFCO. The Department budgets Title XIX Federal Financial Participation (FFP) for the provision of IHSS Plus Option and PCSP services to Medi-Cal members.

The SPA was approved on August 31, 2012, with an effective date of December 1, 2011. In addition, CMS approved SPA 13-007, effective July 1, 2013, which updated eligibility language for compliance with the Social Security Act section 1915(k)(1) and 42 CFR section 441.510.

The CFCO generates new federal funds and creates General Fund savings to the State and counties who provide matching funds. The anticipated savings would be offset by cost increases to administer CFCO.

COMMUNITY FIRST CHOICE OPTION
REGULAR POLICY CHANGE NUMBER: 12

As a result of the Coronavirus Disease 2019 (COVID-19) national public health emergency, increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

Reason for Change:
There is an increase from the prior estimate for FY 2024-25, due to updated expenditure data provided by CDSS. There is an increase in the current estimate from FY 2024-25 to FY 2025-26 due to updated expenditure data provided by CDSS.

Methodology:
1. Costs for Medi-Cal members enrolled in CFCO are eligible for an additional enhanced FMAP rate of 6%. The CFCO policy change includes 56% Federal Financial Participation.

2. The estimated costs CDSS provided on an accrual basis for FY 2024-25 and FY 2025-26 are in the table below.

(Dollars in Thousands)

FY 2024-25	TF	FF	CDSS GF/ County Share
Title XIX 100% FFP (4260-101-0890)	$18,805,030	$9,402,515	$9,402,515
COVID-19 Tile XIX Increased FMAP	$0	$0	$0
Total	$18,805,030	$9,402,515	$9,402,515
FY 2025-26	**TF**	**FF**	**CDSS GF/ County Share**
Title XIX 100% FFP (4260-101-0890)	$20,820,988	$10,410,494	$10,410,494
COVID-19 Tile XIX Increased FMAP	$0	$0	$0
Total	$20,820,988	$10,410,494	$10,410,494

*Totals may differ due to rounding.

COMMUNITY FIRST CHOICE OPTION
REGULAR POLICY CHANGE NUMBER: 12

3. The estimated costs CDSS provided on a cash basis for FY 2024-25 and FY 2025-26 are in the table below.

(Dollars in Thousands)

FY 2024-25	**TF**	**FF**	**CDSS GF/ County Share**
Title XIX 100% FFP (4260-101-0890)	$18,266,202	$9,133,101	$9,133,101
COVID-19 Tile XIX Increased FMAP	$0	($69)	$69
Total	$18,266,202	**$9,133,032**	$9,133,170
FY 2025-26	**TF**	**FF**	**CDSS GF/ County Share**
Title XIX 100% FFP (4260-101-0890)	$20,077,981	$10,038,990	$10,038,991
COVID-19 Tile XIX Increased FMAP	$0	$0	$0
Total	$20,077,981	**$10,038,990**	$10,038,991

*Totals may differ due to rounding.

Funding:
100% Title XIX FFP (4260-101-0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)

HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS

REGULAR POLICY CHANGE NUMBER: 13
IMPLEMENTATION DATE: 2/2016
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 1967

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$18,208,000	$18,208,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$18,208,000	$18,208,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$18,208,000	$18,208,000

Purpose:
This policy change estimates the payment and technical adjustment in funding from Title XIX 50/50 Federal Medical Assistance Percentage (FMAP) to the enhanced Title XIX Affordable Care Act (ACA) FMAP for services provided at Designated Public Hospitals (DPHs) for Hospital Presumptive Eligibility (HPE) to the ACA Optional Expansion Population. HPE is a required provision of the ACA.

Authority:
Title 42, CFR, Section 435.1110
Social Security Act 1902(a)(47)
SB 28 (Chapter 442, Statutes of 2013)
California State Plan Amendment 13-0027-MM7

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2014, the ACA requires the Department to give hospitals the option to determine HPE for Medicaid. The HPE program offers qualified individuals immediate access to temporary Medi-Cal while applying for permanent Medi-Cal coverage or other health coverage. Individuals complete the HPE application on-line with a qualified HPE provider at a participating, qualified hospital. Eligibility is determined in real-time.

Individuals granted temporary HPE must complete the Medi-Cal application process to enroll in a permanent Medi-Cal program.

Reason for Change:
There is an increase for FY 2024-25 from the prior estimate, due to adding two quarters of actuals higher than previously projected, and due to updated projections being higher than previously estimated.

There is no change from FY 2024-25 to FY 2025-26 in the current estimate.

HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS

REGULAR POLICY CHANGE NUMBER: 13

Methodology:

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

2. The Department processes claims for members 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 $4,522,000 for FY 2023-24 Q 3-4, FY 2024-25 Q 1-4, and FY 2025-26 Q1-2 based on the average expenditures of the most recent ten quarters of data available (FY 2021-22 Q1-4, FY 2022-23 Q1-4, and FY 2023-24 Q1-2).

3. The Department will also claim the enhanced Title XIX ACA FMAP for members receiving services in DPHs and estimates to pay DPHs $18,208,000 in FY 2024-25 and $18,208,000 in FY 2025-26. The estimated pass-through costs are included in the chart below.

(Dollars in Thousands)

FY 2024-25	TF	FF
FY 2023-24 Q3	$4,552	$4,552
FY 2023-24 Q4	$4,552	$4,552
FY 2024-25 Q1	$4,552	$4,552
FY 2024-25 Q2	$4,552	$4,552
Net Impact	**$18,208**	**$18,208**

FY 2025-26	TF	FF
FY 2024-25 Q3	$4,552	$4,552
FY 2024-25 Q4	$4,552	$4,552
FY 2025-26 Q1	$4,552	$4,552
FY 2025-26 Q2	$4,552	$4,552
Net Impact	**$18,208**	**$18,208**

Funding:

ACA 100% FFP (4260-101-0890)

1% FMAP INCREASE FOR PREVENTIVE SERVICES

REGULAR POLICY CHANGE NUMBER: 14
IMPLEMENTATION DATE: 1/2016
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 1791

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$5,393,000	-$5,393,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$5,393,000	-$5,393,000
FEDERAL FUNDS	$5,393,000	$5,393,000

Purpose:
This policy change estimates an additional 1% in federal medical assistance percentage (FMAP) for specified preventive services.

Authority:
Affordable Care Act (ACA), Section 4106

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2013, the ACA provides states with the option to receive an additional 1% in FMAP for providing specified preventive services. Eligible preventive services are those assigned Grade A or B by the United States Preventive Services Task Force (USPSTF), and approved adult vaccines and their administration as recommended by the Advisory Committee on Immunization Practices (ACIP). To be eligible to receive the enhanced FMAP, States must cover the specified preventive services in their standard Medicaid benefit package and cannot impose cost sharing for these services. States may only claim the 1% FMAP on services that adhere to the USPSTF Grade A and B recommendations on age, gender, periodicity, and other criteria as indicated in the summary of recommendations. The Department previously incorporated and continues to provide USPSTF recommended Grade A and B preventative services and ACIP approved adult vaccines as part of the Medi-Cal benefit package without cost-sharing.

The majority of the USPSTF Grade A and B recommendations include preventive screening services for adults only. The 1% FMAP policy does not apply to family planning services that are eligible for 90% match and prescription drugs (including over the counter).

For Fee-for-Service (FFS) members, many of the 1% FMAP eligible services for children, such as those for newborns prior to discharge from the hospital, cannot be pulled from the bundled rate. Additionally, the 1% FMAP can only be claimed if the primary purpose of the visit is the delivery of preventive services under USPSTF and ACIP.

1% FMAP INCREASE FOR PREVENTIVE SERVICES

REGULAR POLICY CHANGE NUMBER: 14

Reason for Change:
The change in FY 2024-25, from the prior estimate, is a net decrease in savings due to the following:

- Increased FFS savings based on updated actual data through December 2023; and
- Decreased managed care savings based on updated Calendar Year (CY) 2023 actual data.

There is no change from FY 2024-25 to FY 2025-26, in the current estimate.

Methodology:

1. The 1% FMAP savings will include the following periods of savings in FY 2024-25:
   - FFS – July 1, 2023 through June 30, 2024
   - Managed care – January 1, 2024 through December 31, 2024

2. FY 2025-26 will include the following periods of savings:
   - FFS – July 1, 2024 through June 30, 2025
   - Managed care – January 1, 2025 through December 31, 2025

3. Total savings for the 1% FMAP increase for preventive services are as follows:

FY 2024-25	TF	GF	FF
FFS:			
FY 2023-24 Savings	$0	($447,000)	$447,000
Total FFS	$0	($447,000)	$447,000
Managed Care:			
FY 2023-24 Savings (Jan 2024 to Jun 2024)	$0	($2,473,000)	$2,473,000
FY 2024-25 Savings (Jul 2024 to Dec 2024)	$0	($2,473,000)	$2,473,000
Total Managed Care	$0	($4,946,000)	$4,946,000
Total FY 2024-25	**$0**	**($5,393,000)**	**$5,393,000**

FY 2025-26	TF	GF	FF
FFS:			
FY 2024-25 Savings	$0	($447,000)	$447,000
Total FFS	$0	($447,000)	$447,000
Managed Care:			
FY 2024-25 Savings (Jan 2025 to Jun 2025)	$0	($2,473,000)	$2,473,000
FY 2025-26 Savings (Jul 2025 to Dec 2025)	$0	($2,473,000)	$2,473,000
Total Managed Care	$0	($4,946,000)	$4,946,000
Total FY 2025-26	**$0**	**($5,393,000)**	**$5,393,000**

1% FMAP INCREASE FOR PREVENTIVE SERVICES

REGULAR POLICY CHANGE NUMBER: 14

Funding:
100% Title XIX (4260-101-0890)
100% GF (4260-101-0001)

HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.

REGULAR POLICY CHANGE NUMBER: 15
IMPLEMENTATION DATE: 1/2014
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 1821

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$33,933,400	-$36,510,400
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$33,933,400	-$36,510,400
FEDERAL FUNDS	$33,933,400	$36,510,400

Purpose:
This policy change estimates the technical adjustment in funding from Title XIX 50/50 Federal Medical Assistance Percentage (FMAP) to the enhanced Title XIX Affordable Care Act (ACA) FMAP for providing Hospital Presumptive Eligibility (HPE) to the ACA Optional Expansion Population. HPE is a required provision of the ACA.

Authority:
Title 42, CFR, Section 435.1110
Social Security Act 1902(a)(47)
SB 28 (Chapter 442, Statutes of 2013)
California State Plan Amendment 13-0027-MM7
State Plan Amendment (SPA) 20-0024
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

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.

On May 13, 2020, the Centers for Medicare & Medicaid Services approved SPA 20-0024, which expanded the HPE Program to include the aged (65 years of age and older), disabled, and blind population, or the HPE Expansion Group.

HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.

REGULAR POLICY CHANGE NUMBER: 15

As a result of the Coronavirus Disease 2019 (COVID-19) national public health emergency, increased FMAP was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is a slight decrease in GF savings due to adding two additional quarters of actuals lower than previously projected. The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase in GF savings due to FY 2024-25 utilizing three quarters of actuals while FY 2025-26 utilizes four quarters of projections with higher expenditure and caseload trends.

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. Costs are developed using actual claims from FY 2023-24 Q1-3 and an average for the four most recent quarters of actual claims data where actuals are not available. The estimated average quarterly adjustment is $21,725,000 for FY 2024-25 and $22,819,000 for FY 2025-26.

4. The Department estimates to adjust $86,901,000 TF claims from Title XIX 50/50 FMAP to claim the enhanced Title XIX ACA FMAP in FY 2024-25 and $91,276,000 TF in FY 2025-26. The estimated funding adjustment is included in the chart below.

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
50% Title XIX FF / 50% GF	($86,901,000)	($43,451,000)	($43,450,000)
90% Title XIX FF / 10% GF	$86,901,000	$8,690,000	$78,211,000
COVID-19 Title XIX Increased FMAP	$0	$827,000	($827,000)
Net Impact	**$0**	**($33,934,000)**	**$33,934,000**

FY 2025-26	TF	GF	FF
50% Title XIX FF / 50% GF	($91,276,000)	($45,638,000)	($45,638,000)
90% Title XIX FF / 10% GF	$91,276,000	$9,128,000	$82,148,000
COVID-19 Title XIX Increased FMAP	$0	$0	$0
Net Impact	**$0**	**($36,510,000)**	**$36,510,000**

*Totals may not add due to rounding

HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.

REGULAR POLICY CHANGE NUMBER: 15

Funding:
90% Title XIX FF/10% GF (4260-101-0890/0001)
50% Title XIX FF/50% GF (4260-101-0890/0001)
COVID-19 Title XXI Increased FFP (4260-101-0890)
COVID-19 Title XXI GF (4260-101-0001)

ACA DSH REDUCTION

REGULAR POLICY CHANGE NUMBER: 16
IMPLEMENTATION DATE: 1/2025
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 2105

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	-$1,475,611,000	-$1,712,230,000
- STATE FUNDS	-$676,601,000	-$774,479,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,475,611,000	-$1,712,230,000
STATE FUNDS	-$676,601,000	-$774,479,000
FEDERAL FUNDS	-$799,010,000	-$937,751,000

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

Authority:
ACA, HR 3590, Section 2551
HR 4366 (2024)

Interdependent Policy Changes:
Private DSH Replacement
DSH Payment
Global Payment Program

Background:
The federal DSH allotment is available for uncompensated Medi-Cal and uninsured costs incurred by DSHs. The ACA requires the aggregate, nationwide reduction of DSH allotments in the amount of $8 billion annually Federal Fiscal Year (FFY) 2024 through FFY 2027, for a total aggregate reduction of $32 billion. The distribution of the aggregate reductions is determined by the Centers for Medicare & Medicaid Services (CMS).

The ACA requires a reduction to the DSH allotments and was previously scheduled to go into effect on October 1, 2013. Subsequent federal action has delayed the reduction; see the ACA DSH Reduction policy change for more information. Most recently, on March 9, 2024, HR 4366 was enacted which eliminated the Federal Fiscal Year (FFY) 2024 reduction and postponed implementation of the FFY 2025 reduction until January 1, 2025. In September 2023, CMS released a preliminary California DSH reduction amount of $821 million for FFY 2024, representing 10.27% of that year's total national reduction. Based on the FFY 2024 amounts released from CMS and the national aggregate total of $8 billion per year, for estimation purposes for all DSH years impacted by the reduction (FFY 2025-2027), California's percent share of the national reduction is assumed to be 10.27%.

ACA DSH REDUCTION
REGULAR POLICY CHANGE NUMBER: 16

The non-federal share of DSH payments are funded via the General Fund (GF), certified public expenditures (CPEs), or intergovernmental transfers (IGTs). The source of the federal portion of payments varies depending on the program, with Private Hospital DSH Replacement receiving federal funding from Title XIX, and all other programs receiving federal funding from the DSH allotment. See the Private Hospital DSH Replacement, DSH Payment, and Global Payment Program (GPP) policy changes for more information.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to:

- Updated FY 2024-25 hospital type allocations due to updated Major Teaching Hospital determinations. This resulted in Private DSH Replacement's reduction allocation increasing.
- The inclusion of GPP Program Year (PY) 11 Quarter 1 reduction.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due the estimated FFY 2025 DSH allotment being higher, which is derived by trending forward the estimated FY 2024-25 allotment by 2%.

Methodology:

1. California's DSH allotment is estimated to be $1.55 billion for FY 2024-25 and $1.59 billion for FY 2025-26.

2. California's anticipated reduction results in a total reduction of $821 million federal funds (FF) for FY 2024-25 and FY 2025-26, for NDPHs and DPHs. The DSH allotment reduction will offset DSH payments for NDPHs and UC DPHs in the DSH Payment policy change and the remaining DPHs in the GPP policy change.

3. The DSH allotment amount is applied in the DSH payment methodology to determine the reduction amount for the estimated aggregate Private DSH Replacement funding. The total reduction amount is estimated to be $196 million FF for FY 2024-25 and FY 2025-26. The Private DSH Replacement reduction will offset Private DSH replacement payments in the Private Hospital DSH Replacement policy change.

4. Assume the following DSH reduction on an accrual basis:

(Dollars in Thousands)

FY 2024-25	TF	GF	IGT	FF
Private DSH Replacement	($392,016)	($196,008)	$0	($196,008)
DSH NDPH	($40,146)	($20,073)	$0	($20,073)
DSH UC	($163,212)	$0	$0	($163,212)
GPP	($1,275,968)	$0	($637,984)	($637,984)
Total Reduction FY 2024-25	**($1,871,342)**	**($216,081)**	**($637,984)**	**($1,017,277)**

ACA DSH REDUCTION
REGULAR POLICY CHANGE NUMBER: 16

(Dollars in Thousands)

FY 2025-26	TF	GF	IGT	FF
Private DSH Replacement	($392,816)	($196,408)	$0	($196,408)
DSH NDPH	($39,358)	($19,679)	$0	($19,679)
DSH UC	($163,292)	$0	$0	($163,292)
GPP	($1,276,596)	$0	($638,298)	($638,298)
Total Reduction FY 2025-26	**($1,872,062)**	**($216,087)**	**($638,298)**	**($1,017,677)**

5. For Private Hospital DSH Replacement and DSH NDPH:
   - Assume 11/12 of the FY 2024-25 DSH payment reduction will occur in FY 2024-25 and 1/12 will occur in FY 2025-26.
   - Assume 11/12 of the FY 2025-26 DSH payment reduction will occur in FY 2025-26 and 1/12 will occur in FY 2026-27.

6. For UC DSH:
   - Assume 3/4 of the FY 2024-25 DSH payment reduction will occur in FY 2024-25 and 1/4 will occur in FY 2025-26.
   - Assume 3/4 of the FY 2025-26 DSH payment reduction will occur in FY 2025-26 and 1/4 will occur in FY 2026-27.

7. GPP program years are paid on a calendar year basis, but the ACA DSH Reduction is applied based on a state fiscal year. The reduction methodology assumes that each GPP program year will be impacted by two DSH reduction allocations (50% of the first applicable FFY DSH reduction for Jan-Jun, and 50% of the second applicable FFY DSH reduction for Jul-Dec).
   - All 4 quarters of the PY 10 reduction and the FFY 2025 portion of the PY 11 Q1 reduction is estimated to occur in FY 2024-25.
   - The remaining FFY 2025 portion of the PY 11 Q2-Q4 reductions is estimated to occur in FY 2025-26.
   - The FFY 2026 portion of the PY 11 Q1 reduction is estimated to be implemented when the payment is made in FY 2024-25.
   - The remaining FFY 2026 portion of the PY 11 Q2-Q4 reductions as well as the FFY 2026 portion of the PY 12 Q1 reduction is estimated to occur in FY 2025-26.
   - The remaining FFY 2026 portion of the PY 12 Q2-Q4 reductions is estimated to occur in FY 2026-27.

ACA DSH REDUCTION
REGULAR POLICY CHANGE NUMBER: 16

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

(Dollars in Thousands)

FY 2024-25	TF	GF***	IGT	FF
FY 2024-25 Private DSH Replacement	($359,348)	($179,674)	$0	($179,674)
FY 2024-25 DSH NDPH	($36,800)	($18,400)	$0	($18,400)
FY 2024-25 DSH UC*	($122,409)	$0	$0	($122,409)
PY 10 GPP**	($637,984)	$0	($318,992)	($318,992)
PY 11 GPP**	($319,070)	$0	($159,535)	($159,535)
Total Reduction FY 2024-25	**($1,475,611)**	**($198,074)**	**($478,527)**	**($799,010)**

(Dollars in Thousands)

FY 2025-26	TF	GF***	IGT	FF
FY 2024-25 Private DSH Replacement	($32,668)	($16,334)	$0	($16,334)
FY 2024-25 DSH NDPH	($3,346)	($1,673)	$0	($1,673)
FY 2024-25 DSH UC*	($40,803)	$0	$0	($40,803)
PY 11 GPP**	($957,212)	$0	($478,606)	($478,606)
FY 2025-26 Private DSH Replacement	($360,080)	($180,040)	$0	($180,040)
FY 2025-26 DSH NDPH	($36,078)	($18,039)	$0	($18,039)
FY 2025-26 DSH UC*	($122,469)	$0	$0	($122,469)
PY 12 GPP**	($159,574)	$0	($79,787)	($79,787)
Total Reduction FY 2025-26	**($1,712,230)**	**($216,086)**	**($558,393)**	**($937,751)**

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

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

REGULAR POLICY CHANGE NUMBER: 17
IMPLEMENTATION DATE: 7/2000
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 25

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$954,239,000	$842,467,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$954,239,000	$842,467,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$954,239,000	$842,467,000

Purpose:
This policy change estimates the federal match provided to Local Educational Agencies (LEAs) for Medi-Cal eligible services through the LEA Medi-Cal Billing Option Program (LEA BOP).

Authority:
Welfare & Institutions Code 14132.06 and 14115.8
State Plan Amendment (SPA) 15-021

Interdependent Policy Changes:
Not Applicable

Background:
Local Educational Agencies, which consist of school districts, county offices of education, charter schools, community colleges, and university campuses, may enroll as Medi-Cal providers through the LEA BOP. Through the program, LEAs receive federal reimbursement for certified public expenditures (CPEs) incurred while providing specific eligible health services to Medi-Cal enrolled students to the extent federal financial participation (FFP) is available. LEAs receive interim reimbursement through claims payments and then calculate their total cost of providing these services to Medi-Cal-enrolled students using a Cost and Reimbursement Comparison Schedule (CRCS) that is submitted to the Department annually for the preceding fiscal year (FY). Final payment settlements based on actual CPEs for a given year are considered completed when the Department has audited the LEA's CRCS.

- If interim reimbursements exceed the audited CPE settlement, the Department collects the overpayment and returns the excess federal match from the LEA to the federal government by means of withholding funds from future interim claims until the LEA's account is reconciled.
- If interim claims reimbursements are less than the audited CPE settlement, the Department draws additional federal funds to reimburse the LEA. These additional draws have not previously been reported on any estimate.

SPA 15-021, approved by the Centers for Medicare and Medicaid Services (CMS) expanded the LEA BOP by increasing the types of covered practitioners, the types of services covered,

LOCAL EDUCATION AGENCY (LEA) PROVIDERS
REGULAR POLICY CHANGE NUMBER: 17

and by allowing students without an Individualized Education Program (IEP)/ Individualized Family Service Plan (IFSP) to receive covered services as long as they have a care plan in place. Additionally, SPA 15-021 added the Random Moment Time Survey (RMTS) as a statistically valid method of capturing the time that is spent providing direct services to Medi-Cal enrolled students. When combined with the Medi-Cal Eligibility Ratio (MER), it accurately captures the time spent providing LEA BOP services to Medi-Cal members. It is anticipated that this new method will demonstrate an increase in CPE for the LEAs. Although the SPA was approved in 2020, the covered services go back to FY 2015-16. To allow the LEAs to claim for the newly approved practitioners, services, and members, CMS approved a back-casting methodology, which includes the RMTS percentages and MER methodology. Those backcasting payments for direct services, and final settlements started in FY 2023-24.

SPA 15-021 also requires the Department to issue annual interim settlements when an audit and final settlement has not been completed within one year of when the CRCS was filed by the LEA. FY 2022-23 is the first year that the interim settlements was implemented for the CRCS forms that were due on March 1, 2022. Additionally, LEA BOP previously has not reported the final settlement amounts because the final settlement amounts are determined over the course of three years after the CRCS is filed. In conjunction with reporting the interim settlements, FY 2022-23 was the first year that LEA BOP reported the final settlement amounts.

Because LEA BOP is a CPE program, the total cost of providing the covered services to Medi-Cal members is reflected on the CRCS. The federal medical assistance percentage (FMAP) is then broken down as components of the total reported cost: The interim claims submitted by the LEAs are reimbursed at various FMAPs.

Established as part of Budget Act of 2021 [AB 128 (Chapter 21, Statutes of 2021)], the Children and Youth Behavioral Health Initiative (CYBHI) impacts the LEA BOP through cross-over of services, practitioners, and potential members. This program aims to enhance access to critical behavioral health interventions, including those focused on prevention, early intervention, and resiliency/recovery, for children and youth. Welfare and Institutions Code § 5961.4(b) authorizes the department to “develop and maintain a school-linked statewide provider network of school-site behavioral health counselors.” CYBHI will utilize this multi-payer school-linked fee schedule (Fee Schedule) and statewide provider network to offer behavioral health services to the general education school population, creating an overlap with services provided by the LEA BOP. The impact will result in a decrease in the population of students receiving behavioral health-related services and claiming through the LEA BOP, ultimately drawing down less FFP.

As a result of the COVID-19 national public health emergency, increased FMAP was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

LOCAL EDUCATION AGENCY (LEA) PROVIDERS
REGULAR POLICY CHANGE NUMBER: 17

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to:

- Decrease in estimated interim reimbursement:
  - Based on lower actual paid claims from FY 2023-24 compared to FY 2022-23.
  - LEA BOP's anticipated 40% reimbursement reduction from CYBHI Fee Schedule adjusted to 2% after reviewing actual claims data. The CYBHI phased implementation caused less impact for FY 2024-25.

- Increase in interim settlement amount:
  - Payments paused in FY 2023-24 due to a system issue, now expected to be resolved in FY 2024-25.
  - All cost reports now estimated to receive an interim settlement, increasing the estimate.

- Decrease in estimated settlement amounts:
  - Final settlement amounts for back-casted cost reports (FYs 2015-16 to 2018-19) decreased, reflecting actual reported settlement amounts.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to:

- Decrease in estimated settlement amounts. The adjustments are as follows:
  - Decrease in overall total interim reimbursement amounts:
    - CYBHI impact expected to increase in FY 2025-26, reducing LEA BOP claims.
    - The rate of inflation is expected to be lower at 1.4501%.
    - There is a trend of slightly decreasing interim reimbursements.
  - Decrease in the final settlement amount:
    - As the Department finalizes the backcasting audits, fewer audits will be outstanding, leading to continued decreases. This policy change will soon reflect only one or two fiscal years' payments instead of five or six.
      - Back-casting payments will continue through FY 2025-26 based on the audit schedule but will keep decreasing as the audits are completed.
      - The final settlements for the CRCS reports follow the audit schedule and will keep decreasing as the audits are completed.

Methodology:

1. For FY 2024-25, the estimated interim reimbursement is based on the average of the preceding two FYs of actual paid claims data.

2. For FY 2025-26, the estimated interim reimbursement is based on the average of the preceding two FYs of paid and estimated claims data.

3. FY 2024-25 and FY 2025-26 interim payments include a rate inflation that is based on the Implicit Deflator for Gross Domestic Products. The rate tables include the rate inflation in the established rates.

4. System Development Notice (SDN) 23005 was implemented on June 26, 2023, to disallow Unsatisfactory Immigration Status (UIS) claims for FFP. The actual recouped amount was included in the FY 2023-24 estimate to reflect an overall reduction of interim claims. An

LOCAL EDUCATION AGENCY (LEA) PROVIDERS
REGULAR POLICY CHANGE NUMBER: 17

additional SDN was created for the blank indicator error and LEA BOP anticipates that this Erroneous Payment Correction for $551,000 will be issued in the FY 2024-25.

5. Approximately 100% of the FY 2022-23 and FY 2023-24 CRCS reports will receive an interim settlement. This amount is calculated at 60% of the reported amount, which is the amount LEA BOP will be paying LEAs for the interim settlement.

6. Final settlements are calculated based on the reported settlement amounts for the remaining CRCS reports that have been submitted and are pending audits, as audited CRCS reports from the previous FY have already been paid out.
   a. Anticipated payouts in FY 2024-25 include:

FY	Per audit schedule	Comments
2019-20	100%	N/A
2020-21	100%	N/A
2022-23	50%	For the remaining 40% adjusting for the 60% interim settlement

   b. Anticipated payouts in FY 2025-26 include:

FY	Per audit schedule	Comments
2021-22	100%	N/A
2022-23	50%	For the remaining 40% adjusting for the 60% interim settlement
2023-24	50%	For the remaining 40% adjusting for the 60% interim settlement

7. Back-casting for expansion services is based on actual reported amounts from the submitted CRCS reports for Fiscal Year End 2016 through 2019. Back-casting payments for 97.54% submitted CRCS reports FY 2015-16 and FY 2018-19 are expected to be completed in FY 2025-26.
   a. Anticipated payouts in FY 2024-25 include:

FY	Per audit schedule
2015-16	100%
2016-17	75%
2018-19	56.82%

   b. Anticipated payouts in FY 2025-26 include:

FY	Per audit schedule
2016-17	25%
2017-18	100%
2018-19	43.18%

LOCAL EDUCATION AGENCY (LEA) PROVIDERS
REGULAR POLICY CHANGE NUMBER: 17

8. Apply enhanced FMAPs proportionately to estimated interim reimbursements, interim settlements, and final settlements. Enhanced FMAPs do not apply to the back-casting settlements. FMAPs are specific to each LEA, based upon the aid codes of Medi-Cal members for whom claims are submitted.

9. Under the American Rescue Plan Act, COVID-19 counseling service claims are paid at 100% FFP. After October 1, 2024, FMAP will revert to 50% FFP. No claims were received during the Public Health Emergency, so the 100% FMAP is not applicable.

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

REGULAR POLICY CHANGE NUMBER: 17

FY 2024-25	TF	Title XIX FFP	Title XXI FFP	COVID-19 FF
Estimated Interim Reimbursement	$145,286,000	$118,263,000	$27,023,000	$0
Rate Inflation (8.2254%)	$11,950,000	$9,728,000	$2,222,000	$0
Reduction due to UIS Blank Indicator	($551,000)	($449,000)	($102,000)	$0
Reduction due to CYBHI Impact	($90,000)	($74,000)	($16,000)	$0
Interim Settlements for SFY 2022-23	$265,469,000	$193,321,000	$46,427,000	$25,721,000
Final Settlements (FYs 2019-20, 2020-21 & 2022-23)	$390,804,000	$294,437,000	$69,657,000	$26,710,000
Back-casting (FYs 2015-16, 2016-17 & 2018-19)	$141,371,000	$115,076,000	$26,295,000	$0
Total	**$954,239,000**	**$730,302,000**	**$171,506,000**	**$52,431,000**

FY 2025-26	TF	Title XIX FFP	Title XXI FFP	COVID-19 FF
Estimated Interim Reimbursement	$144,775,000	$117,847,000	$26,928,000	$0
Rate Inflation (1.4501%)	$2,098,000	$1,708,000	$390,000	$0
Reduction due to CYBHI Impact	($933,000)	($761,000)	($172,000)	$0
Interim Settlements for SFY 2023-24	$265,469,000	$193,321,000	$46,427,000	$25,721,000
Final Settlements (FYs 2021-22 & 2022-23)	$317,545,000	$230,698,000	$55,460,000	$31,387,000
Back-casting (FYs 2016-17, 2017-18 & 2018-19)	$113,513,000	$92,399,000	$21,114,000	$0
Total	**$842,467,000**	**$635,212,000**	**$150,147,000**	**$57,108,000**

Funding:
100% Title XIX FF (4260-101-0890)
100% Title XXI FF (4260-101-0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)
COVID-19 Title XXI Increased FFP (4260-101-0890)

FAMILY PACT PROGRAM

REGULAR POLICY CHANGE NUMBER: 18
IMPLEMENTATION DATE: 1/1997
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 1

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$141,858,000	$144,214,000
- STATE FUNDS	$34,715,500	$35,292,400
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$141,858,000	$144,214,000
STATE FUNDS	$34,715,500	$35,292,400
FEDERAL FUNDS	$107,142,500	$108,921,600

Purpose:
This policy change estimates the costs of family planning services provided by the Family Planning, Access, Care, and Treatment (Family PACT) program.

Authority:
Welfare & Institutions Code 14132(aa)

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 1997, family planning services expanded under the Family PACT program to provide contraceptive services to persons in need of such services with incomes under 200% of the Federal Poverty Level. The Centers for Medicare & Medicaid Services (CMS) approved a Section 1115 demonstration project waiver, effective December 1, 1999.

On March 24, 2011, CMS approved a State Plan Amendment (SPA), in accordance with the Affordable Care Act, to transition the current Family PACT waiver into the State Plan. Under the SPA, eligible family planning services and supplies, formerly reimbursed exclusively with 100% State General Fund, receive a 90% federal financial participation (FFP), and family planning-related services receive reimbursement at Title XIX 50/50 FFP.

This policy change is inclusive of CMS approved, time-limited supplemental payments, at a rate equal to 150 percent of the current Family PACT rates, to Family PACT providers for specific family planning services. Expenditures for these services are delineated in the Proposition 56-Women’s Health Supplemental Payments policy change.

Drug rebates for Family PACT drugs are included in the Family PACT Drug Rebates policy change.

FAMILY PACT PROGRAM
REGULAR POLICY CHANGE NUMBER: 18

Reason for Change:
The change in FY 2024-25, from the prior estimate, is a decrease due to Family PACT users transitioning to Medi-Cal because of the full-scope expansion occurring on January 1, 2024.The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to a growth in projected expenditures for Family PACT users from FY 2024-25 to FY 2025-26.

Methodology:
1. The Department used linear regressions based upon the most recent 36 months of actual data for users, units per user, and dollars per unit.

2. Family planning services and testing for sexually transmitted infections (STIs) are eligible for 90% FFP.

3. The treatment of STIs and other family planning-related services are eligible for Title XIX 50/50 FFP.

4. It is assumed that 13.95% of the Family PACT population are undocumented persons and are budgeted at 100% GF.

(Dollars in Thousands)

Fiscal Years	TF	GF	FF
FY 2024-25	**$141,858**	**$34,715**	**$107,143**
FY 2025-26	**$144,214**	**$35,292**	**$108,922**

*Totals may differ due to rounding.

Funding:
(Dollars in Thousands)

FY 2024-25	TF	GF	FF
90% Family Planning / 10% GF (4260-101-0890/0001)	$115,270	$11,527	$103,743
50% Title XIX / 50% GF (4260-101-0890/0001)	$6,799	$3,400	$3,399
100% GF (4260-101-0001)	$19,789	$19,789	$0
Total	**$141,858**	**$34,716**	**$107,142**

FY 2025-26	TF	GF	FF
90% Family Planning / 10% GF (4260-101-0890/0001)	$117,184	$11,718	$105,466
50% Title XIX / 50% GF (4260-101-0890/0001)	$6,912	$3,456	$3,456
100% GF (4260-101-0001)	$20,118	$20,118	$0
Total	**$144,214**	**$35,292**	**$108,922**

*Totals may differ due to rounding.

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER: 19
IMPLEMENTATION DATE: 12/2008
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 1228

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$101,991,000	$111,173,000
- STATE FUNDS	$41,761,500	$22,357,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$101,991,000	$111,173,000
STATE FUNDS	$41,761,500	$22,357,000
FEDERAL FUNDS	$60,229,500	$88,816,000

Purpose:
This policy change estimates the costs of providing demonstration services to Medi-Cal eligible members enrolled in the California Community Transitions (CCT) Demonstration Project who will transition to the community and receive qualified home and community-based services for up to 365 days following their transition.

Authority:
Federal Deficit Reduction Act (DRA) of 2005 (P.L. 109-171), Section 6071
Affordable Care Act (ACA) (P.L. 111-148), Section 2403
Medicaid Extenders Act of 2019 (P.L. 116-3), Section 2
California Welfare and Institutions Code, Chapter 300, Section 14196.2
Consolidated Appropriations Act, 2021 (P.L. 108-361), Section 204
California Welfare and Institutions Code, Section14196.6

Interdependent Policy Changes:
CCT Fund Transfer to CDSS

Background:
The CCT demonstration is authorized under Section 6071 of the Federal DRA of 2005 and was extended by the ACA.

The Money Follows the Person (MFP) grant requires the Department to develop and implement strategies to assist Medi-Cal eligible members, who have continuously resided in health care facilities for 60 days or longer, transition into qualified residences with the support of Medi-Cal Home and Community-Based Services (HCBS). Members are enrolled in the demonstration for a maximum of 365-days post-transition, but also receive transition coordination services prior to leaving the inpatient facility.

The Extenders Act provided the Centers for Medicare and Medicaid Services (CMS) with authority to allocate new funding to state grantees for FY 2019-20, to allow funding appropriated through the Extenders Act to be spent through 2023.

CALIFORNIA COMMUNITY TRANSITIONS COSTS
REGULAR POLICY CHANGE NUMBER: 19

On December 27, 2020, the President signed the Consolidated Appropriations Act, 2021 into law, which included an extension of the MFP grant through FFY 2023 and appropriated funding through FFY 2023. Under the Act, the CCT Program received grant funding to continue to transition eligible members through September 2023 and up to four years after, as long as grant funding remains available. The Act also reduced the number of days a member had to reside in a facility to be eligible for MFP from 90 to 60 days.

Beginning January 1, 2021, SB 214 created a temporary program that revised the requirement for members residing in an inpatient facility from 90 days and longer to less than 90 days. The temporary program required the Department to end enrolling specified members by the end of December 31, 2022, and end providing services at the end of December 31, 2023. However, SB 214 was invalidated due to federal legislation that modified criteria for the MFP grant. As a result, the Department proposed amendments to the statute through trailer bill language to align the state-funded CCT population with the new federal requirements.

On July 27, 2021, AB 133 was approved and resulted in necessary changes to state law to align with federal MFP requirements, which removed barriers to the Department's implementation of the state-only CCT program. AB 133 aligned state statute with the amended federal statute, by reducing the required period of residence in an inpatient facility from 90 days to 60 days. The state-funded, CCT-like program allows CCT Lead Organizations to provide transition services to Medi-Cal members who have not yet met the federal, MFP residency eligibility criteria, as a way to help reduce the amount of time members are required to remain in an institution during the COVID-19 public health emergency.

On March 31, 2022, CMS issued a Memorandum to MFP grantees informing it is increasing the reimbursement rate for MFP supplemental services. These services are now 100% federally funded with no state share. Effective January 1, 2022, supplemental services are fully covered by MFP grant funds at a federal reimbursement rate of 100%. Implementation of CCT supplemental services is pending.

On September 30, 2022, California Welfare and Institutions Code, Section 14196.6 was amended to extend the CCT-like program's end date from December 31, 2023, to December 31, 2026.

On December 29, 2022, the President signed the Consolidated Appropriations Act of 2023 into law, which appropriates additional funding for each fiscal year 2024 through 2027. Unexpended grant funds awarded for any fiscal year can continue to be spent for up to four additional years, through September 30, 2031.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase due to the average cost for CCT and Qualified HCBS members being significantly higher than previously estimated. The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to additional enrollments for the Qualified HCBS members occurring in FY 2025-26.

Methodology:
1. Assume estimated costs of waiver impacted services for members residing year-round in Nursing Facility (NF)-Bs are $115,263 in FY 2024-25 and $116,645 FY 2025-26. The savings from moving members from NF-Bs to the waiver are 50% FF and 50% GF.

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER: 19

2. Assume 100% of CCT members will receive pre-transition demonstration services for up to six months; reimbursed at 75% MFP and 25% GF.

3. Assume the Department will pay 100% GF for pre-transition services and unsuccessful pre-transition services and 50% FF / 50% GF for post-transition services for the state-funded CCT members.

4. Assume 652 members will transition from an inpatient facility to the CCT program in FY 2024-25 and in FY 2025-26.

5. Assume 160 ALW members in FY 2024-25 and 188 ALW members in FY 2025-26 who transitioned from an institution to a community setting qualify to draw down post-transition Qualified Home and Community-Based Services.

6. Assume $41,760,000 was awarded for CY 2024, which allowed CCT transitions to continue through December 31, 2024.

7. Assume the federal government will issue a new grant award in CY 2025 at least equal to the current grant awarded, which will allow CCT transitions to continue through December 31, 2025.

8. Below is the estimated impact of the CCT Demonstration project in FY 2024-25 and FY 2025-26.

FY 2024-25	**TF**	**GF**	**FF**
CCT Costs PC:			
Regular CCT Population	$49,778,000	$21,059,000	$28,719,000
State-Funded CCT Population	$118,000	$10,229,000	($10,111,000)
ALW Transition Costs	$52,095,000	$10,473,000	$41,622,000
Total Costs	**$101,991,000**	**$41,761,000**	**$60,230,000**
CCT Savings:			
Total GF savings and Total FFP	($115,724,000)	($69,434,000)	($46,290,000)
CCT Fund Transfer to CDSS PC:	$65,000	$0	$65,000
CCT Outreach - Admin costs PC:	$340,000	$0	$340,000
Total of CCT PCs including savings	($13,328,000)	($27,673,000)	$14,345,000

*The savings are included in the total, however, they are fully reflected in the base estimates.

CALIFORNIA COMMUNITY TRANSITIONS COSTS

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FY 2025-26	TF	GF	FF
CCT Costs PC:			
Regular CCT Population	$49,779,000	$10,008,000	$39,771,000
State-Funded CCT Population	$118,000	$11,147,000	($11,029,000)
ALW Transition Costs	$61,277,000	$12,319,000	$48,957,000
Total Cost	**$111,174,000**	**$33,474,000**	**$77,699,000**
CCT Savings:			
Total GF savings and Total FFP	($40,806,000)	($24,484,000)	($16,322,000)
CCT Fund Transfer to CDSS PC:	$65,000	$0	$65,000
CCT Outreach - Admin costs PC:	$340,000	$0	$340,000
Total of CCT PCs including savings	$70,773,000	$8,990,000	$61,782,000

*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)
50% Title XIX FFP / 50% GF (4260-101-0890/0001)

MULTIPURPOSE SENIOR SERVICES PROGRAM

REGULAR POLICY CHANGE NUMBER: 20
IMPLEMENTATION DATE: 7/2019
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 28

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$63,951,000	$63,951,000
- STATE FUNDS	$31,975,500	$31,975,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$63,951,000	$63,951,000
STATE FUNDS	$31,975,500	$31,975,500
FEDERAL FUNDS	$31,975,500	$31,975,500

Purpose:
This policy change estimates the cost of the Multipurpose Senior Services Program (MSSP).

Authority:
Welfare & Institutions Code 9560-9568
Welfare & Institutions Code 14132.275
Welfare & Institutions Code 14186
SB 1008 (Chapter 33, Statutes of 2012)
American Rescue Plan (ARP) Act (2021)
AB 128 (Chapter 21, Statutes of 2021)

Interdependent Policy Changes:
Not Applicable

Background:
The MSSP provides social and health care management and purchases supplemental services to assist persons aged 65 and older who are "at risk" of needing nursing facility placement but who wish to remain in the community. The program provides services under a federal 1915(c) home and community-based services waiver.

In October 2015, Health Plan of San Mateo (HPSM) successfully transitioned to a full managed care benefit and fully integrated MSSP services into health plan operations.

The Coordinated Care Initiative (CCI) was previously scheduled to transition MSSP to a managed care benefit effective January 1, 2023. However, MSSP was instead carved-out of CCI with a January 1, 2022, implementation date, and a May 1, 2022, effective date. The MSSP Waiver was amended to revert the managed care payment methodology for the six impacted CCI counties back to a Fee-for-Service (FFS) payment methodology.

Effective January 1, 2022, the total MSSP reimbursement is budgeted in this policy change as a result of AB 128 (Chapter 21, Statutes of 2021), and all MSSP sites are FFS.

MULTIPURPOSE SENIOR SERVICES PROGRAM

REGULAR POLICY CHANGE NUMBER: 20

Reason for Change:
There is no change from the prior estimate for FY 2024-25. There is no change from FY 2024-25 to FY 2025-26 in the current estimate.

Methodology:
1. Assume the MSSP has 11,940 slots at a rate of $5,356 per slot.

2. The estimates below were provided on a cash basis.

FY 2024-25	TF	GF	FF
50% Title XIX FFP / 50% GF	$63,951,000	$31,975,000	$31,976,000
Total	**$63,951,000**	**$31,975,000**	**$31,976,000**
FY 2025-26	**TF**	**GF**	**FF**
50% Title XIX FFP / 50% GF	$63,951,000	$31,975,000	$31,976,000
Total	**$63,951,000**	**$31,975,000**	**$31,976,000**

*Totals may differ due to rounding.

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

BEHAVIORAL HEALTH TREATMENT

REGULAR POLICY CHANGE NUMBER: 21
IMPLEMENTATION DATE: 10/2016
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 1855

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$19,392,000	$12,537,000
- STATE FUNDS	$9,696,000	$6,268,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$19,392,000	$12,537,000
STATE FUNDS	$9,696,000	$6,268,500
FEDERAL FUNDS	$9,696,000	$6,268,500

Purpose:
This policy change estimates the fee-for-service (FFS) costs for providing Behavioral Health Treatment (BHT) services for children under age 21 with a diagnosis of autism spectrum disorder (ASD), or Behavioral Intervention Services (BIS) for the same age group who do not have an ASD diagnosis.

Authority:
Social Security Act Section 1905(a)(13)
SB 870 (Chapter 40, Statutes of 2014)
SPA 14-026
Welfare & Institutions Code 14132.56
Interagency Agreement (IA) 15-92451

Interdependent Policy Changes:
Not Applicable

Background:
SB 870 added Welfare & Institutions Code (WIC), Section 14132.56 to direct the Department to implement BHT services to the extent it is required by the federal government to be covered by Medi-Cal for individuals under 21 years of age. On July 7, 2014, the Centers for Medicare and Medicaid Services (CMS) released guidance for states to cover BHT services for Medicaid members with an ASD diagnosis.

On September 15, 2014, the Department issued interim guidance to Medi-Cal managed care health plans (MCPs) requiring the MCPs to cover all medically necessary BHT services effective on or after September 15, 2014. The Department received approval of State Plan Amendment (SPA) 14-026 on January 21, 2016, to include BHT as a covered Medi-Cal benefit.

Prior to the addition of BHT as a Medi-Cal benefit, BHT and other Medi-Cal related services were provided under the Medicaid 1915(c) and (i) waivers for individuals with developmental disabilities that met certain eligibility criteria. These services were provided through a system of Regional Centers (RC) contracted with the Department of Developmental Services (DDS).

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The Department, in collaboration with DDS, began transitioning responsibility for BHT services starting February 1, 2016 in both Medi-Cal FFS and managed care. The transition was completed in September 2016. Medi-Cal members 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.

On March 1, 2018, the Department transitioned additional RC clients enrolled in FFS Medi-Cal, who did not have an ASD diagnosis but were receiving BHT Behavioral Intervention Services (BIS), to Medi-Cal coverage for BHT/BIS. The transition of Medi-Cal managed care clients began on July 1, 2018, and was completed by December 1, 2018.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is an increase due to updated claims data and the deferral of a portion of FY 2022-23 and FY 2023-24 claims payments from FY 2023-24 to FY 2024-25.

The change in the current estimate, from FY 2024-25 to FY 2025-26, is due to more prior year payments estimated for FY 2024-25 than FY 2025-26.

Methodology:
1. Coverage for BHT began on September 15, 2014. FFS members transitioned from DDS on February 1, 2016.

2. The IA contract between the Department and DDS was executed in July 2017, with a retroactive effective date of February 1, 2016.

3. The Department amended the BHT IA contract to include BHT/BIS. The amended contract was executed on October 29, 2018, and DDS began submitting claims starting April 2019.

4. FFS cost reimbursement estimates were provided by DDS. The estimated annual cost on an accrual basis is $11,481,000 TF for FY 2024-25 and FY 2025-26 claims.

5. Managed care payments for BHT services began in October 2016, based on a supplemental capitation payment methodology, retroactive to the implementation date.

6. Starting January 1, 2023, managed care costs for BHT transitioned to the base capitation rates and no longer included in this policy change.

7. On a cash basis, FFS reimbursements are estimated to be paid as follows:

(Dollars in Thousands)

Behavioral Health Treatment	Accrual	FY 2024-25	FY 2025-26
FY 2022-23 claims	$11,014	$2,956	$0
FY 2023-24 claims	$11,481	$6,868	$1,056
FY 2024-25 claims	$11,481	$9,568	$1,913
FY 2025-26 claims	$11,481	$0	$9,568
Total		$19,392	$12,537

BEHAVIORAL HEALTH TREATMENT

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(Dollars in Thousands)

Behavioral Health Treatment	TF	GF	FF
FY 2024-25	$19,392	$9,696	$9,696
FY 2025-26	$12,537	$6,269	$6,268

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

CYBHI WELLNESS COACH BENEFIT

REGULAR POLICY CHANGE NUMBER: 22
IMPLEMENTATION DATE: 1/2025
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 2457

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$12,687,000	$43,142,000
- STATE FUNDS	$5,501,500	$18,707,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$12,687,000	$43,142,000
STATE FUNDS	$5,501,500	$18,707,200
FEDERAL FUNDS	$7,185,500	$24,434,800

Purpose:
This policy change estimates the costs to establish a new Medi-Cal benefit and provider type, Wellness Coach, as part of the Child and Youth Behavioral Health Initiative (CYBHI).

Authority:
Budget Act of 2024
State Plan Amendment (SPA)
AB 133 (Chapter 143, Statutes of 2021)

Interdependent Policy Changes:
Not Applicable

Background:
The 2021-22 California Budget authorized the Children and Youth Behavioral Health Initiative (CYBHI), a $4 billion investment and five-year plan to transform the behavioral health system so every child and youth in California, 0-25 years of age, has increased access to behavioral health supports.

As part of the CYBHI funding and plan, the Department of Health Care and Access Information (HCAI) received funding to design and build the Certified Wellness Coach (formerly known as behavioral health coach) workforce. The Department, in partnership with HCAI will implement a Certified Wellness Coach Medi-Cal benefit to improve access to services and supports to children and youth with existing and emerging behavioral health needs. This benefit will be available in Medi-Cal fee-for-service (FFS) and managed care for Medi-Cal members.

In accordance with the Health and Safety Code Section 127825, the Certified Wellness Coach role is a new category of behavioral health provider, certified to address the unmet behavioral health needs of children and youth in California.

Certified Wellness Coaches will primarily serve children and youth and operate as part of a care team, including in school-linked settings; however, Certified Wellness Coaches could be deployed across the Medi-Cal behavioral delivery system. Certified Wellness Coaches will offer

CYBHI WELLNESS COACH BENEFIT
REGULAR POLICY CHANGE NUMBER: 22

six core services, including: 1) wellness promotion and education; 2) screening; 3) care coordination; 4) individual support; 5) group support; and 6) crisis referral. Furthermore, the Certified Wellness Coach will operate under the direction of and coordination of a Pupil Personnel Services (PPS) credentialed or licensed behavioral health provider.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to accelerated ramp-up of Certified Wellness Coaches completing the state certification program.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to 12 months impact is included in FY 2025-26 compared to half the year for FY 2024-25.

Methodology:
1. Assume the effective date of the benefit is January 2025.

2. Assume FFS payments will begin in January 2025 and managed care payments will begin February 2025.

3. Assume the benefit will phase in over several years and the annual impact at full ramp up is $152 million TF ($66 million GF).

4. The estimated costs on a cash basis in FY 2024-25 and FY 2025-26 are:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
FFS (Lagged)	$123	$53	$70
Managed Care	$12,564	$5,448	$7,116
Total	**$12,687**	**$5,501**	**$7,186**

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
FFS (Lagged)	$426	$184	$242
Managed Care	$42,716	$18,523	$24,193
Total	**$43,142**	**$18,707**	**$24,435**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX / 10% GF (4260-101-0001/0890)
65% Title XXI / 35% GF (4260-101-0001/0890)

MEDICAL INTERPRETER PILOT PROJECT

REGULAR POLICY CHANGE NUMBER: 23
IMPLEMENTATION DATE: 2/2022
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 1989

	FY 2024-25	FY 2025-26
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

Purpose:
This policy change estimates the costs for establishing a medical interpreter pilot project.

Authority:
SB 165 (Chapter 365, Statutes of 2019)
AB 118 (Chapter 42, Statutes of 2023)

Interdependent Policy Changes:
Not Applicable

Background:
SB 165 appropriated $5 million General Fund (GF) for the support of medical interpreter pilot project. Funding will be awarded for pilot projects in up to four pilot sites to deliver language assistance services to patients/clients who are unserved or underserved because they are limited English proficient (LEP).

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to all necessary funds being encumbered in prior years, with no additional costs budgeted in FY 2024-25.

The change in the current estimate, from FY 2024-25 to FY 2025-26, is due to no further funding available to be budgeted after FY 2023-24.

Methodology:
1. The Medical Interpreter Pilot Project was effective October 1, 2021.

2. A delay in the pilot project launch in FY 2021-22, resulted in a rollover of funds to FY 2022-23. The remaining dollars of the $5,000,000 budget was encumbered by FY 2023-24.

3. A one-time $60,000 GF start-up cost for pilot site contractors was paid in February 2022.

MEDICAL INTERPRETER PILOT PROJECT
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4. SB 165 in FY 2019-20, provided $5 million GF available for expenditure through June 30, 2024. Availability has been extended due to approval of AB 118 which extends the program through June 30, 2025, with no other programmatic changes.

	TF	GF
Appropriation Year 2019-20		
Prior Years	$5,000,000	$5,000,000
Estimated in FY 2024-25	$0	$0
Total Estimated Remaining	$0	$0

Funding:
100% General Fund (4260-101-0001)

HEARING AID COVERAGE FOR CHILDREN PROGRAM

REGULAR POLICY CHANGE NUMBER: 24
IMPLEMENTATION DATE: 12/2021
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2189

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$654,000	$1,552,000
- STATE FUNDS	$654,000	$1,552,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	22.80 %	9.62 %
APPLIED TO BASE		
TOTAL FUNDS	$504,900	$1,402,700
STATE FUNDS	$504,890	$1,402,700
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the cost of providing hearing aids and associated services to children ages 20 and under, who are otherwise not eligible for Medi-Cal, do not have health insurance coverage for hearing aids and related services or have qualifying partial other health coverage for hearing aids, and are at or below 600% Federal Poverty Level (FPL).

Authority:
AB 89 (Chapter 7, Statutes of 2020)
Budget Act of 2022 [AB 179 (Chapter 249, Statutes of 2022)]

Interdependent Policy Changes:
Not Applicable

Background:
The Department introduced the Hearing Aid Coverage for Children Program (HACCP) as a new California state-only benefit for children, ages 0-17, who are otherwise not eligible for Medi-Cal, and with a household income up to 600% of the federal poverty level, effective July 1, 2021. This benefit is available to children with no health insurance or whose existing health insurance does not cover hearing aids and related services. Valid hearing aid prescription from an otolaryngologist or physician, or referral from a hearing-related professional or medical provider will be required for program enrollment. This program is funded with 100% General Fund (GF).

Without this benefit, eligible children are at a high risk for developmental and educational delays. It is especially important to make this benefit available, given the current pandemic that has resulted in school closures and distance learning. Children who are deaf and hard of hearing must be able to utilize every medical assistance/device available to ensure continued learning.

Effective January 1, 2023, the eligibility criteria for HACCP has been revised and updated to:
- Expand the age range of eligible children through 20 years of age, and
- Expand coverage to children with qualifying partial other health coverage for hearing aids.

HEARING AID COVERAGE FOR CHILDREN PROGRAM

REGULAR POLICY CHANGE NUMBER: 24

Reason for Change:
The change in FY 2024-25, from the prior estimate, is a decrease due to lower-than-expected overall HACCP enrollment and a slower ramp-up in projected enrollment.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to the continuation of enrollment ramp-up in FY 2025-26.

Methodology:
1. HACCP began on July 1, 2021. Claim reimbursement payments began in December 2021.

2. Annual costs are estimated to be $733,000 in FY 2024-25 and $1,650,000 in FY 2025-26.

3. The hearing aid costs in this policy change are budgeted without the impact of the Medi-Cal provider rate increases.

4. FY 2024-25 and FY 2025-26 lagged payments for HACCP claims are estimated to be:

Hearing Aid Coverage for Children Program	TF	GF
FY 2024-25 (Lagged)	$654,000	$654,000
FY 2025-26 (Lagged)	$1,552,000	$1,552,000

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

CCT FUND TRANSFER TO CDSS

REGULAR POLICY CHANGE NUMBER: 25
IMPLEMENTATION DATE: 10/2011
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 1562

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$65,000	$65,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$65,000	$65,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$65,000	$65,000

Purpose:
This policy change estimates the enhanced federal funding associated with providing the California Department of Social Services (CDSS) additional Title XIX for waiver services provided to Medi-Cal members who participate in the California Community Transitions (CCT) project.

Authority:
Federal Deficit Reduction Act (DRA) of 2005 (P.L. 109-171), Section 6071
Affordable Care Act (ACA) (P.L. 111-148), Section 2403)
Medicaid Extenders Act of 2019 (P.L. 116-3), Section 2
IA 10-87274 (CDSS)
Consolidated Appropriations Act, 2021 (P.L. 108-361), Section 204

Interdependent Policy Changes:
Not Applicable

Background:
The CCT demonstration is authorized under Section 6071 of the Federal DRA of 2005 and was extended by the ACA.

The Money Follows the Person (MFP) grant requires the Department to develop and implement strategies to assist Medi-Cal eligible members, who have continuously resided in health care facilities for 60 days or longer, transition into qualified residences with the support of Medi-Cal Home and Community-Based Services (HCBS).

The Extenders Act provided the Centers for Medicare and Medicaid Services with authority to allocate new funding to state grantees for FY 2019-20, to allow funding appropriated through the Extenders Act to be spent through 2023.

On December 27, 2020, the President signed the Consolidated Appropriations Act, 2021 into law, which included an extension of the MFP grant through FFY 2023 and appropriated funding through FFY 2023. Under the Act, the CCT Program received grant funding to continue to

CCT FUND TRANSFER TO CDSS
REGULAR POLICY CHANGE NUMBER: 25

transition eligible members through September 2023 and up to four years after, as long as grant funding remains available. The Act also reduced the number of days a member had to reside in a facility to be eligible for MFP from 90 to 60 days.

On December 29, 2022, the President signed the Consolidated Appropriations Act of 2023 into law, which appropriates additional funding for each fiscal year 2024 through 2027. Unexpended grant funds awarded for any fiscal year can continue to be spent for up to four additional years, through September 30, 2031.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a decrease due to estimating less CCT enrollees using In-Home Supportive Services (IHSS) under CCT. There is no change from FY 2024-25 to FY 2025-26 in the current estimate.

Methodology:
1. The Department provides HCBS to CCT members who are receiving IHSS. The Department provides federal funding to CDSS as the base federal match through HCBS policy changes.

2. CCT services are reimbursed at 75% FFP and 25% GF. The GF for CDSS is provided by CDSS and is budgeted in the Personal Care Services (Misc. Svcs.) policy change.

3. The Department established IA 10-87274 with CDSS. The IA transfers the additional 25% FFP for HCBS provided to CCT members who are receiving IHSS services during their 365 days of participation in the CCT demonstration.

4. It is assumed that 5% of all members utilize IHSS under CCT in FY 2024-25 and in FY 2025-26. Assume each case costs $7,795 in FY 2024-25 and in FY 2025-26. The Department will provide 25% of these costs to CDSS.

5. Assume 652 unduplicated IHSS members will transition in FY 2024-25 and in FY 2025-26.

6. Assume $41,760,000 TF was awarded for calendar year (CY) 2024, which allowed CCT transitions to continue through December 31, 2024.

7. Assume the federal government will issue a new grant award in CY 2024 at least equal to the current grant awarded, which will allow CCT transitions to continue through December 31, 2025.

8. Below is the overall impact of the CCT Demonstration project in FY 2024-25 and FY 2025-26.

CCT FUND TRANSFER TO CDSS

REGULAR POLICY CHANGE NUMBER: 25

FY 2024-25	TF	GF	FF
CCT Costs PC:			
Regular CCT Population	$49,778,000	$21,059,000	$28,719,000
State-Funded CCT Population	$118,000	$10,229,000	($10,111,000)
ALW Transition Costs	$52,095,000	$10,473,000	$41,622,000
Total Costs	$101,991,000	$41,761,000	$60,230,000
CCT Savings:			
Total GF savings and Total FFP	($115,724,000)	($69,434,000)	($46,290,000)
CCT Fund Transfer to CDSS PC:	**$65,000**	**$0**	**$65,000**
CCT Outreach - Admin costs PC:	$340,000	$0	$340,000
Total of CCT PCs including savings	($13,328,000)	($27,673,000)	$14,345,000

*The savings are included in the total, however, they are fully reflected in the base estimates.

FY 2025-26	TF	GF	FF
CCT Costs PC:			
Regular CCT Population	$49,779,000	$10,008,000	$39,771,000
State-Funded CCT Population	$118,000	$11,147,000	($11,029,000)
ALW Transition Costs	$61,277,000	$12,319,000	$48,957,000
Total Cost	$111,174,000	$33,474,000	$77,699,000
CCT Savings:			
Total GF savings and Total FFP	($40,806,000)	($24,484,000)	($16,322,000)
CCT Fund Transfer to CDSS PC:	**$65,000**	**$0**	**$65,000**
CCT Outreach - Admin costs PC:	$340,000	$0	$340,000
Total of CCT PCs including savings	$70,773,000	$8,990,000	$61,782,000

*The savings are included in the total, however, they are fully reflected in the base estimates.

Funding:
MFP Federal Grant (4260-106-0890)

RESPIRATORY SYNCYTIAL VIRUS VACCINES

REGULAR POLICY CHANGE NUMBER: 26
IMPLEMENTATION DATE: 10/2023
ANALYST: Whitney Li
FISCAL REFERENCE NUMBER: 2454

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$214,043,000	$227,228,000
- STATE FUNDS	$95,198,850	$101,063,100
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	14.07 %	13.02 %
APPLIED TO BASE		
TOTAL FUNDS	$183,927,200	$197,642,900
STATE FUNDS	$81,804,370	$87,904,680
FEDERAL FUNDS	$102,122,780	$109,738,230

Purpose:
This policy change estimates the costs for the Respiratory Syncytial Virus (RSV) vaccines and injectables.

Authority:
Inflation Reduction Act of 2022

Interdependent Policy Changes:
Not Applicable

Background:
RSV is a contagious virus causing lower respiratory infections and can lead to pneumonia or other infections. Older adults and young children are more suspectable to serious conditions due to RSV causing hospitalization and deaths. Two RSV vaccines and one injectable drug were approved by the Food and Drug Administration (FDA) and Centers for Disease Control and Prevention (CDC) for protecting this vulnerable population. The Inflation Reduction Act of 2022 mandated all Advisory Committee on Immunization Practices (ACIP) recommended vaccine coverage for Medicaid members ages 19 and over.

With the ACIP recommended coverage, the new RSV vaccines and injectable drug, Medi-Cal will offer this benefit to members. RSV can lead to hospitalization in infants, young children, and older adults and even lead to deaths. Until recently, vaccines for RSV have not existed. These vaccines are targeted to older adults and pregnant individuals. Healthy children have the option of the injectable drug.

RESPIRATORY SYNCYTIAL VIRUS VACCINES

REGULAR POLICY CHANGE NUMBER: 26

Reason for Change:
The change in FY 2024-25, from the prior estimate, is an increase due a higher administration fee for pharmacies effective October 2024.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to estimated annual utilization being fully reflected in FY 2025-26 and annual implementation of the increased vaccination administration fee for pharmacists.

Methodology:
1. Assume approximately 860,000 Medi-Cal members will receive the RSV vaccines or injectable drug in FY 2024-25 and FY 2025-26.

2. Assume the Vaccine for Children program will cover the ingredient cost for the injectable drug for Medi-Cal children. Medi-Cal will cover the ingredient costs for RSV vaccines for adults ages 19 and over.

3. Assume the average RSV vaccine ingredient reimbursement is approximately $280 per dose.

4. Assume the RSV vaccine administration fee through September 2024 is:

Administration Fee	VFC/Medi-Cal	Provider Type
$4.46	Medi-Cal	Non-Pharmacy Providers
$3.79	Medi-Cal	Pharmacy Providers
$9.00	VFC	Non-Pharmacy Providers
$7.65	VFC	Pharmacy Providers

5. Beginning October 2024, the administration fee for pharmacies will increase to $15.95.

6. Assume pharmacies receive an average dispensing fee on average of $11.63.

RESPIRATORY SYNCYTIAL VIRUS VACCINES
REGULAR POLICY CHANGE NUMBER: 26

7. Total costs are estimated to be:

(Dollars in Thousands)

	FY 2024-25	FY 2025-26
Administrative Fee	$8,807	$11,313
Dispensing Fee	$6,426	$6,888
Ingredient Fee	$198,810	$209,027
Total Cost	**$214,043**	**$227,228**

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
RSV (FFS lagged)	**$214,043**	**$95,199**	**$118,844**

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
RSV (FFS lagged)	**$227,228**	**$101,063**	**$126,165**

Funding:
50% title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX / 10% GF (4260-101-0001/0890)
65% Title XXI / 35% GF (4260-101-0001/0890)

PHARMACY RETROACTIVE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 27
IMPLEMENTATION DATE: 7/2024
ANALYST: Whitney Li
FISCAL REFERENCE NUMBER: 2194

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$11,000,000	$0
- STATE FUNDS	$43,763,200	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$11,000,000	$0
STATE FUNDS	$43,763,200	$0
FEDERAL FUNDS	-$32,763,200	$0

Purpose:
This policy change estimates the retroactive adjustments to payments for pharmacy providers related to the April 1, 2017 change in the pharmacy reimbursement methodology.

Authority:
CMS Final Rule (CMS-2345-FC), 42 CFR Part 447
State Plan Amendment (SPA) #17-002
Budget Act of 2022 [AB 179 (Chapter 249, Statutes of 2022)]

Interdependent Policy Changes:
Not Applicable

Background:
The Centers for Medicare and Medicaid Services (CMS), under the provisions of the Affordable Care Act, required each state Medicaid agency to adopt an actual acquisition cost (AAC) based methodology for Covered Outpatient Drugs (CODs) and to adjust their professional dispensing fee. To satisfy this requirement, California, along with many other state Medicaid agencies, adopted CMS' National Average Drug Acquisition Cost (NADAC) as the basis for AAC for drug ingredient reimbursement. CMS approved SPA 17-002 authorizing the Department to implement a new pharmacy reimbursement methodology and professional dispensing fee, effective April 1, 2017. This reimbursement methodology requires all CODs be billed at the AAC.

Providers continued to be paid using the Average Wholesale Price reimbursement methodology until the AAC methodology was implemented on February 23, 2019. Retroactive adjustments for the 23-month period, from April 1, 2017, to February 23, 2019 were to be implemented. The initial retroactive adjustment was for one month of claims (April 2017) and installed on May 23, 2019.

PHARMACY RETROACTIVE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 27

In June of 2019, the Department paused the retroactive adjustments prior to a lawsuit, *California Pharmacists Association, et al. v. Kent, et al.,* being filed in U.S. District Court on June 5, 2019, seeking to enjoin the Department from implementing the retroactive adjustments. In addition, the Department developed a process to address the plaintiff's concerns regarding recoupments resulting from the retroactive adjustments.

The Department was scheduled to resume retroactive pharmacy claim adjustments in February 2021. However, due to factors related to ongoing litigation at the time, the Department continued the pause. This pause applied to all pharmacy claims billed through the Medi-Cal Fee-for-Service Fiscal Intermediary. Recoupments for the retroactive adjustments resumed in October 2023 and have now been completed.

The Budget Act of 2022 cancelled the retroactive recoupments for independent pharmacy providers.

Reason for Change:
The change in FY 2024-25 from the prior estimate, is a net decrease in state costs due more payments to CMS related to independent pharmacy forgiveness were completed in 2023-24 than previously expected, leading to smaller payments in 2024-25. This is partially offset by some remaining payments to pharmacies shifting from 2023-24 to 2024-25.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to adjustments concluding in 2024-25, with no transactions anticipated in 2025-26.

PHARMACY RETROACTIVE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 27

Methodology:

1. Federal Repayment:
   Assume the retroactive recoupments for independent pharmacy providers will not be collected, and the General Fund will be used to repay CMS the federal funds amount of the cancelled pharmacy recoupments.

2. Remaining Payments:
   Assume remaining net payments to independent and chain pharmacies (estimated at $11 million) occurs in FY 2024-25.

3. Assume the Remaining Payments from FY 2023-24 and FY 2024-25 will require an adjustment as these are payments were made past the two-year CMS claiming limit. This adjustment will occur in FY 2024-25.

4. On a cash basis, the net impact in FY 2024-25 is estimated to be:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
Federal Repayment	$0	$8,361	($8,361)
Remaining Payments	$11,000	$3,939	$7,061
Remaining Payment Adjustment	$0	$31,463	($31,463)
Total	**$11,000**	**$43,763**	**($32,763)**

Funding:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$6,748	$3,374	$3,374
90% Title XIX / 10% GF (4260-101-0001/0890)	$3,696	$370	$3,326
65% Title XXI / 35% GF (4260-101-0001/0890)	$556	$195	$361
100% Title XXI GF (4260-101-001)	$2,031	$2,031	$0
100% Title XXI FFP (4260-101-0890)	($2,031)	$0	($2,031)
100% Title XIX GF (4260-101-0001)	$37,793	$37,793	$0
100% Title XIX FFP (4260-101-0890)	($37,793)	$0	($37,793)
Total	**$11,000**	**$43,763**	**($32,763)**

MEDICATION THERAPY MANAGEMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 28
IMPLEMENTATION DATE: 7/2022
ANALYST: Whitney Li
FISCAL REFERENCE NUMBER: 2263

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$144,000	$144,000
- STATE FUNDS	$45,250	$45,250
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	100.00 %	100.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the costs for providing medication management payments to Medi-Cal enrolled pharmacies who, by means of signed contracts with the Department, provide a list of specialized services to high-risk and medically complex populations with certain disease states by implementing a new Medication Therapy Management (MTM) program.

Authority:
AB 133 (Chapter 143, Statutes of 2021)
SPA 21-0028

Interdependent Policy Change:
Not Applicable

Background:
In February 2019, following implementation of the new Fee-For-Service (FFS) Actual Acquisition Cost (AAC)-based pharmacy reimbursement methodology, independent pharmacy providers and the California Pharmacists Association (CPhA), notified the Department that the new methodology, and associated reduced reimbursement could cause certain pharmacies to cease providing specialized medication management services. These specialized services are designed to ensure “at risk” populations remain adherent and compliant with their drug treatment regimens. Characteristics of the “at risk” population receiving medication management services may include homelessness, mental illness, and/or history/evidence of non-compliance or non-adherence with medications.

The Department authorized a survey to determine acquisition costs and identify specialized services provided by those pharmacies in the dispensing of specific drugs. The survey confirmed the AAC methodology resulted in a potential for member access issues with respect to certain drugs, while being an appropriate reimbursement methodology overall. The drug therapy categories surveyed were identified through direct communications from Medi-Cal providers to the Department including reports from stakeholders and CPhA.

MEDICATION THERAPY MANAGEMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 28

The Department has implemented a separate specific reimbursement methodology for FFS pharmacy services provided in person or via video/audio-only telehealth visits in conjunction with certain complex chronic medical conditions including but not limited to, Severe Mental Illness (SMI), Human Immunodeficiency Virus (HIV), Hepatitis C Virus (HCV), cancer, cystic fibrosis and other genetic diseases, Multiple Sclerosis (MS), Hemophilia, Cardio-vascular diseases, lung and respiratory diseases, severe/progressive nervous system disorders, chronic Kidney Disease, Alzheimer's disease or other dementia, End Stage Renal Disease, Osteoporosis and Diabetes. Such services were formerly not reimbursable in Medi-Cal. To participate in this program, Medi-Cal enrolled pharmacies are required to enter into a contract with the Department. The contract outlines the specific requirements and guidelines necessary to receive reimbursement under this methodology. The Department has adopted nationally recognized MTM billing codes, as well as the associated rates paid for each. A review of literature, and other state's MTM programs, suggests an aggregated average of six MTM encounter sessions per member annually is typical (prior authorization requests will be considered for the medical necessity of additional sessions).

Reason for Change:
There is no substantial change from the prior estimate for FY 2024-25.

There is no change from FY 2024-25 to FY 2025-26 in the current estimate.

Methodology:
1. Assume provider payment per encounter is $75.00 based on the rate paid for the medication therapy management code in the marketplace.

2. As of June 2024, approximately 155 pharmacies have contracted with the Department to provide MTM services.

3. Assume that recent total expenditures below have been completely incorporated into the base:

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF	$74,000	$37,000	$37,000
90% Title XIX / 10% GF	$65,000	$6,000	$59,000
65% Title XXI / 35% GF	$5,000	$2,000	$3,000
Total	**$144,000**	**$45,000**	**$99,000**

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF	$74,000	$37,000	$37,000
90% Title XIX / 10% GF	$65,000	$6,000	$59,000
65% Title XXI / 35% GF	$5,000	$2,000	$3,000
Total	**$144,000**	**$45,000**	**$99,000**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX / 10% GF (4260-101-0001/0890)
65% Title XXI / 35% GF (4260-101-0001/0890)

MEDI-CAL DRUG REBATE FUND

REGULAR POLICY CHANGE NUMBER: 29
IMPLEMENTATION DATE: 11/2019
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 2124

	FY 2024-25	FY 2025-26
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

Purpose:
This policy change estimates the transfer of drug rebate collections from the Medi-Cal Drug Rebate Fund to the General Fund (GF).

Authority:
SB 78 (Chapter 38, Statues of 2019)

Interdependent Policy Changes:
COVID-19 Redeterminations Impact

Background:
SB 78 established the Medi-Cal Drug Rebate Fund, effective July 1, 2019. The non-federal share of federal and state supplemental Medi-Cal rebate collections will be deposited into the Medi-Cal Drug Rebates Fund. Transfers will occur from the Medi-Cal Drug Rebate Fund to offset the GF.

For information on the federal share of the rebate collections, see the Federal Drug Rebates, State Supplemental Drug Rebates, Family PACT Drug Rebates, and BCCTP Drug Rebates policy changes.

On January 7, 2019, the Governor issued Executive Order N-01-19 which required the Department to transition Medi-Cal pharmacy services from Managed Care (MC) to the Fee-For-Service (FFS) delivery system. Additional state supplemental rebates are being collected as a result of the MC population shift to Medi-Cal Rx.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is a decrease in the GF transfer due to an increase in actual and estimated Affordable Care Act (ACA) populations rebate collections and ACA Offset rebate collections, and a decrease in actual and estimated rebate collections from the non-ACA populations resulting in a decrease in estimated GF rebate collections and lower state funds available for transfer to the GF.

MEDI-CAL DRUG REBATE FUND
REGULAR POLICY CHANGE NUMBER: 29

The change from FY 2024-25 to FY 2025-26 in the current estimate, is a decrease in the GF transfer due to:

- The actual ending balance in the Medi-Cal Drug Rebate Fund for FY 2023-24 is included in the FY 2024-25 transfer, and
- A decrease in the estimated non-ACA populations pharmacy expenditures and an increase in the estimated ACA populations pharmacy expenditures from FY 2024-25 to FY 2025-26 resulting in less rebates collected at the Title XIX 50/50 FMAP, more rebates collected at the Title XIX ACA FMAP and therefore less GF rebate collections.

Methodology:

1. In FY 2024-25, it is estimated that $2.1 billion will be transferred from the Medi-Cal Drug Rebate Fund to the GF and $1.95 billion will be transferred from the Medi-Cal Drug Rebate Fund to the GF in FY 2025-26.

2. A balance of $126.55 million was in the Medi-Cal Drug Rebate Fund as of July 2024. In FY 2024-25 and FY 2025-26 all rebate collections will be transferred to the GF leaving no reserve in the Medi-Cal Drug Rebate Fund.

3. The summary of the non-federal share and federal share of the estimated FY 2024-25 and FY 2025-26 rebates and the estimated reserve for each respective fiscal year are:

(Dollars in Thousands)

FY 2024-25 Summary of Drug Rebates	**TF**	**Fund 3331**	**FF**
Federal Drug Rebates	($6,199,126)	($1,802,018)	($4,397,108)
State Supplemental Drug Rebates	($569,494)	($165,975)	($403,519)
Family PACT Drug Rebates	($2,636)	($352)	($2,284)
BCCTP Drug Rebates	($3,232)	($981)	($2,251)
Subtotal Rebates	($6,774,488)	($1,969,326)	($4,805,162)
FY 2023-24 Fund Balance		($126,551)	
Medi-Cal Drug Rebate Fund Transfer		**($2,095,877)**	

MEDI-CAL DRUG REBATE FUND
REGULAR POLICY CHANGE NUMBER: 29

(Dollars in Thousands)

FY 2025-26 Summary of Drug Rebates	TF	Fund 3331	FF
Federal Drug Rebates	($6,302,458)	($1,786,871)	($4,515,587)
State Supplemental Drug Rebates	($583,643)	($165,697)	($417,946)
Family PACT Drug Rebates	($2,504)	($333)	($2,171)
BCCTP Drug Rebates	($3,434)	($1,043)	($2,391)
Subtotal Rebates	($6,892,039)	($1,953,944)	($4,938,095)
Medi-Cal Drug Rebate Fund Transfer		**($1,953,944)**	

4. The estimated transfers from the Medi-Cal Drug Rebate Fund to GF are:

(Dollars in Thousands)

FY 2024-25	TF	GF	SF
Drug Rebates Transfer	**$0**	**($2,095,877)**	**$2,095,877**

(Dollars in Thousands)

FY 2025-26	TF	GF	SF
Drug Rebates Transfer	**$0**	**($1,953,944)**	**$1,953,944**

Funding:

(Dollars in Thousands)

FY 2024-25	TF	GF	SF
Medi-Cal Drug Rebate Fund (4260-601-3331)	$2,095,877	$0	$2,095,877
100% GF (4260-101-0001)	($2,095,877)	($2,095,877)	$0
Total	**$0**	**($2,095,877)**	**$2,095,877**

(Dollars in Thousands)

FY 2025-26	TF	GF	SF
Medi-Cal Drug Rebate Fund (4260-601-3331)	$1,953,944	$0	$1,953,944
100% GF (4260-101-0001)	($1,953,944)	($1,953,944)	$0
Total	**$0**	**($1,953,944)**	**$1,953,944**

LITIGATION SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 30
IMPLEMENTATION DATE: 8/2009
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 1449

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	-$276,000	$0
- STATE FUNDS	-$276,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$276,000	$0
STATE FUNDS	-$276,000	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the settlement amounts expected to be received by the Department from pharmaceutical and other entities due to illegal promotion of drugs, kickbacks, sanctions, and overcharges.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
The Department imposes sanctions and 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 2024-25, is an increase due to additional settlement payments expected to be received. The change from FY 2024-25 to FY 2025-26, 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: 30

Methodology:
The following settlements are expected to be received in FY 2024-25:

Settlement Name	FY 2024-25
Progenity Inc.	($6,000)
DHCS v. Sonoma Specialty Hospital	($270,000)
Total GF Savings	**($276,000)**

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

BCCTP DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 31
IMPLEMENTATION DATE: 1/2010
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1433

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	-$2,251,000	-$2,391,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$2,251,000	-$2,391,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$2,251,000	-$2,391,000

Purpose:
This policy change estimates the revenues collected from the Breast and Cervical Cancer Treatment Program (BCCTP) drug rebates.

Authority:
Social Security Act, section 1927 [42 U.S.C. 1396r–8]
Omnibus Budget Reconciliation Act (OBRA) of 1990, Title IV, sec. 4401(a)(3), 104 Stat.
Welfare & Institutions Code 14105.33
SB 78 (Chapter 38, Statues of 2019)

Interdependent Policy Changes:
Medi-Cal Drug Rebate Fund

Background:
Enhanced Title XIX Medicaid funds are claimed for drugs under the federal Medicaid BCCTP. The Department is required by federal law to collect drug rebates whenever there is federal participation. The Department began collecting rebates for beneficiary drug claims for the full-scope federal BCCTP in January 2010. This policy change reflects ongoing rebates collected.

SB 78 established the Medi-Cal Drug Rebate Fund (Fund 3331), effective July 1, 2019. The non-federal share of Medi-Cal federal and state supplemental drug rebates will be deposited into Fund 3331. See the Medi-Cal Drug Rebate Fund policy change for the estimated total transfers from Fund 3331 to the General Fund (GF).

Reason for Change:
The change in FY 2024-25, from the prior estimate, is a decrease in savings due:

- Including two additional quarters of actual rebate collection data through the quarter ending June 2024, and
- A decrease in estimated BCCTP pharmacy expenditures for the applicable expenditure period.

BCCTP DRUG REBATES
REGULAR POLICY CHANGE NUMBER: 31

The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase in rebate savings due to an increase in estimated BCCTP pharmacy expenditures from FY 2024-25 to FY 2025-26.

Methodology:
1. Payments began in January 2010.

2. Rebates are invoiced quarterly.

3. The estimated rebates to collect are $3,232,000 in FY 2024-25 and $3,434,000 in FY 2025-26.

4. Assume, of the total BCCTP rebates collected, the ACA offset for BCCTP is $428,000 TF in FY 2024-25 and $455,000 TF in FY 2025-26.

5. The Department estimates $981,000 and $1,043,000 BCCTP drug rebates to be collected and transferred to the Medi-Cal Drug Rebate Fund in FY 2024-25 and FY 2025-26, respectively.

FY 2024-25	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	($1,823,000)	($1,823,000)	($981,000)
ACA Offset	($428,000)	($428,000)	$0
Total	**($2,251,000)**	**($2,251,000)**	($981,000)

FY 2025-26	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	($1,936,000)	($1,936,000)	($1,043,000)
ACA Offset	($455,000)	($455,000)	$0
Total	**($2,391,000)**	**($2,391,000)**	($1,043,000)

*The Fund 3331 Transfer column is for informational purposes only. See Methodology #5.

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

FAMILY PACT DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 32
IMPLEMENTATION DATE: 12/1999
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 51

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	-$2,284,000	-$2,171,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$2,284,000	-$2,171,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$2,284,000	-$2,171,000

Purpose:
This policy change estimates the revenues collected from the Family Planning Access, Care and Treatment (FPACT) drug rebates.

Authority:
Social Security Act, section 1927 [42 U.S.C. 1396r–8]
Omnibus Budget Reconciliation Act (OBRA) of 1990, Title IV, sec. 4401(a)(3), 104 Stat.
Welfare & Institutions Code 14105.33
SB 78 (Chapter 38, Statues of 2019)

Interdependent Policy Changes:
Medi-Cal Drug Rebate Fund

Background:
Rebates for drugs covered through the FPACT program are obtained by the Department from the drug companies involved. Rebates are estimated by using the actual Fee-for-Service (FFS) trend data for drug expenditures, and applying a historical percentage of the actual amounts collected to the trend projection.

In October 2008, the Department discontinued the collection of rebates for drugs that are not eligible for federal financial participation (FFP), which the Centers for Medicare & Medicaid Services (CMS) determined to be 24% of the FPACT drug costs. Effective July 2009, it is assumed 13.95% of the FPACT drug costs are not eligible for rebates.

SB 78 established the Medi-Cal Drug Rebate Fund (Fund 3331), effective July 1, 2019. The non-federal share of Medi-Cal federal and state supplemental drug rebates will be deposited into Fund 3331. See the Medi-Cal Drug Rebate Fund policy change for the estimated total transfers from Fund 3331 to the General Fund (GF).

FAMILY PACT DRUG REBATES
REGULAR POLICY CHANGE NUMBER: 32

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a decrease in rebates savings due to:
- Including two additional quarters of actual rebate collection data through quarter ending June 2024, and
- Decreased estimated FPACT pharmacy expenditures for the applicable expenditure period.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease in rebate savings due to an estimated decrease in FPACT pharmacy expenditures from FY 2024-25 to FY 2025-26.

Methodology:
1. The regular Federal Medical Assistance Percentage (FMAP) percentage is applied to 10.79% of the FPACT rebates to account for the purchase of non-family planning drugs, and the family planning percentage (90% FFP) is applied to 89.21% of the FPACT rebates.

2. Assume the ACA offset is $184,000 TF for FY 2024-25 and $175,000 TF for FY 2025-26.

3. Actual data from July 2013 to June 2024 is used to project rebates.

4. The Department estimates $352,000 and $333,000 FPACT rebate collections to be collected and transferred to the Medi-Cal Drug Rebate Fund in FY 2024-25 and FY 2025-26, respectively.

FY 2024-25	TF	FF	Fund 3331 Transfer
100% Title XIX FF	($2,100,000)	($2,100,000)	($352,000)
ACA Offset	($184,000)	($184,000)	$0
Total	**($2,284,000)**	**($2,284,000)**	($352,000)

FY 2025-26	TF	FF	Fund 3331 Transfer
100% Title XIX FF	($1,996,000)	($1,996,000)	($333,000)
ACA Offset	($175,000)	($175,000)	$0
Total	**($2,171,000)**	**($2,171,000)**	($333,000)

*The Fund 3331 Transfer column is for informational purposes only. See Methodology #4.

Funding:

MEDICAL SUPPLY REBATES

REGULAR POLICY CHANGE NUMBER: 33
IMPLEMENTATION DATE: 10/2006
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1181

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	-$188,800,000	-$136,800,000
- STATE FUNDS	-$94,400,000	-$51,983,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$188,800,000	-$136,800,000
STATE FUNDS	-$94,400,000	-$51,983,300
FEDERAL FUNDS	-$94,400,000	-$84,816,700

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 contracts with interested medical supply manufacturers for a negotiated Maximum Acquisition Cost (MAC) for specific medical supplies which guarantees the best price available to all providers, from at least one source. The amount, per unit, reimbursed to Medi-Cal pharmacy providers for these contracted specific medical supplies is the contracted MAC. In addition, manufacturers may opt to contract for a MAC plus a Rebate. The rebates are a percentage of the MAC per unit of services (quantity) reimbursed.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is an increase in savings due to:

- Estimating four quarters of rebate will be collected instead of three quarters due to shifting the implementation of rebate collection from a manual system to an automated system from FY 2024-25 to FY 2025-26,
- Revised projections based on updated actual rebate collection data, and
- Estimating retroactive rebates will be collected for new rebate contracts.

MEDICAL SUPPLY REBATES
REGULAR POLICY CHANGE NUMBER: 33

The change from FY 2024-25 to FY 2025-26 in the current estimate, is a decrease in savings due to:

- A one-time shift in the timing of rebate collections as a result of switching from a manual system to an automated system causing only three quarters of rebates to be collected in FY 2025-26, and
- No retroactive rebates estimated in FY 2025-26.

Methodology:

1. Assume the average FFS quarterly collections are for medical supply rebates are $45,600,000.

2. Assume retroactive rebates totaling $6,400,000 will be collected in FY 2024-25 for new rebate contracts.

3. There is a one quarter lag for medical supply rebate collections under the current manual process.

4. In FY 2025-26, medical supply rebate collections will transition to an automated system with a two quarter lag in rebate collections. This one-time adjustment will result in three quarter of rebates collected in FY 2025-26.

5. Assume the total rebates collected are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2024-25	**($188,800)**	**($94,400)**	**($94,400)**
FY 2025-26	**($136,800)**	**($51,983)**	**($84,817)**

Funding:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF	($188,800)	($94,400)	($94,400)
Total	**($188,800)**	**($94,400)**	**($94,400)**

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF	($93,477)	($46,738)	($46,738)
90% Title XIX / 10% GF	($39,673)	($3,967)	($35,706)
65% Title XXI / 35% GF	($3,650)	($1,278)	($2,373)
Total	**($136,800)**	**($51,983)**	**($84,817)**

STATE SUPPLEMENTAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 34
IMPLEMENTATION DATE: 1/1991
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 54

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	-$403,519,000	-$417,946,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$403,519,000	-$417,946,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$403,519,000	-$417,946,000

Purpose:
This policy change estimates the revenues collected from the State Supplemental Drug rebates.

Authority:
Welfare & Institutions Code 14105.33
SB 78 (Chapter 38, Statues of 2019)

Interdependent Policy Changes:
Medi-Cal Drug Rebate Fund
COVID-19 Redeterminations Impact

Background:
State supplemental drug rebates for drugs provided through Fee-for-Service (FFS) and County Organized Health Systems are negotiated by the Department with drug manufacturers to provide additional drug rebates over and above the federal rebate levels (see the Federal Drug Rebate policy change).

SB 78 established the Medi-Cal Drug Rebate Fund (Fund 3331) effective July 1, 2019. The non-federal share of Medi-Cal federal and state supplemental drug rebates will be deposited into Fund 3331. See the Medi-Cal Drug Rebate Fund policy change for the estimated total transfers from Fund 3331 to the General Fund (GF).

Reason for Change:
The change in FY 2024-25, from the prior estimate, is an increase in rebate savings due to:

- Including two additional quarters of actual rebate collection data through the quarter ending June 2024,
- An increase in FFS pharmacy expenditures for the applicable expenditure period, and
- Projections for state supplemental rebates are based on trends from actual rebate collection data to FFS drug expenditures.

STATE SUPPLEMENTAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 34

The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase in rebate savings due to estimating an increase in FFS pharmacy expenditures from FY 2024-25 to FY 2025-26.

Methodology:

1. Rebates are estimated by using actual FFS trend data for drug expenditures and applying a historical percentage of actual rebates collected to the FFS trend projection.

2. Assume family planning drugs account for 0.21% of the regular federal drug rebates and are funded with 90% FF and 10% GF.

3. CHIP rebates are funded at 65% FF / 35% GF beginning October 1, 2020. Assume CHIP drug rebates collections are $13,616,000 FF and $12,965,000 FF in FY 2024-25 and FY 2025-26, respectively.

4. The optional expansion ACA population collections are estimated to be $288,528,000 TF for FY 2024-25, of which $259,675,000 FF is budgeted in this policy change. The amount of $28,853,000 SF is the estimated non-federal share in the Medi-Cal Drug Rebate Fund. For FY 2025-26, the ACA collections are estimated to be $307,294,000 TF, of which $276,565,000 FF is budgeted in this policy change. The amount of $30,729,000 SF is the estimated non-federal share in the Medi-Cal Drug Rebate Fund.

5. The Department estimates to transfer $165,975,000 and $165,697,000 state supplemental rebates to be collected and transferred to the Medi-Cal Drug Rebate Fund in FY 2024-25 and FY 2025-26, respectively.

FY 2024-25	TF	FF	Fund 3331 Transfer
100% Title XIX FF	($130,228,000)	($130,228,000)	($137,122,000)
100% Title XIX ACA FF	($259,675,000)	($259,675,000)	($28,853,000)
100% Title XXI FF	($13,616,000)	($13,616,000)	$0
Total	**($403,519,000)**	**($403,519,000)**	($165,975,000)

FY 2025-26	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	($128,416,000)	($128,416,000)	($134,968,000)
100% Title XIX ACA FF	($276,565,000)	($276,565,000)	($30,729,000)
100% Title XXI FF	($12,965,000)	($12,965,000)	$0
Total	**($417,946,000)**	**($417,946,000)**	($165,697,000)

*The Fund 3331 Transfer column is for informational purposes only. See Methodology #5.

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

FEDERAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 35
IMPLEMENTATION DATE: 7/1990
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 55

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	-$4,397,108,000	-$4,515,587,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$4,397,108,000	-$4,515,587,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$4,397,108,000	-$4,515,587,000

Purpose:
This policy change estimates the revenues collected from the Federal Drug rebates.

Authority:
Social Security Act, section 1927 [42 U.S.C. 1396r–8]
Omnibus Budget Reconciliation Act (OBRA) of 1990, Title IV, sec. 4401(a)(3), 104 Stat.
SB 78 (Chapter 38, Statues of 2019)

Interdependent Policy Changes:
Medi-Cal Drug Rebate Fund
COVID-19 Redeterminations Impact

Background:
The Medicaid Drug Rebate Program, created by OBRA 1990, allows the Department to obtain price discounts for drugs. The Affordable Care Act (ACA), HR 3590, and the Health Care and Education Reconciliation Act of 2010 (HCERA), extended the federal drug rebate requirement to Medicaid managed care outpatient covered drugs. The Medicaid Drug Rebate Program helps lower Medicaid spending on outpatient prescription drugs. Drug manufacturers must enter into a national Medicaid drug rebate agreement in order to obtain Medicaid coverage for their prescription drugs. Drug manufacturers are required to pay a rebate for all outpatient drugs that are dispensed and paid for by the State's Medi-Cal program.

SB 78 established the Medi-Cal Drug Rebate Fund (Fund 3331), effective July 1, 2019. The non-federal share of Medi-Cal federal and state supplemental drug rebates will be deposited into Fund 3331. See the Medi-Cal Drug Rebate Fund policy change for the estimated total transfers from Fund 3331 to the General Fund (GF).

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to:

- Including two additional quarters of actual rebate collection data through the quarter ending June 2024, and

FEDERAL DRUG REBATES
REGULAR POLICY CHANGE NUMBER: 35

- An increase in actual and estimated ACA populations rebate collections resulting in higher federal funds (FF).

The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase in rebate savings due to estimating an increase in pharmacy expenditures from FY 2024-25 to FY 2025-26.

Methodology:

1. Rebates are invoiced quarterly and payments occur six months after the conclusion of each quarter.

2. Fee-for-Service (FFS) rebates are estimated by using actual FFS trend data for drug expenditures and applying a historical percentage of actual rebates collected to the FFS trend projection.

3. MC rebates are estimated by using the actual trend data for MC eligibles and applying a historical percentage of actual rebates collected to the trend projection.

4. Assume family planning drugs account for 0.21% of the regular federal drug rebates and are funded with 90% FF and 10% GF.

5. CHIP rebates are funded at 65% FF / 35% GF beginning October 1, 2020. Assume CHIP drug rebate collections are $124,946,000 FF and $118,975,000 FF in FY 2024-25 and FY 2025-26, respectively.

6. The optional expansion ACA population collections are estimated to be $2,519,545,000 TF for FY 2024-25, of which $2,267,591,000 FF is budgeted in this policy change. The amount of $251,954,000 SF is the estimated non-federal share in the Medi-Cal Drug Rebate Fund. For FY 2025-26, a total of $2,681,432,000 TF is estimated for the optional expansion population, of which $2,413,289,000 FF is budgeted in this policy change. The amount of $268,143,000 SF is the estimated non-federal share in the Medi-Cal Drug Rebate Fund.

7. The ongoing additional FF claimed by CMS (ACA Offset) is reflected in this policy change. The additional FF is $516,795,000 TF for FY 2024-25 and $523,763,000 TF for FY 2025-26.

8. The Department estimates $1,802,018,000 and $1,786,871,000 federal drug rebates to be collected and transferred to the Medi-Cal Drug Rebate Fund in FY 2024-25 and FY 2025-26, respectively.

(Dollars in Thousands)

FY 2024-25	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	($1,487,776)	($1,487,776)	($1,550,064)
100% Title XIX ACA FF	($2,267,591)	($2,267,591)	($251,954)
100% Title XXI FF	($124,946)	($124,946)	$0
ACA Offset	($516,795)	($516,795)	$0
Total	**($4,397,108)**	**($4,397,108)**	($1,802,018)

FEDERAL DRUG REBATES
REGULAR POLICY CHANGE NUMBER: 35

(Dollars in Thousands)

FY 2025-26	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	($1,459,560)	($1,459,560)	($1,518,728)
100% Title XIX ACA FF	($2,413,289)	($2,413,289)	($268,143)
100% Title XXI FF	($118,975)	($118,975)	$0
ACA Offset	($523,763)	($523,763)	$0
Total	**($4,515,587)**	**($4,515,587)**	($1,786,871)

*The Fund 3331 Transfer column is for informational purposes only. See Methodology #8.

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

HCBS SP - CONTINGENCY MANAGEMENT

REGULAR POLICY CHANGE NUMBER: 37
IMPLEMENTATION DATE: 5/2022
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2278

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$35,085,000	$48,581,000
- STATE FUNDS	$6,801,000	$9,532,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$35,085,000	$48,581,000
STATE FUNDS	$6,801,000	$9,532,000
FEDERAL FUNDS	$28,284,000	$39,049,000

Purpose:
This policy change estimates the cost of adding Contingency Management (CM) in select Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver counties as an optional evidence-based Medi-Cal benefit under the federally approved CalAIM Section 1115(a) Waiver Program using enhanced federal funding from the American Rescue Plan Act of 2021 (ARP).

Authority:
American Rescue Plan (ARP) Act (2021)
Budget Act of 2021 [SB 129 (Chapter 69, Statutes of 2021)]
CalAIM 1115 Demonstration Waiver

Interdependent Policy Changes:
Not Applicable

Background:
The ARP Act of 2021 provides additional Coronavirus Disease 2019 (COVID-19) relief to states. Section 9817 of the ARP provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS). Increased FMAP is available from April 1, 2021, through March 31, 2022. States must use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021, and states must use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. State funds equivalent to the amount of federal funds attributable to the increased FMAP are deposited in the Home and Community-Based Services American Rescue Plan (HCBS ARP) Fund pursuant to Section 11.95 of the 2021 Budget Act. Section 11.95 appropriates this funding to eligible HCBS activities identified in the HCBS Spending Plan.

The Centers for Medicare and Medicaid Services (CMS) approved the addition of CM as an optional benefit in DMC-ODS counties as part of the 1115 Demonstration Waiver renewal, as a pilot, beginning July 1, 2022 through December 31, 2026. Contingency management uses small

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motivational incentives combined with behavioral health treatment and has been shown in repeated meta-analyses to be the most effective treatment for stimulant use disorder. Contingency management was approved in the 2021 Budget Act, funded from the HCBS ARP Fund. The Department will extend the Recovery Incentives Program as an optional CM benefit for all DMC-ODS counties who opt-in to cover CM as a DMC-ODS service in alignment with the timeline of the CalAIM 1115 Demonstration waiver (through December 31, 2026). Funding for the non-federal share of administrative costs for CM services will continue with HCBS funds through the final claiming date of August 15, 2024. After the end of the HCBS Spending Plan, counties will have the option to continue offering Contingency Management services and provide the non-federal share of the funding.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is a decrease due to a slower-than-expected rollout of the program, which led to a lower-than-projected number of operational sites. In addition, county funds are used instead of intergovernmental transfers (IGTs) for CM Incentive costs.

The change in the current estimate, from FY 2024-25 to FY 2025-26, is an increase due to a higher projected number of participating sites and increased utilization of the benefit. In addition, spending from the HCBS funds was completed in FY 2024-25.

Methodology:
1. Contingency management was added as an optional service to the CalAIM 1115 Demonstration Waiver effective January 1, 2022, and services began in April 2023.

2. Prior to implementation of the benefit, $3,535,000 in initial start-up funding was provided to counties in FY 2021-22 and distributed through the Behavioral Health Quality Improvement Program (BH-QIP).

3. Ongoing services for Contingency Management include the following costs:
    - Incentive costs for members averaging $300 per year (up to a maximum of $599)
    - Contingency management services costs

4. Assume HCBS funding will be available for the non-federal share of Contingency Management services through August 15, 2024 claiming dates.

5. The Department implemented the CalAIM Behavioral Health Payment Reform and a new IGT process. For all claims with dates of service on or after July 1, 2023, counties transfer the county portion of the submitted claims before FF can be used for payment.

6. Total estimated costs for contingency management, on a cash basis, is as follows:

FY 2024-25	TF	HCBS ARP Fund	IGT*	FF	CF
CM Incentive Costs	$2,978,000	$10,000	$0	$2,360,000	$608,000
CM Services Costs	$32,715,000	$117,000	$6,674,000	$25,924,000	$0
Total	$35,693,000	**$127,000**	**$6,674,000**	**$28,284,000**	$608,000

HCBS SP - CONTINGENCY MANAGEMENT

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FY 2025-26	TF	IGT*	FF	CF
CM Incentive Costs	$4,339,000	$0	$3,423,000	$916,000
CM Services Costs	$45,158,000	$9,532,000	$35,626,000	$0
Total	$49,497,000	**$9,532,000**	**$39,049,000**	$916,000

Funding:
100% Title XIX (4260-101-0890)
100% Title XXI (4260-101-0890)
100% ACA Title XIX FF (4260-101-0890)
Medi-Cal County Behavioral Health Fund (4260-601-3420)*
Home and Community-Based Services American Rescue Plan Fund (4260-101-8507)

DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 39
IMPLEMENTATION DATE: 7/2021
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 1724

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$20,290,000	$21,416,000
- STATE FUNDS	$4,489,450	$4,738,350
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	29.07 %	27.54 %
APPLIED TO BASE		
TOTAL FUNDS	$14,391,700	$15,518,000
STATE FUNDS	$3,184,370	$3,433,410
FEDERAL FUNDS	$11,207,330	$12,084,630

Purpose:
This policy change budgets the annual rate adjustment to the Drug Medi-Cal (DMC) rates.

Authority:
Welfare & Institutions Code 14021.51; 14021.6(b)(1); 14021.9(c); and 14105(a)
Title 22, California Code of Regulations, Section 51516.1(a)(g)

Interdependent Policy Changes:
Not Applicable

Background:
The DMC program currently covers the following Substance Use Disorder (SUD) services under the State Plan: Outpatient Drug-Free Treatment Services (ODF), Intensive Outpatient Treatment Services (IOT), Residential Treatment Services (RTS) for pregnant and postpartum women, and the Narcotic Treatment Program (NTP).

Prior to FY 2023-24, on an annual basis, the Department adjusted 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 were based either on the developed rates using annual cost report settlement data, or the FY 2009-10 Budget Act rates adjusted for the CIP deflator, whichever was lower.

Under the of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the Department has developed rates for DMC services using new methodologies which are more specific to the provider type providing the service and/or to each county's costs. DMC rates using these methodologies were implemented on July 1, 2023. Annually, the Department will adjust the DMC rates by the percentage change in the four-quarter average Home Health Agency (HHA) Market Basket Index.

DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 39

The proposed DMC rates for the following services are based on county specific, outpatient, hourly rates per provider type developed under the CalAIM initiative:

- NTP Individual Counseling – Regular and Perinatal
- NTP Group Counseling – Regular and Perinatal
- IOT – Regular and Perinatal
- ODF Individual Counseling – Regular and Perinatal
- ODF Group Counseling – Regular and Perinatal

The proposed DMC rates for the following services are based on county specific, per dose, dosing rates developed under the CalAIM initiative:

- NTP Dosing – Regular and Perinatal
- (Medication Addiction Treatment) MAT Dosing – Regular and Perinatal

The proposed DMC rates for 24-Hour Services – Regular and Perinatal (formerly RTS) are based on county-specific daily rates established under the CalAIM initiative.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is a net decrease due to the following:

- Updated FY 2023-24 and FY 2024-25 rates for 24-Hour Services (formerly RTS),
- Including an estimate for the MAT rate adjustments,
- Assuming a portion of the FY 2023-24 rate adjustments are reflected in the Drug Medi-Cal State Plan base estimate, and
- A revised payment lag for FY 2023-24 and FY 2024-25 claims. For FY 2023-24, the proportion of claims paid within the same year decreases from 76% to 21.1%, with 78.4% paid in the second year, and 0.5% in the third year. For FY 2024-25, the payment lag is revised to 62.6% of claims paid in the same year, 37% in the second year, and 0.4% in the third year.

The change in the current estimate, from FY 2024-25 to FY 2025-26, is due to including the HHA market basket increase for the FY 2025-26 rates.

Methodology:
1. The FY 2023-24 developed rates, FY 2024-25 developed rates, and FY 2025-26 estimated rates for regular and perinatal services are:

Regular Services	FY 2023-24 Developed Rates	FY 2024-25 Developed Rates	FY 2025-26 Estimated Rates
NTP	$21.44	$22.10	$22.78
NTP Individual Counseling	$75.72	$78.05	$80.45
NTP Group Counseling	$16.83	$17.34	$17.87
Intensive Outpatient Treatment	$340.74	$351.23	$362.05
24-Hour Services	$221.85	$228.68	$235.73
ODF Individual Counseling	$378.60	$390.26	$402.28
ODF Group Counseling	$151.44	$156.10	$160.91
MAT	$57.74	$59.51	$61.35

DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 39

Perinatal Services	FY 2023-24 Developed Rates	FY 2024-25 Developed Rates	FY 2025-26 Estimated Rates
NTP	$32.94	$33.95	$35.00
NTP Individual Counseling	$75.72	$78.05	$80.45
NTP Group Counseling	$16.83	$17.34	$17.87
Intensive Outpatient Treatment	$340.74	$351.23	$362.05
24-Hour Services	$221.85	$228.68	$235.73
ODF Individual Counseling	$378.60	$390.26	$402.28
ODF Group Counseling	$151.44	$156.10	$160.91
MAT	$66.90	$68.97	$71.09

2. The incremental rate changes for FY 2024-25 and FY 2025-26 are shown below:

Incremental Difference	FY 2024-25 Regular	FY 2024-25 Perinatal	FY 2025-26 Regular	FY 2025-26 Perinatal
NTP	$0.66	$1.01	$0.68	$1.05
NTP Individual Counseling	$2.33	$2.33	$2.40	$2.40
NTP Group Counseling	$0.51	$0.51	$0.53	$0.53
Intensive Outpatient Treatment	$10.49	$10.49	$10.82	$10.82
24-Hour Services	$6.83	$6.83	$7.04	$7.04
ODF Individual Counseling	$11.66	$11.66	$12.02	$12.02
ODF Group Counseling	$4.66	$4.66	$4.81	$4.81
MAT	$1.78	$2.06	$1.83	$2.12

3. The cost estimate for FY 2024-25, based on the incremental rate changes for FY 2023-24 and FY 2024-25 are:

FY 2024-25 - Regular	Total Number of Units	FY 2023-24 Rate Adj. (A)	FY 2024-25 Incremental Difference	FY 2024-25 Rate Adj. (B)	Total Rate Adj. Cost (C=A+B)
NTP	426,671	$2,238,000	$0.66	$280,000	$2,518,000
NTP Individual Counseling	211,627	$12,001,000	$2.33	$493,000	$12,494,000
Intensive Outpatient Treatment	2,138	$542,000	$10.49	$22,000	$564,000
ODF Individual Counseling	8,073	$2,289,000	$11.66	$94,000	$2,383,000
ODF Group Counseling	23,178	$2,574,000	$4.66	$108,000	$2,682,000
MAT	746	$5,000	$1.78	$1,000	$6,000
Total for Regular Services		$19,649,000		$998,000	$20,647,000

DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 39

FY 2024-25 - Perinatal	Total Number of Units	FY 2023-24 Rate Adj. (D)	FY 2024-25 Incremental Difference	FY 2024-25 Rate Adj. (E)	Total Rate Adj. Cost (F=D+E)
Intensive Outpatient Treatment	377	$89,000	$10.49	$4,000	$93,000
24-Hour Services	241	$23,000	$6.83	$2,000	$25,000
ODF Individual Counseling	15	$4,000	$11.66	$0	$4,000
ODF Group Counseling	34	$2,000	$4.66	$0	$2,000
Total for Perinatal Services		$118,000		$6,000	$124,000

4. The cost estimate for FY 2025-26, based on the incremental rate changes for FY 2023-24, FY 2024-25 and FY 2025-26 are:

FY 2025-26 - Regular	Total Number of Units	FY 2025-26 Incremental Difference	FY 2025-26 Rate Adj. (G)	Total Rate Adj. Cost (H=A+B+G)
NTP	426,671	$0.68	$290,000	$2,808,000
NTP Individual Counseling	211,627	$2.40	$509,000	$13,003,000
Intensive Outpatient Treatment	2,138	$10.82	$23,000	$587,000
ODF Individual Counseling	8,073	$12.02	$97,000	$2,480,000
ODF Group Counseling	23,178	$4.81	$111,000	$2,793,000
MAT	746	$1.83	$1,000	$7,000
Total for Regular Services			$1,031,000	$21,678,000

FY 2025-26 – Perinatal	Total Number of Units	FY 2025-26 Incremental Difference	FY 2025-26 Rate Adj. (I)	Total Rate Adj. Cost (J=D+E+I)
Intensive Outpatient Treatment	377	$10.82	$4,000	$97,000
24 Hour Services	241	$7.04	$2,000	$27,000
ODF Individual Counseling	15	$12.02	$0	$4,000
ODF Group Counseling	34	$4.81	$0	$2,000
Total for Perinatal Services			$6,000	$130,000

5. Effective July 1, 2023, non-federal share of costs that was initially funded with county funds (CF), will be funded through an inter-governmental transfer (IGT).

6. For FY 2023-24 rates, assume 21.1% of DMC claims are paid in the same year the services occur, 78.4% in the second year, and the remaining 0.5% in the third year.

7. For FY 2024-25 and FY 2025-26 rates, assume 62.6% of DMC claims are paid in the same year the services occur, 37% in the second year, and the remaining 0.4% in the third year.

DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT
REGULAR POLICY CHANGE NUMBER: 39

8. Total estimated costs for the annual rate adjustments are:

Annual Rate Adj. Cost	FY 2024-25 Rates (C+F)	FY 2025-26 Rates (H+J)	FY 2024-25 (Lagged)	FY 2025-26 (Lagged)
NTP	$15,012,000	$15,811,000	$14,664,000	$15,527,000
ODF	$5,071,000	$5,279,000	$4,954,000	$5,184,000
IOT	$657,000	$684,000	$642,000	$671,000
24-Hour Services	$25,000	$27,000	$24,000	$27,000
MAT	$6,000	$7,000	$6,000	$7,000
Total	$20,771,000	$21,808,000	**$20,290,000**	**$21,416,000**

FY 2024-25	TF	GF	IGT*	FF
Regular				
Current	$6,042,000	$83,000	$2,933,000	$3,026,000
ACA Optional	$14,126,000	$1,412,000	$0	$12,714,000
Perinatal				
Current	$122,000	$0	$61,000	$61,000
Total	**$20,290,000**	**$1,495,000**	**$2,994,000**	**$15,801,000**

FY 2025-26	TF	GF	IGT*	FF
Regular				
Current	$6,378,000	$86,000	$3,097,000	$3,195,000
ACA Optional	$14,910,000	$1,491,000	$0	$13,419,000
Perinatal				
Current	$128,000	$0	$64,000	$64,000
Total	**$21,416,000**	**$1,577,000**	**$3,161,000**	**$16,678,000**

Funding:
100% Title XIX FF (4260-101-0890)
100% Title XXI FF (4260-101-0890)
Medi-Cal County Behavioral Health Fund (4260-601-3420)*
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)
65% Title XXI / 35% GF (4260-101-0001/0890)
50% Title XIX / 50% GF (4260-101-0001/0890)

DRUG MEDI-CAL PROGRAM COST SETTLEMENT

REGULAR POLICY CHANGE NUMBER: 40
IMPLEMENTATION DATE: 7/2021
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 1723

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$927,000	$874,000
- STATE FUNDS	$108,000	$103,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$927,000	$874,000
STATE FUNDS	$108,000	$103,000
FEDERAL FUNDS	$819,000	$771,000

Purpose:
This policy change estimates the cost settlements to counties and contracted providers for payments related to Drug Medi-Cal (DMC) services.

Authority:
Welfare & Institutions Code 14124.24 (g)(1)
Title 22, California Code of Regulations 51516.1

Interdependent Policy Changes:
Not Applicable

Background:
The DMC program currently covers the following Substance Use Disorder (SUD) services under the State Plan: Outpatient Drug-Free Treatment Services (ODF), Intensive Outpatient Treatment Services (IOT), Residential Treatment Services (RTS) for pregnant and postpartum women, and Narcotic Treatment Program (NTP).

The DMC program initially pays a claim for SUD services at a provisional rate, not to exceed the State's maximum allowance. At the end of each fiscal year, providers for non-NTP services must submit actual cost information. The DMC program completes a final settlement after receipt and review of the provider's cost report. The cost settlement is based on the county's certified public expenditures (CPE). The Department has the authority to audit the cost reports within three years of the cost settlement.

Cost settlements for non-NTP services is limited to the lowest of the following costs:

- Provider's usual and customary charge to the general public for the same or similar services,
- Provider's allowable costs of providing the service, or
- DMC statewide maximum allowance for the service.

DRUG MEDI-CAL PROGRAM COST SETTLEMENT

REGULAR POLICY CHANGE NUMBER: 40

Cost settlements for NTP services is limited to the lowest of the following costs:

- Provider's usual and customary charge to the general public for the same or similar services, or
- DMC statewide maximum allowance for the service.

Starting July 1, 2014, as instructed by the Centers for Medicare & Medicaid Services (CMS), the Department changed its cost settlement process to counties for their administrative expenses through a quarterly claims and cost settlement process. Prior to that, counties were paid for their DMC expenses (services and administration) through CPE as part of an all-inclusive rate. Starting from the FY 2014-15 annual cost report settlement, all amounts for administrative cost reimbursements or recoupments will be included in the Drug Medi-Cal County Administration policy change.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is due to an overall increase in processed cost settlement invoices. As a result, the estimate for FY 2024-25 has shifted from a net recoupment to a net payment.

The change in the current estimate, from FY 2024-25 to FY 2025-26, is a net decrease due to the expectation of more county recoupments for audit settlements in FY 2025-26.

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 audit settlements are based on comparing actual expenditures against the audited cost settlements. 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 following estimated cost settlements and audit settlements for the annual cost reports will be recouped in FY 2024-25 and FY 2025-26:

FY 2024-25	TF	GF	Title XIX	Title XXI	CF
FY 2018-19 Audit Settlements	($1,611,000)	($80,000)	($905,000)	($9,000)	($617,000)
FY 2019-20 Audit Settlements	($162,000)	($8,000)	($91,000)	($1,000)	($62,000)
FY 2018-19 Cost Settlements	$1,968,000	$191,000	$1,575,000	$202,000	$0
FY 2019-20 Cost Settlements	$53,000	$5,000	$43,000	$5,000	$0
Total	$248,000	**$108,000**	**$622,000**	**$197,000**	($679,000)

DRUG MEDI-CAL PROGRAM COST SETTLEMENT

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FY 2025-26	TF	GF	Title XIX	Title XXI	CF
FY 2018-19 Audit Settlements	($80,000)	($4,000)	($45,000)	$0	($31,000)
FY 2019-20 Audit Settlements	($1,451,000)	($72,000)	($815,000)	($9,000)	($555,000)
FY 2020-21 Audit Settlements	($241,000)	($12,000)	($136,000)	($1,000)	($92,000)
FY 2019-20 Cost Settlements	$1,862,000	$181,000	$1,490,000	$191,000	$0
FY 2020-21 Cost Settlements	$106,000	$10,000	$85,000	$11,000	$0
Total	$196,000	**$103,000**	**$579,000**	**$192,000**	($678,000)

Funding:
100% General Fund (4260-101-0001)
100% Title XIX (4260-101-0890)
100% Title XXI (4260-101-0890)

BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE

REGULAR POLICY CHANGE NUMBER: 43
IMPLEMENTATION DATE: 7/2022
ANALYST: Tyler Shimizu
FISCAL REFERENCE NUMBER: 2262

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$530,635,000	$411,695,000
- STATE FUNDS	$350,135,000	$411,695,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$530,635,000	$411,695,000
STATE FUNDS	$350,135,000	$411,695,000
FEDERAL FUNDS	$180,500,000	$0

Purpose:
This policy change estimates the funding available for competitive grants to qualified entities to construct, acquire and rehabilitate real estate assets or to invest in infrastructure, including mobile crisis services, to expand the community continuum of behavioral health treatment resources.

Authority:
SB 129 (Chapter 69, Statutes of 2021)
AB 179 (Chapter 249, Statutes of 2022)
American Rescue Plan (ARP) Act (2021)

Interdependent Policy Changes:
Not Applicable.

Background:
The Department aims to reduce homelessness, incarceration, unnecessary hospitalizations, and inpatient days and improve outcomes for people with behavioral health conditions by expanding access to community-based treatment. The Department also seeks to ensure Medi-Cal members have access to sufficient treatment resources across the behavioral health continuum of care, prioritizing community-based, non-institutional treatment options to address needs in crisis and for longer-term residential treatment. To support these efforts, the Behavioral Health Continuum Infrastructure Program (BHCIP) expands the community continuum of behavioral health treatment resources by providing grants to qualified entities to construct, acquire, and rehabilitate real estate assets or to invest in mobile crisis infrastructure. The investment in real estate assets expands the continuum of services by increasing capacity for short-term crisis stabilization, acute and sub-acute care, crisis residential, community-based mental health residential treatment, substance use disorder residential treatment, peer respite, community and outpatient behavioral health services, and other clinically enriched longer-term treatment and rehabilitation opportunities for persons with behavioral health disorders in the least restrictive and least costly setting.

BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE
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The BHCIP grant funds will be awarded in the rounds focused on the following: mobile crisis infrastructure, county and tribal planning grants, new launch-ready infrastructure projects, infrastructure focused on children and youth 25 years of age and younger (which is part of the Children and Youth Behavioral Health Initiative (CYBHI)), and infrastructure to address gaps in the state's behavioral health continuum.

Behavioral treatment resources funded pursuant the program may qualify for an exemption from the California Environmental Quality Act and automatic zoning compliance requirements.

The American Rescue Plan Act (ARPA) includes funding to state and local governments. The funds are distributed to states, tribes, and territories based on a formula that considers the state's share of the nation's unemployment. The ARPA funds can be used for specific purposes including addressing public health impacts, negative economic impacts, and water, sewer, and broadband. State and local governments have until December 31, 2024, to encumber the funds and until December 31, 2026, to liquidate the funds. Given that the DHCS Medi-Cal Estimate is budgeted on a cash basis, DHCS has until December 31, 2026, to expend of the State Fiscal Recovery Fund (SFRF) funds.

The CYBHI augments the BHCIP funding for FY 2021-22 and FY 2022-23. The CYBHI is a multiyear package of investments as part of the 2021 Budget Act. The CYBHI is intended to transform California's behavioral health system for children and youth aged 0-25 into a world-class, innovative, up-stream focused, ecosystem where all children and young adults are routinely screened, supported, and served for emerging behavioral health needs. BHCIP infrastructure grants targeted to children and youth aged 25 or younger are part of the CYBHI, however, costs are reflected solely in this policy change.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is an increase due to the reassessment of project progress and status of construction phase. Projected funding increase in expenditures for FY 2024-25 align with funding needs of BHCIP grantees.

The change from FY 2024-25 to FY 2025-26, in the current estimate is a net decrease due to lower GF spending with no SFRF spending from the 2021-22 allocation in FY 2025-26; and higher GF spending from the 2022-23 allocation in FY 2025-26.

Methodology:
1. The 2021-22 Budget Act amount of $743,499,000 TF in local assistance funding is included in the Medi-Cal Estimate. The approved local assistance funding included $300 million from SFRF available for expenditure through December 31, 2026, and $443,499,000 from the General Fund available for expenditure through June 30, 2026. The 2022-23 Budget Act appropriated $713,050,000 GF in local assistance funding available for expenditure through June 30, 2027, and $218,500,000 from SFRF, available for expenditure through December 31, 2026.
   - Of the GF funding, $480,500,000 is available to support the Children and Youth RFA, $430,049,000 for the Crisis and Behavioral Health Continuum RFA.
   - The $218,500,000 SFRF will be allocated to the Launch Ready RFA (progress payments.

2. Of the funds appropriated in the 2021 Budget Act, assume $466,000,000 TF will be expended for qualified entities to expand resources. This includes:

BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE

REGULAR POLICY CHANGE NUMBER: 43

- $166,000,000 GF including, $150,000,000 to support mobile crisis infrastructure and $16,000,000 for County and Tribal Planning Grants.
- $300,000,000 SFRF will be allocated to the Launch Ready RFA (initial payments).

3. Assume $530,635,000 TF will be paid in FY 2024-25 from the 2021-22 and 2022-23 Budget Act amounts. Funding was made available via a competitive application process.

4. Assume $411,695,000 TF will be paid in FY 2025-26 from the 2021-22 and 2022-23 Budget Act amounts.

5. The table below displays the estimated spending and remaining funds by Appropriation Years:

(Dollars in Thousands)

	TF	GF	SFRF
Appropriation Year 2021-22	$743,499	$443,499	$300,000
Prior Years	$317,509	$198,009	$119,500
Estimated in FY 2024-25	$355,120	$174,620	$180,500
Estimated in FY 2025-26	$70,870	$70,870	$0
Total Estimated Remaining	$0	$0	$0
Appropriation Year 2022-23	$931,550	$713,050	$218,500
Prior Years	$298,500	$80,000	$218,500
Estimated in FY 2024-25	$175,515	$175,515	$0
Estimated in FY 2025-26	$340,825	$340,825	$0
Total Estimated Remaining	$116,710	$116,710	$0

6. The estimated costs in FY 2024-25 and FY 2025-26 are as follows:

(Dollars in Thousands)

FY 2024-25	TF	GF	SFRF
Appropriation Year 2021-22	$355,120	$174,620	$180,500
Appropriation Year 2022-23	$175,515	$175,515	$0
Total FY 2024-25	**$530,635**	**$350,135**	**$180,500**

(Dollars in Thousands)

FY 2025-26	TF	GF
Appropriation Year 2021-22	$70,870	$70,870
Appropriation Year 2022-23	$340,825	$340,825
Total FY 2025-26	**$411,695**	**$411,695**

BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE

REGULAR POLICY CHANGE NUMBER: 43

Funding:
100% GF (4260-101-0001)
State Fiscal Recovery Fund of 2021 (4260-162-8506)

MHP COSTS FOR FFPSA

REGULAR POLICY CHANGE NUMBER: 44
IMPLEMENTATION DATE: 10/2021
ANALYST: Tyler Shimizu
FISCAL REFERENCE NUMBER: 2252

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$60,616,000	$37,299,000
- STATE FUNDS	$29,915,000	$18,648,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$60,616,000	$37,299,000
STATE FUNDS	$29,915,000	$18,648,000
FEDERAL FUNDS	$30,701,000	$18,651,000

Purpose:
This policy change estimates the reimbursement to mental health plans (MHPs) for expenditures related to pre and post care of foster children and youth treated in Short-Term Residential Therapeutic Programs (STRTPs). Beginning October 1, 2021, MHPs implemented a Qualified Individual (QI) to provide specific intensive case management prior to or within 30 days of an admission to a STRTP. Beginning October 1, 2021, MHPs began providing six months of intensive aftercare treatment to foster children and youth for six months after being discharged from a STRTP to a family-based setting.

Authority:
Family First Prevention Services Act (Public Law 115-123)
AB 153 (Chapter 86, Statutes of 2021)

Interdependent Policy Changes:
Not Applicable

Background:
FFPSA – Qualified Individual
The federal Family First Prevention Services Act (FFPSA) was signed into law on February 9, 2018. Prior to enactment of FFPSA, MHPs were only required to provide Medi-Cal beneficiaries, including those in the Foster Care system, all medically necessary specialty mental health services (SMHS). Current law provides for an Interagency Placement Committee (IPC), representing Child Welfare, Probation and County Mental Health (at a minimum), to determine eligibility for STRTP placement. However, historically there had been no specified criteria or process for making the determination. The MHP's only obligation was to determine medical necessity for the mental health services provided within the facility (e.g., group therapy), not for the need for a residential level of care.

FFPSA requires the independently certified QI to perform a detailed assessment of the strengths and needs of the child, including reviewing past clinical and social service records, meeting with the child and family team (CFT) members, completing a detailed Child and Adolescent Needs and Strengths (CANS) tool, and conducting a clinical assessment to

MHP COSTS FOR FFPSA
REGULAR POLICY CHANGE NUMBER: 44

determine if home-based placement and services are more appropriate than residential care and if not, that the placement in a STRTP provides the most effective and appropriate level of care setting in the least restrictive environment, and the placement is consistent with the short-term and long-term mental and behavioral health goals and permanency plan for the child. The QI must engage with the CFTs and mental health providers, and if the STRTP is not medically necessary, must provide intensive care coordination (ICC) and make recommendations for more appropriate services. This is a much higher level of care coordination and care management than was provided prior to FFPSA and is expected to require at least 10 hours per client.

FFPSA – After Care
FFPSA also requires states to provide discharge planning and family-based after care support for at least 6 months after a foster child or youth is discharged from an STRTP. Discharge planning with a focus on family-based support for 6 months post-discharge is expected to result in an increase in utilization of medically necessary SMHS during the 6 months after discharge. The California Department of Social Services (CDSS) and the Department will utilize the High-Fidelity Wraparound (HFW) model to meet the aftercare requirement of FFPSA, as its substantial research base demonstrates improved outcomes in children and youth in foster care with complex mental health needs.

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

The requirements for FFPSA - QI are beyond what is currently required for medical necessity determinations, and therefore would trigger Proposition 30. For FFPSA - After Care, the Department has created a process for HFW services to ensure the enhanced match rate only applies to aftercare services meeting criteria for the HFW model and meeting medical necessity criteria for SMHS. SMHS provided to beneficiaries that are not part of a HFW model are considered existing county obligations and are not expected to prompt additional state funding requests pursuant to Proposition 30.

As a result of the COVID-19 national public health emergency, increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to updated SMHS payment lag percentages and minor updates to FY 2024-25 assessment costs.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to COVID-19 increased FFP ending, caseload updates for FY 2025-26, and lower aftercare costs estimated in FY 2025-26.

MHP COSTS FOR FFPSA
REGULAR POLICY CHANGE NUMBER: 44

Methodology:
FFPSA Qualified Individual
Standardized Assessments

1. Assume 5,914 children and youth will be placed in an STRTP in FY 2022-23, 3,850 in FY 2023-24, 3,339 in FY 2024-25, and 3,227 in FY 2025-26. Additionally, it is assumed that there will be an average of 1.37 assessments per child in FY 2022-23, 1.41 assessments per child in FY 2023-24 through FY 2024-25, and 1.43 assessments per child in FY 2025-26.

2. Assume Standardized Assessment by a QI began on October 1, 2021.

3. Assume that the total number of assessments will be a factor of the assumed number of youths to be placed, multiplied by the assumed number of assessments per youth. Assume standardized assessments performed by a QI totaled 8,102 in FY 2022-23, 5,429 in FY 2023-24, 4,695 in FY 2024-25, and 4,611 in FY 2025-26. Each standardized assessment takes 10 total hours to complete.

4. Assume MHPs will spend, on average, $283.20 per hour for a qualified individual to complete an assessment. The Department estimates MHPs will spend $22,945,374 for a QI to complete standardized assessments in FY 2022-23 and $15,373,512 in FY 2023-24, and $13,296,240 in FY 2024-25, and $13,058,352 in FY 2025-26.

Fiscal Year	Total Assessments Per Year	Assessment Hours	Cost Per Hour (QI)	Assessment Cost
FY 2022-23	8,102	10	$283.20	$22,945,374
FY 2023-24	5,429	10	$283.20	$15,373,512
FY 2024-25	4,695	10	$283.20	$13,296,240
FY 2025-26	4,611	10	$283.20	$13,058,352

Child and Family Team (CFT)

5. Assume the QI spends 2 hours providing a reimbursable SMHS in each CFT. Assume MHPs will spend, on average, $283.20 per hour for a QI to participate in CFT meetings while children and youth are placed in an STRTP. The Department estimates MHPs will spend $10,149,559 for QI participation in CFTs in FY 2022-23 and $6,759,984 in FY 2023-24, and $5,843,838 in FY 2024-25, and $5,647,818 in FY 2025-26.

MHP COSTS FOR FFPSA
REGULAR POLICY CHANGE NUMBER: 44

Fiscal Year	CFT Meetings	CFT Hours	Cost Per Hour (QI)	CFT Cost
FY 2022-23	17,919	2	$283.20	$10,149,559
FY 2023-24	11,935	2	$283.20	$6,759,984
FY 2024-25	10,318	2	$283.20	$5,843,838
FY 2025-26	9,971	2	$283.20	$5,647,818

FFPSA – After Care

6. CDSS estimates the total cost of providing services pursuant to the HFW model to be $54,450,000 in FY 2022-23, $44,733,000 in FY 2023-24, and $34,203,000 in FY 2024-25, and $32,955,000 in FY 2025-26.

7. Analysis of the set of services contained in the HFW model show that, on average, 45% of these services are likely to be billable to child welfare departments and 55% are estimated to meet medical necessity criteria for SMHS.

8. The Department projects the total cost of providing SMH aftercare services will be $29,947,500 in FY 2022-23, $24,603,150 in FY 2023-24, and $18,811,650 in FY 2024-25, and $18,125,250 in FY 2025-26.

9. The Department will implement the CalAIM Behavioral Health Payment Reform and a new Intergovernmental Transfers (IGTs) process. For all claims with dates of service on or after July 1, 2023, counties will transfer the county portion of the submitted claims to the Department before Federal Financial Participation can be used for payment. IGTs are budgeted in the Medi-Cal County Behavioral Health Fund beginning July 1, 2023.

Funding Summary

10. Assume on a cash basis for FY 2024-25, the Department will pay 0.39% of FY 2022-23, 76.92% of FY 2023-24 claims and 64.55 % of FY 2024-25 claims. On a cash basis for FY 2025-26, the Department will pay 0.39% of FY 2023-24 claims, 35.16% of FY 2024-25 claims, and 64.55% of FY 2025-26 claims. The estimated costs, on a cash basis, are:

MHP COSTS FOR FFPSA
REGULAR POLICY CHANGE NUMBER: 44

(Dollars in Thousands)

	TF	GF	FF	COVID-19 FF	IGT	CF
FY 2022-23						
Assessments	$87	$19	$44	$5	$0	$19
CFTs	$40	$9	$20	$2	$0	$9
After care	$96	$23	$47	$1	$0	$25
Total	$223	$51	$111	$8	$0	$53
FY 2023-24						
Assessments	$11,825	$2,897	$5,913	$118	$2,897	$0
CFTs	$5,200	$1,274	$2,600	$52	$1,274	$0
After care	$18,923	$4,636	$9,462	$189	$4,636	$0
Total	$35,948	$8,807	$17,975	$359	$8,807	$0
FY 2024-25						
Assessments	$8,583	$2,146	$4,291	$0	$2,146	$0
CFTs	$3,772	$943	$1,886	$0	$943	$0
After care	$12,143	$3,036	$6,071	$0	$3,036	$0
Total	$24,498	$6,125	$12,248	$0	$6,125	$0
TOTAL FY 2024-25	$60,669	**$14,983**	**$30,334**	**$367**	**$14,932**	$53

MHP COSTS FOR FFPSA

REGULAR POLICY CHANGE NUMBER: 44

(Dollars in Thousands)

	TF	GF	FF	COVID-19 FF	IGT*	CF
FY 2023-24						
Assessments	$61	$15	$30	$1	$15	$0
CFTs	$25	$6	$13	$0	$6	$0
After care	$94	$23	$47	$1	$23	$0
Total	$180	$44	$90	$2	$44	$0
FY 2024-25						
Assessments	$4,675	$1,169	$2,337	$0	$1,169	$0
CFTs	$2,055	$514	$1,027	$0	$514	$0
After care	$6,615	$1,654	$3,307	$0	$1,654	$0
Total	$13,345	$3,337	$6,671	$0	$3,337	$0
FY 2025-26						
Assessments	$8,429	$2,107	$4,215	$0	$2,107	$0
CFTs	$3,645	$911	$1,823	$0	$911	$0
After care	$11,700	$2,925	$5,850	$0	$2,925	$0
Total	$23,774	$5,943	$11,888	$0	$5,943	$0
TOTAL FY 2025-26	$37,299	**$9,324**	**$18,649**	**$2**	**$9,324**	$0

Funding:
100% Title XIX FFP (4260-101-0890)
100% Title XIX GF (4260-101-0001)
COVID-19 Title XIX Increased FFP (4260-101-0890)
Medi-Cal County Behavioral Health Fund* (4260-601-3420)

CALAIM - BH - CONNECT DEMONSTRATION

REGULAR POLICY CHANGE NUMBER: 45
IMPLEMENTATION DATE: 1/2025
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2394

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$29,593,000	$784,384,000
- STATE FUNDS	$9,470,000	$258,378,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$29,593,000	$784,384,000
STATE FUNDS	$9,470,000	$258,378,000
FEDERAL FUNDS	$20,123,000	$526,006,000

Purpose:
This policy change estimates the cost of the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration to expand access and strengthen the continuum of mental health services for Medi-Cal members living with significant behavioral health needs.

Authority:
Medicaid Section 1115 Demonstration Waiver
Welfare & Institutions Code 14184.400(c)

Interdependent Policy Changes:
Not Applicable

Background:
California is facing a growing mental health crisis exacerbated by the COVID-19 pandemic. As a result, the Department has made strengthening California's behavioral health system a top priority and is already making many investments in expanding behavioral health services. The BH-CONNECT Demonstration was designed to expand on these investments, complement existing major behavioral health initiatives, and strengthen the continuum of care for Medi-Cal members.

The Department applied for a new Medicaid Section 1115 demonstration in October 2023, titled the BH-CONNECT Demonstration, to expand access to and strengthen the continuum of behavioral health services for Medi-Cal members living with significant behavioral health needs. The disparities addressed in the demonstration are based largely on California's 2022 Assessment, titled Assessing the Continuum of Care for Behavioral Health Services in California.

The proposed BH-CONNECT Demonstration approach included five key components:

- Strengthening the statewide continuum of community-based services and evidence-based practices available through Medi-Cal for individuals living with significant behavioral health needs.

CALAIM - BH - CONNECT DEMONSTRATION
REGULAR POLICY CHANGE NUMBER: 45

- Supporting statewide practice transformations and improvements in the county-administered behavioral health system.
- Improving statewide county accountability for meeting service improvement requirements and implementing new benefits through incentives, robust technical assistance, and oversight.
- Establishing a county option to provide enhanced community-based services.
- Establishing a county option to receive Federal Funds Participation (FFP) for services provided during short-term stays in Institutes of Mental Disease (IMDs), contingent on counties meeting robust accountability requirements.

If counties opt in to participate, counties will be required to reinvest the FFP they receive through the demonstration into expanding Medi-Cal behavioral health service provision and capacity.

Counties participating in the demonstration will be required to submit an implementation plan, which among other requirements, is expected to outline how the county intends to reinvest the FFP received.

In December 2024, the Centers for Medicare and Medicaid Services (CMS) approved a modified version of the BH-CONNECT Demonstration proposal. For budgeting purposes, this policy change displays estimated amounts for the BH-CONNECT Demonstration as proposed. Adjustments to the Estimate will be made to reflect the final approved BH-CONNECT Demonstration as part of the May Revision.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a net decrease due to the following:
- Inclusion of new proposed BH-CONNECT services.
- IMD services will now begin in FY 2024-25, compared to the prior estimate, which projected a start in FY 2025-26.
- The estimate for supported employment has decreased due to adjustments in caseload assumptions and the inclusion of ramp up assumptions.

The change in the current estimate, from FY 2024-25 to FY 2025-26, is due to FY 2025-26 reflecting a full year's cost and the ramp-up of additional features for the BH-CONNECT Demonstration.

Methodology:
1. Assume the BH-CONNECT Demonstration will be implemented in January 2025.

2. The demonstration relies upon updated guidance from CMS and the new availability of FFP for services in IMDs. Milestones must be met to qualify for this FFP.

3. Some features of the demonstration will be available starting FY 2024-25, however, features that require more lead-in time will be phased in over FY 2025-26 and FY 2026-27.

4. The Department and counties will partner to provide the non-federal share of the demonstration features. The share differs between features of the demonstration.

5. Total estimated costs for the BH-CONNECT Demonstration, on a cash basis, is as follows:

CALAIM - BH - CONNECT DEMONSTRATION

REGULAR POLICY CHANGE NUMBER: 45

FY 2024-25	TF	GF	FFP	IGT*
SMHS – Statewide	$1,310,000	$655,000	$655,000	$0
SMHS – Opt-in	$28,283,000	$0	$19,468,000	$8,815,000
Total	**$29,593,000**	**$655,000**	**$20,123,000**	**$8,815,000**

FY 2025-26	TF	GF	FFP	IGT*
SMHS – Statewide	$63,509,000	$31,667,000	$31,842,000	$0
SMHS – Opt-in	$720,875,000	$0	$494,164,000	$226,711,000
Total	**$784,384,000**	**$31,667,000**	**$526,006,000**	**$226,711,000**

Funding:
100% GF (4260-101-0001)
100% Title XIX FF (4260-101-0890)
Medi-Cal County Behavioral Health Fund (4260-601-3420)*

MHP COSTS FOR CONTINUUM OF CARE REFORM

REGULAR POLICY CHANGE NUMBER: 46
IMPLEMENTATION DATE: 1/2017
ANALYST: Tyler Shimizu
FISCAL REFERENCE NUMBER: 1957

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$3,970,000	$3,494,000
- STATE FUNDS	$2,867,350	$2,634,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,970,000	$3,494,000
STATE FUNDS	$2,867,350	$2,634,000
FEDERAL FUNDS	$1,102,650	$860,000

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)
California Constitution Article XIII Section 36

Interdependent Policy Changes:
Not Applicable

Background:
AB 403 is part of an effort to reform congregate care in California. AB 403 established 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) must have a mental health approval and that process is overseen by the Department.

County mental health departments currently participate in CFTs for children receiving intensive care coordination services once the initial mental health screening has been completed by a county social worker. AB 403 requires county mental health departments to perform the following additional workload:

- Complete a mental health assessment that determines if the child or youth has a serious emotional disturbance, or meets medical necessity criteria for SMHS for eligible members under the age of 21 (Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)). Either a CFT or an interagency placement committee (IPC) must decide that a STRTP is the appropriate level of care for the child or youth.

MHP COSTS FOR CONTINUUM OF CARE REFORM
REGULAR POLICY CHANGE NUMBER: 46

- A CFT will be convened for all children or youth who have an open child welfare case. The county mental health department is expected to participate in all CFTs when the child needs SMHS.

The responsibility for SMHS for children was realigned to the counties in 2011 as part of 2011 Public Safety Realignment. Pursuant to Proposition 30, legislation enacted after September 30, 2012, that has an overall effect of increasing the costs already borne by a local agency for programs or levels of service mandated by 2011 Realignment shall apply to local agencies only to the extent that the state provides annual funding for the cost increase. The new activities began January 2017 and the current year and budget year costs are included in this policy change.

Reason for Change:
The change for FY 2024-25, from the prior estimate, is due to updated estimated based on actual claims data through FY 2022-23 and updated payment lag assumptions.

The change, in the current estimate, from FY 2024-25 to FY 2025-26, is a net decrease due to increased annual projections and assuming payment lags return to historical trends.

Methodology:
1. The FY 2024-25 and FY 2025-26 estimated costs are forecasted based on actual claims data.

2. The CFT costs are estimated by using actual claims data from FY 2018-19 through FY 2022-23.

3. The Placement Assessments costs are estimated by using actual claims data from FY 2018-19 through FY 2022-23.

4. Training costs are based on CDSS 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 53% for FY 2024-25 and FY 2025-26, 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 2024-25: Federal Share: $3,000,000 x 0.75 x 0.53 = $1,192,000 (Rounded)
   FY 2025-26: Federal Share: $3,000,000 x 0.75 x 0.53 = $1,192,000 (Rounded)
   FY 2024-25: General Fund Match: $3,000,000 x (1-(0.75 x 0.53)) = $1,808,000 (Rounded)
   FY 2025-26: General Fund Match: $3,000,000 x (1-(0.75 x 0.53)) = $1,808,000 (Rounded)

Funding Summary
5. The estimate and lag are based on Short Doyle/Medi-Cal Children paid claims data. On a cash basis for FY 2024-25, the Department will pay 0.39% of FY 2022-23 claims, 76.92% of FY 2023-24 claims and 64.55% of FY 2024-25 claims. On a cash basis For FY 2025-26, the Department will pay 0.39% of FY 2023-24 claims, 35.16% of FY 2024-25 claims, and 64.55% of FY 2025-26 claims. There is no lag in payment for training costs.

6. The FY 2024-25 estimate and FY 2025-26 estimate, on a cash basis, is:

MHP COSTS FOR CONTINUUM OF CARE REFORM

REGULAR POLICY CHANGE NUMBER: 46

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
CFT	$474	$233	$241
Placement Assessments	$1,688	$826	$862
Training	$1,808	$1,808	$0
Total	**$3,970**	**$2,867**	**$1,103**

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
CFT	$365	$180	$185
Placement Assessments	$1,321	$646	$675
Training	$1,808	$1,808	$0
Total	**$3,494**	**$2,634**	**$860**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX / 10% GF (4260-101-0001/0890)
65% Title XXI / 35% GF (4260-101-0001/0890)
100% GF (4260-101-0001)

OUT OF STATE YOUTH - SMHS

REGULAR POLICY CHANGE NUMBER: 47
IMPLEMENTATION DATE: 1/2021
ANALYST: Tyler Shimizu
FISCAL REFERENCE NUMBER: 2268

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$1,070,000	$986,000
- STATE FUNDS	$535,000	$493,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,070,000	$986,000
STATE FUNDS	$535,000	$493,000
FEDERAL FUNDS	$535,000	$493,000

Purpose:
This policy change estimates the payments to County Mental Health Plans (MHPs) to provide additional resources to address the higher level needs and increase in intensive specialty mental health services (SMHS) for the youth returning to California from out-of-state placements, as well as those youth who would have been placed out-of-state if the California Department of Social Services (CDSS) had not implemented a new policy against out-of-state placements.

Authority:
Welfare & Institutions Code, Division 9, Part 3, Chapter 8.8, Article 5
Welfare & Institutions Code, Division 9, Part 3, Chapter 8.9

Interdependent Policy Changes:
Not Applicable.

Background:
Approximately 130 youth in foster care returned to California from out-of-state placements in January 2021. The CDSS limited certification of all out-of-state facilities due to patterns of failures to meet California standards, including improper and unwarranted use of restraints, poor use of de-escalation interventions, and preventing youth from leaving facilities, among other issues.

These returning youth have higher levels of need and will require more intensive SMHS than the typical children and youth in foster care. In addition to the needs of those youth recently returned from out-of-state, the Department assumes there will be an average of 64 youth per month currently residing in California with needs that are so significant that they would have been placed in an out-of-state facility if one were available. The Department estimates ongoing intensive treatment costs for these youth as well, using the following criteria:

The child or youth is assessed by an independent clinical provider (qualified individual, per the Family First Prevention Service Act) to be at a level of severity that would have required placement in out-of-state facility. The child/youth must meet one of the requirements below:

OUT OF STATE YOUTH - SMHS
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a. Unable to be placed with other children or youth and requires intensive supervision and support (such as requiring a “Short-Term Residential Therapeutic Program (STRTP) of one”); or

b. Multiple 5150s, STRTP placement, or hospitalizations without improvement.

The responsibility for SMHS and Drug Medi-Cal (DMC) services 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.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is a decrease due updating the projections based on more recent actual data.

The change, from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due to an estimated reduction of out of state youth member claims.

Methodology:
1. The 130 youth in foster care that returned to California from out-of-state placements in January 2021 are represented in the monthly estimate of members.

2. Based on actual claims incurred in FY 2022-23 and the adjustment for payment lag, the FY 2022-23 accrual is estimated to be $1,223,000 for the 130 youth returned to California.

3. Assume annual costs will decrease by 10% from the prior year with a 2.42% growth based on the forecasted increase of SMHS children’s services approved claims. for the FY 2023-24, FY 2024-25, and FY 2025-26 annual estimates

4. Assume the Department will pay for 65% of claims received, in the same year the service is provided, and the remaining 35% is paid in the next fiscal year.

5. The cash estimates for FY 2024-25 and FY 2025-26 are:

(Dollars in Thousands)

Fiscal Year	Accrual	FY 2024-25	FY 2025-26
FY 2022-23	$1,223	$0	$0
FY 2023-24	$1,127	$395	$0
FY 2024-25	$1,039	$675	$364
FY 2025-26	$958	$0	$622
Total		$1,070	$986

OUT OF STATE YOUTH - SMHS

REGULAR POLICY CHANGE NUMBER: 47

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2024-25	$1,070	$535	$535
FY 2025-26	$986	$493	$493

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

CALAIM - BH - CONNECT WORKFORCE INITIATIVE

REGULAR POLICY CHANGE NUMBER: 48
IMPLEMENTATION DATE: 7/2025
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2468

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$0	$95,095,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$95,095,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$95,095,000

Purpose:
This policy change estimates the federal share of cost for the new Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration Workforce Initiative.

Authority:
Medicaid Section 1115 Demonstration Waiver
Welfare & Institutions Code 14184.400(c)

Interdependent Policy Changes:
Not Applicable

Background:
The Department applied for a new Medicaid Section 1115 demonstration in October 2023, titled the BH-CONNECT Demonstration, to expand access to and strengthen the continuum of mental health services for Medi-Cal members living with significant behavioral health needs.

In December 2024, the Centers for Medicare and Medicaid Services (CMS) approved a modified version of the BH-CONNECT Demonstration proposal. Adjustments to the Estimate will be made to reflect the final approved BH-CONNECT Demonstration as part of the May Revision.

The BH-CONNECT Section 1115 Demonstration Waiver Application approved by the Centers for Medicare and Medicaid Services, includes $1.9 billion total funds over the life of the demonstration, for a workforce initiative. Of this amount, half would be funded with Medicaid matching funds and 85 percent of the remaining state share would be covered by funding from the Designated State Health Programs (DSHP) funding stream.

Proposition 1 provides state-directed resources from the recast Behavioral Health Services Fund (BHSF) for the Department of Health Care Access and Information (HCAI) to provide the 15 percent of the non-federal share of costs.

CALAIM - BH - CONNECT WORKFORCE INITIATIVE

REGULAR POLICY CHANGE NUMBER: 48

The estimated BHSF state-directed funds and state General Fund equivalent to the amounts ultimately to be covered by DSHP funding are included in the HCAI budget.

Reason for Change:
This is a new policy change.

Methodology:
1. Assume the BH-CONNECT Workforce Initiative will be implemented in July 2025.

2. The federal share of the BH-CONNECT Workforce Initiative is assumed to be approximately $95 million FFP during the first demonstration year (DY 1), $214 million FFP in DY 2 through DY 4, and $213 million FFP in DY 5, for a total of $950 million FFP.

3. Total estimated cost in FY 2025-26, on a cash basis is:

(Dollars in Thousands)

BH-CONNECT Workforce Initiative	TF	FF
FY 2025-26	$95,095	$95,095

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

SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS

REGULAR POLICY CHANGE NUMBER: 49
IMPLEMENTATION DATE: 2/2022
ANALYST: Tyler Shimizu
FISCAL REFERENCE NUMBER: 2247

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$141,000	$142,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$141,000	$142,000
FEDERAL FUNDS	-$141,000	-$142,000

Purpose:
This proposal estimates the ongoing costs resulting from ancillary Medi-Cal services (that is, services other than specialty mental health services) provided to Medi-Cal members while in Short-Term Residential Therapeutic Programs (STRTPs) that are classified as Institutions for Mental Diseases (IMDs). This proposal estimates the amount of federal reimbursement the Department may need to return to the Centers for Medicare and Medicaid Services (CMS) in response to CMS guidance that STRTPs cannot be exempted from IMD determination.

Authority:
P.L. 115-123
42 CFR 435.1009

Interdependent Policy Changes:
Not Applicable.

Background:
The Families First Prevention Services Act (FFPSA) was enacted on February 9, 2018. The intent of the FFPSA is to restrict the use of congregate care, unless absolutely necessary, by limiting Title IV-E maintenance payments to specific congregate care settings meeting defined requirements. The FFPSA added Qualified Residential Treatment Programs (QRTPs) as a congregate care setting that may be used for children and youth requiring a therapeutic placement when specific criteria are met. In California, STRTPs regulatory requirements are similar to QRTPs and the California Department of Social Services (CDSS) is working to ensure STRTPs' current licensing standards meet the requirements of QRTPs. The definition of a QRTP in Title IV-E overlaps with the criteria used by a state to determine if a facility operates as an IMD, as defined in Title XIX. Title XIX prohibits federal reimbursement for covered services provided to members who are residents of an IMD.

SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS

REGULAR POLICY CHANGE NUMBER: 49

On July 3, 2020, the Department sent a letter to CMS explaining why STRTPs do not meet the criteria to be classified as an IMD. CMS responded to the Department on July 30, 2020, and was unable to provide the Department with a blanket assurance that all STRTPs are not IMDs. As a result, the Department assessed each STRTP to determine whether or not the STRTP meets the criteria to be considered an IMD. As federal regulations prohibit federal reimbursement for covered services provided to Medi-Cal members who are residents of an IMD, the Department will no longer receive federal reimbursement for services provided to children and youth residing in STRTPs that meet IMD criteria and would have been qualified for federal funds prior to the IMD determination, including medically necessary services for physical health, mental health, dental, and substance use disorders. Since the IMD exclusion pre-dates realignment, specialty mental health costs for Medi-Cal members in STRTP IMDs would be the responsibility of county mental health plans.

Ancillary services are the state's responsibility. The Department will establish a process to repay federal funds on an ongoing basis for ancillary services provided to members while a resident of an STRTP that is identified to be an IMDs.

Reason for Change:
The change from FY 2024-25, from the prior estimate, is a decrease due to updated actuals for FY 2023-24 and forecasted children's growth percentage change in claim costs which was taken from the May 2024 Specialty Mental Health Services Budget Supplement.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to a slight increase in the forecasted children's growth percentage change in claim costs that was used to estimate FY 2025-26 costs.

Methodology:
1. As of December 31, 2022, the Department have completed assessments of the STRTP facilities and determined three facilities are classified as IMDs.

2. This policy change estimates the cost of providing services to members while residing in an STRTP that would have been Medicaid reimbursable prior to the IMD determination, beginning July 1, 2022 and December 31, 2022.

3. All Medi-Cal costs, other than specialty mental health costs, are included in this estimate (managed care, fee-for-service, and dental).

4. The Department determined the total cost of all ancillary Medi-Cal services provided to children and youth, and not claimed through the Short-Doyle Medi-Cal claiming system, while residing in an STRTP that could meet the criteria of an IMD. The estimates for FY 2024-25 and FY 2025-26 are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2024-25	$0	$141	($141)
FY 2025-26	$0	$142	($142)

SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS

REGULAR POLICY CHANGE NUMBER: 49

Funding:
100% Title XIX FF (4260-101-0890)
100% Title XIX GF (4260-101-0001)

SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT

REGULAR POLICY CHANGE NUMBER: 50
IMPLEMENTATION DATE: 1/2012
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1660

	FY 2024-25	FY 2025-26
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

Purpose:
This policy change estimates the cost of federal fund (FF) repayments made to the Centers for Medicare and Medicaid Services (CMS) for improper claims for Medi-Cal services made by Siskiyou County Mental Health Plan. In addition, Siskiyou County General Fund (GF) reimbursements are also included in this policy change.

Authority:
Title 42, United States Code (USC) 1396b (d)(2)(C)

Interdependent Policy Changes:
Not Applicable

Background:
During the audit and cost settlement processes, the Department identified overpayments to the Siskiyou County Mental Health Plan from improper Medi-Cal billing practices. Pursuant to federal statute, the Department must remit the overpaid FF to CMS within a year of the discovery date. While the county acknowledged its Medi-Cal billing problems, it is unable to repay the amounts owed in a significant or timely manner. Consequently, the County will reimburse the Department $200,000 per year until it fulfills its obligation for repayment. The County repayments began August 2012. The County has submitted twelve payments totaling $2,400,000.

Reason for Change:
There is no change in FY 2024-25, from the prior estimate.

There is no change, from FY 2024-25 to FY 2025-26, in the current estimate.

Methodology:
1. The Department began making repayments to CMS in January 2012 and repaid CMS overpayments discovered during cost settlements for FY 2006-07 through FY 2010-11 and audit settlements for FY 2005-06 through FY 2010-11.

SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT

REGULAR POLICY CHANGE NUMBER: 50

2. Siskiyou County reimburses the GF $200,000 annually. The county has submitted payments totaling $2,400,000.

Date of Overpayment Discovery	Due to DHCS	Paid to CMS	Due to CMS GF
1/11/2011	$1,754,000	$1,754,000	$0
3/2/2011	$116,000	$116,000	$0
8/4/2011	$2,189,000	$2,189,000	$0
11/15/2011	$586,000	$586,000	$0
12/21/2011	$95,000	$95,000	$0
3/26/2012	$443,000	$443,000	$0
4/15/2013	$2,917,000	$2,917,000	$0
5/30/2013	$1,131,000	$1,131,000	$0
4/9/2014	$1,369,000	$1,369,000	$0
9/9/2015	$270,000	$270,000	$0
4/4/2016	$381,000	$381,000	$0
1/18/2018	$738,000	$738,000	$0
Subtotal	$11,989,000	$11,989,000	$0
Repayments	($2,400,000)	$0	$0
Recoupments	($381,000)	$0	$0
Total	$9,208,000	$11,989,000	$0

3. The estimate for FY 2024-25 and FY 2025-26 is as follows:

Fiscal Year	TF	GF	FF	Reimbursement
FY 2024-25	**$0**	**($200,000)**	**$0**	**$200,000**
FY 2025-26	**$0**	**($200,000)**	**$0**	**$200,000**

Funding:
100% GF (4260-101-0001)
Reimbursement GF (4260-601-0995)

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 51
IMPLEMENTATION DATE: 7/2015
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1713

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	-$588,782,000	-$327,583,000
- STATE FUNDS	$1,932,000	$1,959,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$588,782,000	-$327,583,000
STATE FUNDS	$1,932,000	$1,959,000
FEDERAL FUNDS	-$590,714,000	-$329,542,000

Purpose:
This policy change estimates interim and audit settlements as well as any additional supplemental reimbursements for any eligible costs incurred by mental health plans (MHPs) in providing Specialty Mental Health Services (SMHS) which were not previously reimbursed through the interim payment process, interim settlement process or through some other mechanism.

Authority:
Welfare & Institutions Code 14705(c)
Title 9, California Code of Regulations 1840.105
ABX4 5 (Chapter 5, Statutes of 2009)
Welfare & Institutions Code 14723
SPA 09-004

Interdependent Policy Changes:
Not Applicable

Background:
The Department reconciles interim payments to county cost reports for MHPs for children, adults, and Healthy Families SMHS. The Department completes interim settlements within two years of the end of the fiscal year. Audit 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.

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 51

In addition to any reimbursements determined through the interim settlement process, MHPs or other public agencies, are eligible to receive supplemental reimbursements of up to 100% of the allowable costs for providing SMHS to Medi-Cal members that do not exceed the MHP's non-risk upper payment limit.

To receive the supplemental payments, the public agency or MHP must certify that it has incurred the public expenditures. The amount of payment is then based on the difference between the Statewide Maximum Allowances for Specialty Mental Health inpatient and outpatient services and the MHP's certified public expenditures. The Centers for Medicare and Medicaid Services (CMS) approved on February 16, 2016, SPA 09-004, which governs and defines supplemental payments and the Certified Public Expenditure Protocol.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to an increase in the number of interim and audit settlements to be processed in FY 2024-25. Additionally, the estimate assumptions have been updated based on actual settlements processed in FY 2023-24.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due a decrease in the number of interim and audit settlements that will be completed and processed in FY 2025-26 relative to FY 2024-25. The Department plans to complete and process more interim and audit settlements in FY 2024-25 than it plans to complete and process in FY 2025-26.

Methodology:

1. Interim settlements are based on the difference between each county MHP's filed cost report and the payments they received from the Department.

2. Audit settlements are based on the difference between each county MHP's final audited cost report and the payments they received from the Department.

3. Cost settlements for services, administration, utilization review, quality assurance, and mental health Medi-Cal administrative activities are each determined separately.

4. Cost settlements prior to 2011 realignment may consist of General Fund (GF).

5. To estimate expected expenditures for FY 2024-25 and FY 2025-26 for interim and audit settlements not yet received the following procedures are used:

    - The average expenditure of ($1,932,876) per interim settlement is determined by dividing the actual net recoupment of ($63,784,895) from FY 2023-24 by 33, the number of interim settlements processed in FY 2023-24. The average recoupment of ($658,379) per audit settlement is determined by dividing the net recoupment, ($28,968,675), by 44, the number of audit settlements processed in FY 2023-24.

    - The average expenditure per settlement is increased by 3% for fiscal years not yet received and which were not present in calculating the averages in prior step.

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 51

- The total number of interim and audit settlements expected to be processed for each fiscal year is multiplied by the average amount per settlement per fiscal year to determine the total amount to be processed for each fiscal year per settlement type.

- There are no future payments expected to be made with Title XXI funding; the funding involved with this estimate is only Title XIX and GF.

6. To determine final amounts per fund type per settlement type, the following were combined:

   - The estimated amounts per fund, per settlement type, per fiscal year forecasted for FY 2024-25 and FY 2025-26.

7. The net FF to be reimbursed and/or recouped in FY 2024-25 for interim settlements and audit settlements are as shown:

(Dollars in Thousands)

Interim Settlements	**TF**	**GF**	**FF**
FY 2016-17	($95,523)	$38	($95,561)
FY 2017-18	($116,837)	$47	($116,884)
FY 2018-19	($120,342)	$48	($120,390)
FY 2019-20	($123,953)	$49	($124,002)
FY 2020-21	($100,793)	$40	($100,833)
Subtotal	($557,448)	$222	($557,670)

(Dollars in Thousands)

Audit Settlements	**TF**	**GF**	**FF**
FY 2015-16	($3,122)	$170	($3,292)
FY 2016-17	($12,217)	$667	($12,884)
FY 2017-18	($12,584)	$687	($13,271)
FY 2018-19	($3,411)	$186	($3,597)
Subtotal	($31,334)	$1,710	($33,044)
Total FY 2024-25	**($588,782)**	**$1,932**	**($590,714)**

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 51

8. The net FF to be reimbursed and/or recouped in FY 2025-26 for interim settlements and audit settlements are as shown:

(Dollars in Thousands)

Interim Settlements	TF	GF	FF
FY 2020-21	($26,878)	$11	($26,889)
FY 2021-22	($131,501)	$52	($131,553)
FY 2022-23	($135,446)	$54	($135,500)
Subtotal	($293,825)	$117	($293,942)

(Dollars in Thousands)

Audit Settlements	TF	GF	FF
FY 2018-19	($9,551)	$521	($10,072)
FY 2019-20	($13,350)	$729	($14,079)
FY 2020-21	($10,857)	$592	($11,449)
Subtotal	($33,758)	$1,842	($35,600)
Total FY 2025-26	**($327,583)**	**$1,959**	**($329,542)**

Funding:
100% Title XIX FFP (4260-101-0890)
100% GF (4260-101-0001)

GLOBAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 52
IMPLEMENTATION DATE: 12/2015
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 1951

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$2,936,500,000	$2,924,821,000
- STATE FUNDS	$1,468,249,000	$1,462,409,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,936,500,000	$2,924,821,000
STATE FUNDS	$1,468,249,000	$1,462,409,000
FEDERAL FUNDS	$1,468,251,000	$1,462,412,000

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)
California Advancing and Innovating Medi-Cal (CalAIM) Section 1115(a) Medicaid Demonstration

Interdependent Policy Changes:
ACA DSH Reduction

Background:
Since 2005, the Designated Public Hospital (DPH) and Clinic systems have received partial cost-based reimbursement for health expenditures made on behalf of the uninsured through a combination of California's 1115 waivers' Safety Net Care Pool, now known as Uncompensated Care Pool (UC Pool), and Medicaid Disproportionate Share Hospital (DSH) funding. In 2016, the Medi-Cal 2020 waiver created the Global Payment Program (GPP) which provides an innovative approach to financing care to California's remaining uninsured population served by DPH systems by unifying the DSH and UC Pool funding streams into a DPH-specific global payment system. This safety net stabilization program provides an innovative approach to financing care to California's remaining uninsured population by unifying the DSH and UC Pool funding streams into a DPH-specific global payment system. GPP 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).

On August 3, 2020, the Centers for Medicare and Medicaid Services (CMS) approved a six-month GPP extension through December 31, 2020. An additional one-year extension of the Medi-Cal 2020 waiver was approved on December 29, 2020, which extended the GPP program through December 31, 2021. On December 29, 2021, CMS approved CalAIM, a multi-year initiative focused on system, program, and payment reform that will allow California to take a population health, person-centered approach to provided services, with the goal of improving

GLOBAL PAYMENT PROGRAM
REGULAR POLICY CHANGE NUMBER: 52

health outcomes for Medi-Cal and other low-income populations. CalAIM is effective from January 1, 2022, through December 31, 2026. A key change to GPP is the incorporation of equity-enhancing services.

Effective July 1, 2015, DPHs, except State Government-operated University of California (UC) hospitals, receive their allocation of the federal DSH payments through the Global Payment Program. Beginning January 1, 2022, UC Hospitals became eligible to participate in GPP after obtaining CMS approval. Beginning January 1, 2023, CMS approved University of California Los Angeles' (UCLA) request to participate in the GPP rather than the DSH program. Accordingly, beginning with Program Year (PY) 9 (Calendar Year [CY] 2023), the percentage of the DPH DSH Allotment federal financial participation (FFP) allocated to DSH DPH hospitals will be adjusted to 20.371% rather than 21.896%.

The Affordable Care Act (ACA) requires a reduction to the DSH allotments and was previously scheduled to go into effect on October 1, 2013. Subsequent federal action has delayed the reduction; see the ACA DSH Reduction policy change for more information. Most recently, on March 9, 2024, HR 4366 was enacted which eliminated the Federal Fiscal Year (FFY) 2024 reduction and postponed implementation of the FFY 2025 reduction until January 1, 2025.

The American Rescue Plan Act (ARP), HR 1319, enacted on March 11, 2021, requires that for the federal fiscal years in which the FFCRA increased FMAP is applicable, the states' annual DSH allotments be recalculated such that the total computable DSH expenditures for a state are equal to the total computable DSH expenditures that would have resulted in the absence of the FFCRA increased FMAP. The result is an increase in the DSH allotments for the impacted fiscal years. This policy change reflects the revised preliminary ARP-adjusted FFY 2023, and preliminary ARP-adjusted FFY 2024 allotment released by CMS on September 29, 2023, as well as the Department-estimated FFY 2025 and 2026 non-ARP-adjusted allotments.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to:

- The finalization of the DSH Third Party Payer Rule (Final Rule 2024-03542), published by CMS on February 23, 2024. The Final Rule resulted in an updated NDPH DSH allotment for FFY 2022 which resulted in a decreased GPP DSH allotment allocation for PY 7 and PY 8.
- The inclusion of the PY 9 Final Reconciliation payment, which was originally budgeted to be paid in SFY 2023-24 and is pending the receipt of final data from Public Health Care Systems.
- A decrease to the initial reduction applied to the PY 10 Quarter 2 payment in order to maintain compliance with the DSH allotment total computable cap for FFY 2024.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due the estimated FFY 2025 DSH allotment being higher, which is derived by trending forward the estimated FY 2024-25 allotment by 2%.

Methodology:
1. The PY for GPP was originally established as July 1 to June 30, to align with the state fiscal year (SFY) for PY 1 through PY 5. PY 6 (formerly 6A) extends GPP for six months from July 1, 2020, to December 31, 2020. Beginning January 1, 2021, with PY 7 (formerly 6B), GPP will align with a CY period.

GLOBAL PAYMENT PROGRAM
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2. On July 14, 2016, CMS approved $472 million in UC Pool funding for PY 2 through PY 5. The $472 million is subject to an applicable weighted FMAP. On December 29, 2021, CMS approved the continuation of the UC Pool funding in the amount of $472 million annually through December 31, 2026.

3. The total federal funding for the GPP for PY 1 through PY 12 is estimated at:

(Dollars in Thousands)

Program Year	GPP DSH FFP Allotment	UC Pool FFP	Total FFP
PY 1 (7/1/15-6/30/16)	$869,667	$236,000	$1,105,667
PY 2 (7/1/16-6/30/17)	$903,394	$236,000	$1,139,394
PY 3 (7/1/17-6/30/18)	$931,427	$236,000	$1,167,427
PY 4 (7/1/18-6/30/19)	$967,116	$236,000	$1,203,116
PY 5 (7/1/19-6/30/20)	$1,072,741	$257,948	$1,330,689
PY 6 (Formerly 6A) (7/1/20-12/31/20)	$561,224	$132,632	$693,856
PY 7 (Formerly 6B) 1/1/21-12/31/21)	$1,141,594	$265,264	$1,406,858
PY 8 (1/1/22-12/31/22)	$1,159,663	$263,848	$1,423,511
PY 9 (1/1/23-12/31/23)	$1,246,923	$246,620	$1,493,543
PY 10(1/1/24-12/31/24)	$1,189,379	$236,000	$1,425,379
PY 11 (1/1/25-12/31/25)	$1,220,159	$236,000	$1,456,159
PY 12 (1/1/26-12/31/26)	$1,245,167	$236,000	$1,481,167

4. For PY 1 through PY 5, payments were made on a quarterly basis, where three quarters were paid in the current SFY and the fourth quarter was paid the following SFY. For PY 6, two quarterly payments were made in the current SFY. Beginning with PY 7, payments will be made on a quarterly basis, where one quarter is paid in the current SFY, and the remaining three quarters are paid in the subsequent SFY.

5. The FY 2025-26 DSH allotment assumes a 2% annual increase from the FY 2024-25 DSH allotment estimate.

GLOBAL PAYMENT PROGRAM
REGULAR POLICY CHANGE NUMBER: 52

6. The estimated GPP payments on a cash basis are:

(Dollars in Thousands)

FY 2024-25	TF	IGT	FF
PY 7 (Formerly 6B) (1/1/21-12/31/21)	($16)	($8)	($8)
PY 8 (Formerly 7) (1/1/22-12/31/22)	($15)	($8)	($7)
PY 9 (Formerly 8) (1/1/23-12/31/23)	$82,616	$41,308	$41,308
PY 10 (1/1/24-12/31/24)	$2,125,836	$1,062,918	$1,062,918
PY 11 (1/1/25-12/31/25)	$728,079	$364,039	$364,040
Total	**$2,936,500**	**$1,468,249**	**$1,468,251**

(Dollars in Thousands)

FY 2025-26	TF	IGT	FF
PY 11 (1/1/25-12/31/25)	$2,184,237	$1,092,117	$1,092,120
PY 12 (1/1/26-12/31/26)	$740,584	$370,292	$370,292
Total	**$2,924,821**	**$1,462,409**	**$1,462,412**

Funding:
100% Title XIX FFP (4260-101-0890)
100% Global Payment Program Special Fund (4260-601-8108)

CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES

REGULAR POLICY CHANGE NUMBER: 53
IMPLEMENTATION DATE: 2/2022
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2245

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$1,709,080,000	$1,217,962,000
- STATE FUNDS	$729,048,800	$475,113,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,709,080,000	$1,217,962,000
STATE FUNDS	$729,048,800	$475,113,500
FEDERAL FUNDS	$980,031,200	$742,848,500

Purpose:
This policy change estimates the costs to implement a statewide Enhanced Care Management (ECM) benefit, Community Supports, and plan incentives to build infrastructure linked to reform within the Medi-Cal managed care delivery system.

Authority:
California Advancing and Innovating Medi-Cal (CalAIM) Initiative
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2022, the Department implemented a new ECM benefit and 14 Community Supports in the Medi-Cal managed care delivery system and established Medi-Cal managed care health plan (MCP) incentives linked to delivery system reform through investments in Community Supports and ECM. Medi-Cal MCPs in counties without Whole Person Care pilots and/or Health Homes Programs implemented the new ECM benefit on July 1, 2022, for certain mandated populations of focus.

The ECM benefit transitions successful elements from the current Health Homes Program benefit and the Whole Person Care pilot to provide a whole-person approach to care that addresses the clinical and non-clinical needs of high-need/high-cost Medi-Cal members.

The ECM benefit is available for Medi-Cal managed care members at the highest risk level who need long-term and intensive coordination for multiple chronic conditions, including behavioral health conditions, as well as utilization of multiple service types and delivery systems. The benefit aims to improve care coordination, integrate services, facilitate access to and utilization of community resources, improve health outcomes, address social determinants of health, and decrease inappropriate utilization.

CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES

REGULAR POLICY CHANGE NUMBER: 53

Community Supports are voluntary non-traditional services that are deemed medically appropriate and cost-effective alternatives to existing State Plan benefits. These services are statewide within the managed care delivery system effective January 1, 2022. Community Supports provide for flexible wrap-around services that Medi-Cal MCPs would be able to offer as a part of their overall population health management strategy as viable substitutes to more costly services such as hospital inpatient and long-term institutional care. Medium to high-risk and/or high-cost Medi-Cal members who experience, or are at risk of experiencing, poor health outcomes may benefit from accessing non-traditional alternatives to State Plan benefits.

The Community Supports are:

- Housing Transition/Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities
- Nursing Facility Transition to a Home
- Personal Care (beyond In-Home Supportive Services) and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

Incentive payments complement Community Supports and ECM and were intended to incentivize Medi-Cal MCPs to invest in voluntary Community Supports delivery and partner with community-based organizations and on-the-ground providers such as Federally Qualified Health Centers, Rural Health Clinics, Indian Health Service clinics, public hospital safety net systems, and county behavioral health systems and providers. The time-limited incentive funding (January 1, 2022, through June 30, 2024, program period) was focused on building a pathway for Medi-Cal MCPs and providers to invest in the necessary delivery and systems infrastructure, building appropriate and sustainable care management and Community Supports capacity, and achieving improvements in quality performance that can inform future policy decisions to align with the goal of managed long-term services and supports by 2026.

Subject to federal approval, Community Supports will be expanded effective January 1, 2025, to include Transitional Rent, which will provide coverage of up to six months of rent/temporary housing as a Medi-Cal service. Coverage of Transitional Rent will be optional for Medi-Cal MCPs beginning on January 1, 2025, and required beginning on January 1, 2026.

As a result of the COVID-19 national public health emergency, increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year (CY) 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES

REGULAR POLICY CHANGE NUMBER: 53

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase due to updated enrollment and rates, and six months of CY 2023 plan incentive payments shifting from FY 2023-24 to FY 2024-25. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a net decrease due to the completion of plan incentive payments, offset by the increase in ECM expenditures and the addition of Transitional Rent costs.

Methodology:
1. Plan incentive payments ended June 30, 2024.

2. Assume 6.2% Title XIX COVID-19 increased FMAP for the CY 2023 rating period.

3. For CY 2025 and CY 2026, the Department will reimburse Medi-Cal MCPs for Transitional Rent on a supplemental basis, outside of the base capitated rates. Costs for Transitional Rent will be budgeted on a cash basis beginning in FY 2025-26.

4. Costs are estimated to be:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
Community Supports	$220,000	$85,521	$134,479
Plan Incentives	$600,000	$295,250	$304,750
Enhanced Care Management	$889,080	$348,278	$540,802
Total for FY 2024-25	**$1,709,080**	**$729,049**	**$980,031**

*Totals may differ due to rounding.

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
Community Supports	$231,000	$89,797	$141,203
Enhanced Care Management	$955,686	$374,369	$581,317
Transitional Rent	$31,276	$10,947	$20,329
Total for FY 2025-26	**$1,217,962**	**$475,114**	**$742,848**

*Totals may differ due to rounding.

Funding:
50% Title XIX / 50%GF (4260-101-0001/0890)
90% Title XIX ACA FF / 10% GF (4260-101-0001/0890)
65% Title XXI / 35% GF (4260-101-0001/0890)
100% GF (4260-101-0001)
COVID-19 Title XIX Increased FFP (4260-101-0890)
COVID-19 Title XIX GF (4260-101-0001)

UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

REGULAR POLICY CHANGE NUMBER: 54
IMPLEMENTATION DATE: 7/2013
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 1769

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$534,000	$578,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$534,000	$578,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$534,000	$578,000

Purpose:
This policy change estimates the federal fund (FF) 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)
California Advancing and Innovating Medi-Cal Section 1115(a) Medicaid Demonstration (CalAIM)

Interdependent Policy Changes:
Not Applicable

Background:
In April 2013, CMS approved an amendment to the BTR to establish an uncompensated care pool to reimburse tribal health programs for the cost of providing services to American Indian and Alaska Native patients who had been eliminated from Medi-Cal coverage due to previous State budget shortfalls. The amendment was intended to maintain IHS and tribal facilities' financial viability and provide services to eligible individuals. Payments for tribal uncompensated care were subsequently authorized under the Medi-Cal 2020 Demonstration through December 31, 2021. Notably, most services have since been restored in the Medi-Cal program, with the exception of chiropractic services.

On December 29, 2021, CMS approved CalAIM. With this approval, payments for tribal uncompensated care, specifically chiropractic services, will be available through December 31, 2026.

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.

UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

REGULAR POLICY CHANGE NUMBER: 54

Reason for Change:
The change from FY 2024-25, from the prior estimate, is due to:

- Decreased projected encounters based on actual invoices received from service periods in FY 2023-24, which are used to project service periods in FY 2024-25.
- Revised calculations based on the actual CY 2024 rate, which was higher than previously estimated, and an increased projected CY 2025 rate.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to using actual and projected encounters, with an actual encounter rate for calendar year (CY) 2024, and projected encounter rate for CY 2025 in FY 2024-25 compared to using projected encounters with projected encounter rates in FY 2025-26.

Methodology:

1. Assume IHS payments will continue until December 31, 2026.

2. The IHS global encounter rate is updated on the Federal Register for each CY. For CY 2023 the rate is $654, for CY 2024 the rate is $719. The projected CY 2025 rate is $780, and the projected CY 2026 rate is $846.

3. IHS claims are paid for each encounter. Assume IHS payments will be made as follows on a cash basis:

FY 2024-25	TF	FF
Calendar Year 2024	$398,000	$398,000
Calendar Year 2025	$136,000	$136,000
Total	**$534,000**	**$534,000**

FY 2025-26	TF	FF
Calendar Year 2025	$431,000	$431,000
Calendar Year 2026	$147,000	$147,000
Total	**$578,000**	**$578,000**

Funding:
100% Health Care Support Fund (4260-601-7503)

ENHANCED CARE MANAGEMENT RISK CORRIDOR

REGULAR POLICY CHANGE NUMBER: 55
IMPLEMENTATION DATE: 10/2024
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2452

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	-$195,602,000	$0
- STATE FUNDS	-$79,813,300	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$195,602,000	$0
STATE FUNDS	-$79,813,300	$0
FEDERAL FUNDS	-$115,788,700	$0

Purpose:
This policy change estimates the costs or savings from the implementation of the Enhanced Care Management (ECM) two-sided risk corridor.

Authority:
California Advancing and Innovating Medi-Cal (CalAIM) Initiative
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2022, the Department implemented a new ECM benefit in the Medi-Cal managed care delivery system. Medi-Cal managed care plans (MCPs) in counties without Whole Person Care pilots and/or Health Homes Programs implemented the new ECM benefit on July 1, 2022, for certain mandated populations of focus.

To protect the MCPs and the State against excessive gains/losses due to the implementation of the new benefits, the Department has established a two-sided, symmetrical risk corridor for the calendar year (CY) 2022 rating period. Calculations begun January 1, 2024. A risk corridor will also be in place for the CY 2023 rating period, with calculations starting no sooner than January 1, 2025. This risk corridor is expected to be in place for each subsequent rating period through the CY 2025 rating period, subject to the Centers for Medicare and Medicaid Services approval.

As a result of the COVID-19 national public health emergency, increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased FMAP was only available through the end of CY 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

ENHANCED CARE MANAGEMENT RISK CORRIDOR

REGULAR POLICY CHANGE NUMBER: 55

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase in recoupments due to revised calculations resulting in increased projections for the total CY 2022 rating period. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease in recoupments due to CY 2022 recoupments occurring in FY 2024-25 and data for the CY 2023 rating period being unavailable at this time. There are currently no recoupments budgeted in FY 2025-26.

Methodology:
1. The CY 2022 rating period recoupments and repayments are anticipated to occur in FY 2024-25.

2. The CY 2023 rating period recoupments and repayments are unavailable at this time.

3. Assume 6.2% Title XIX and 4.34% Title XXI COVID-19 increased FMAP for the CY 2022 rating period.

4. The ECM risk corridor estimated recoupments for CY 2022 are:

Fiscal Year	TF	GF	FF
FY 2024-25	($195,602,000)	($79,814,000)	($115,788,000)

*Totals may differ due to rounding.

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX ACA FF / 10% GF (4260-101-0001/0890)
65% Title XXI FF / 35% GF (4260-101-0001/0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)
COVID-19 Title XIX GF (4260-101-0001)
COVID-19 Title XXI Increased FFP (4260-101-0890)
COVID-19 Title XXI GF (4260-101-0001)
100% GF (4260-101-0001)

2023 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.

REGULAR POLICY CHANGE NUMBER: 58
IMPLEMENTATION DATE: 3/2024
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2408

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$14,095,818,000	$12,673,059,000
- STATE FUNDS	$5,638,327,150	$5,069,228,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$14,095,818,000	$12,673,059,000
STATE FUNDS	$5,638,327,150	$5,069,228,000
FEDERAL FUNDS	$8,457,490,850	$7,603,831,000

Purpose:
This policy change estimates the cost of capitation rate increases that are offset by managed care organization (MCO) tax proceeds. The tax proceeds will be used for the non-federal share of capitation rate increases.

Authority:
AB 119 (Chapter 13, Statutes of 2023)

Interdependent Policy Changes:
2023 MCO Enrollment Tax Mgd. Care Plans
2023 MCO Enrollment Tax Mgd. Care Plans-Funding Adj.

Background:
Effective April 1, 2023, the Department enacted a multi-year renewal of the MCO provider tax that provides for a statewide tax on managed care plans based on reported enrollment into these plans during the 12-month calendar year (CY) 2022 period. The tax is tiered based on whether the enrollee is a Medi-Cal enrollee or other enrollee.

Reason for Change:
The change from the prior estimate, FY 2024-25, is an increase due to changes in the MCO tax model which impose a higher tax for CY 2024 and subsequent years. As a result, January 2024 through June 2024 retroactive payments will occur in FY 2024-25. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due to six months of CY 2024 retroactive payments occurring in FY 2024-25.

Methodology:
1. The 2023 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 is based on the number of Medi-Cal enrollees and “all-other” enrollees.

2023 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.

REGULAR POLICY CHANGE NUMBER: 58

3. The enrollee count is multiplied by a tiered rate to determine total tax revenue.

4. Increased capitation rates due to the 2023 MCO Enrollment Tax are initially paid from the GF. The GF is then reimbursed by 2023 MCO Enrollment Tax revenue through a funding adjustment. The reimbursement is budgeted in the 2023 MCO Enrollment Tax Mgd. Care Plans-Funding Adjustment policy change.

5. Retroactive payments for CY 2024 will all occur in FY 2024-25.

6. Starting CY 2024, assume a one-month payment lag for all plans subject to MCO tax.

7. The costs of capitation rate increases related to the imposition of the 2023 MCO Enrollment Tax are expected to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2024-25	$14,095,818	$5,638,327	$8,457,491
FY 2025-26	$12,673,059	$5,069,228	$7,603,831

Funding:
50% Title XIX / 50%GF (4260-101-0001/0890)
90% Title XIX ACA FF / 10% GF (4260-101-0001/0890)
65% Title XXI / 35% GF (4260-101-0001/0890)
SCHIP GF (4260-101-0001/0890)

MANAGED CARE HEALTH CARE FINANCING PROGRAM

REGULAR POLICY CHANGE NUMBER: 60
IMPLEMENTATION DATE: 5/2020
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2061

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$2,622,195,000	$3,197,407,000
- STATE FUNDS	$886,614,050	$1,149,678,650
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,622,195,000	$3,197,407,000
STATE FUNDS	$886,614,050	$1,149,678,650
FEDERAL FUNDS	$1,735,580,950	$2,047,728,350

Purpose:
This policy change estimates increased payments to managed care plans (MCPs) designed to provide additional support for counties and/or public entities serving Medi-Cal members.

Authority:
Welfare & Institutions Code 14087.3
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Managed Care Reimbursements to the General Fund

Background:
Effective July 1, 2018, the Department implemented a new voluntary Managed Care Health Care Financing Program which increases payments to MCPs to provide additional support for counties and/or public entities servicing Medi-Cal members. Participation is voluntary and the increased payment levels will be evaluated annually.

As a result of the COVID-19 national public health emergency, increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year (CY) 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase due to updated CY 2023 enrollment and rates. The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to higher projections for the CY 2024 enrollment and rates.

Methodology:
1. The Managed Care Health Care Financing Program began with the FY 2018-19 rating period.

MANAGED CARE HEALTH CARE FINANCING PROGRAM
REGULAR POLICY CHANGE NUMBER: 60

2. Payments for the CY 2023 rating period are anticipated to occur in FY 2024-25. Based on preliminary participation levels for the twelve months of CY 2023, the total payments are estimated to be $2,622,195,000 TF.

3. Payments for the CY 2024 rating period are anticipated to occur in FY 2025-26. Based on growth projections and the preliminary participation levels for the twelve months of CY 2023, the total payments are estimated to be $3,197,407,000 TF.

4. The Title XIX and Title XXI COVID-19 increased FMAP is assumed for expenditures for the CY 2023 rating period.

5. Anticipated costs on a cash basis are:

(Dollars in Thousands)

FY 2024-25	**TF**	**GF**	**FF**
CY 2023 Title XIX 50/50	$1,519,384	$759,692	$759,692
CY 2023 Title XXI 65/35	$139,143	$48,700	$90,443
CY 2023 ACA 90/10	$794,860	$79,486	$715,374
UIS Emergency Title XIX 50/50	$88,258	$44,129	$44,129
UIS Pregnancy Title XXI 65/35	$8,297	$2,904	$5,393
ACA UIS Emergency 90/10	$69,390	$6,939	$62,451
ACA UIS Pregnancy 65/35	$2,863	$1,002	$1,861
COVID-19 Tile XXI Increased FMAP	$0	($3,454)	$3,454
COVID-19 Tile XIX Increased FMAP	$0	($52,784)	$52,784
Total FY 2024-25	**$2,622,195**	**$886,614**	**$1,735,581**

(Dollars in Thousands)

FY 2025-26	**TF**	**GF**	**FF**
CY 2024 Title XIX 50/50	$1,852,680	$926,340	$926,340
CY 2024 Title XXI 65/35	$169,666	$59,383	$110,283
CY 2024 ACA 90/10	$969,222	$96,922	$872,300
UIS Emergency Title XIX 50/50	$107,618	$53,809	$53,809
UIS Pregnancy Title XXI 65/35	$10,117	$3,541	$6,576
ACA UIS Emergency 90/10	$84,612	$8,462	$76,150
ACA UIS Pregnancy 65/35	$3,492	$1,222	$2,270
Total FY 2025-26	**$3,197,407**	**$1,149,679**	**$2,047,728**

*Totals may differ due to rounding.

MANAGED CARE HEALTH CARE FINANCING PROGRAM

REGULAR POLICY CHANGE NUMBER: 60

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX ACA FF / 10% GF (4260-101-0001/0890)
65% Title XXI FF / 35% GF (4260-101-0001/0890)
SCHIP GF (4260-101-0001/0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)
COVID-19 Title XIX GF (4260-101-0001)
COVID-19 Title XXI Increased FFP (4260-101-0890)
COVID-19 Title XXI GF (4260-101-0001)

MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER: 61
IMPLEMENTATION DATE: 9/2019
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2062

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$2,232,379,000	$2,209,565,000
- STATE FUNDS	$610,214,500	$637,722,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,232,379,000	$2,209,565,000
STATE FUNDS	$610,214,500	$637,722,000
FEDERAL FUNDS	$1,622,164,500	$1,571,843,000

Purpose:
This policy change estimates managed care directed payments to fund Quality Incentive Pool (QIP) payments by managed care plans (MCPs) to Designated Public Hospitals (DPHs) including the University of California Health Systems (UCs), and District and Municipal Public Hospitals (DMPHs) based on their performance on designated performance metrics.

Authority:
SB 171 (Chapter 768, Statutes of 2017)
AB 205 (Chapter 768, Statutes of 2017)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Managed Care Reimbursements to the General Fund

Background:
Title 42, Code of Federal Regulations, section 438.6 (c) provides states authority to implement delivery system and provider payment initiatives under MCP contracts based on allowable directed payment mechanisms.

Effective July 1, 2017, for the FY 2017-18 rating period, the Department has directed MCPs to make QIP payments to DPHs tied to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. To receive QIP payments the DPHs must achieve specified improvement targets, which grow more difficult through year-over-year improvement or sustained high performance requirements. The total funding available for the QIP payments are limited to a predetermined amount (pool).

Prior to implementation of a directed payment program, the Centers for Medicare & Medicaid Services (CMS) requires states seek pre-approval of any requested directed payment program through the standard CMS “pre-print” form.

MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER: 61

Effective July 1, 2020, the Department transitioned the existing Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program for DPHs and DMPHs to the QIP directed payment framework. The goal was to enable hospitals to continue quality improvement efforts that have been underway following the June 30, 2020, expiration of the PRIME program.

As a result of the COVID-19 national public health emergency (PHE), increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year (CY) 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

Reason for Change:
There is no total fund change from the prior estimate for FY 2024-25. However, due to updated funding splits, there was an increase in General Funds. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due to the CY 2023 payments in FY 2024-25 including a one-time, time-limited increase in the total pool amount associated with the PHE.

Methodology:
1. Based on actual performance measured, the CY 2023 QIP is estimated to be $2.23 billion total fund and is anticipated to pay out in FY 2024-25.

2. The CY 2024 QIP estimated payments are $2.21 billion total fund and are anticipated to pay out in FY 2025-26.

3. The Title XIX and Title XXI COVID-19 increased FMAP is assumed for expenditures for the CY 2023 rating period.

4. On a cash basis, the estimated QIP payments are:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF	ACA FF
CY 2023 Title XIX	$1,014,454	$507,227	$507,227	$0
CY 2023 ACA 90/10	$1,154,041	$115,404	$0	$1,038,637
CY 2023 Title XXI 65/35	$63,884	$22,360	$41,524	$0
COVID-19 Tile XIX Increased FMAP	$0	($33,308)	$33,308	$0
COVID-19 Tile XXI Increased FMAP	$0	($1,468)	$1,468	$0
Total FY 2024-25	**$2,232,379**	**$610,215**	**$583,527**	**$1,038,637**

*Difference due to rounding.

(Dollars in Thousands)

FY 2025-26	TF	GF	FF	ACA FF
CY 2024 Title XIX	$1,002,540	$501,270	$501,270	$0
CY 2024 ACA 90/10	$1,144,027	$114,403	$0	$1,029,624
CY 2024 Title XXI 65/35	$62,998	$22,049	$40,949	$0
Total FY 2025-26	**$2,209,565**	**$637,722**	**$542,219**	**$1,029,624**

*Difference due to rounding.

MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER: 61

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX ACA FF / 10% GF (4260-101-0001/0890)
65% Title XXI FF / 35% GF (4260-101-0001/0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)
COVID-19 Title XIX GF (4260-101-0001)
COVID-19 Title XXI Increased FFP (4260-101-0890)
COVID-19 Title XXI GF (4260-101-0001)

MANAGED CARE PUBLIC HOSPITAL EPP

REGULAR POLICY CHANGE NUMBER: 62
IMPLEMENTATION DATE: 9/2019
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2060

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$1,944,701,000	$2,369,726,000
- STATE FUNDS	$557,915,700	$712,175,350
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,944,701,000	$2,369,726,000
STATE FUNDS	$557,915,700	$712,175,350
FEDERAL FUNDS	$1,386,785,300	$1,657,550,650

Purpose:
This policy change estimates Managed Care Enhanced Payment Program (EPP) Directed Payments for Designated Public Hospitals (DPHs) including University of California Health Systems (UCs).

Authority:
SB 171 (Chapter 768, Statutes of 2017)
Title 42, Code of Federal Regulations (CFR), Section 438.6(c)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Managed Care Reimbursements to the General Fund

Background:
Title 42, CFR section 438.6(c) provides states authority to implement delivery system and provider payment initiatives under managed care plan (MCP) contracts based on allowable directed payment mechanisms.

Effective July 1, 2017, with the FY 2017-18 rating period, the Department directed MCPs to make enhanced network contracted payments to California's DPHs. The total funding available for the enhanced network contracted payments is limited to a predetermined amount (pool). The EPP Directed Payment Program is divided into two primary sub-pools:

- Capitated sub-pool value is based on a pre-determined pool amount. Actual payments will be increased by a uniform percentage based on actual monthly DPH member assignment for network contracted services.

- Fee-For-Service (FFS) sub-pool value is based on a pre-determined pool amount. Actual payments will be increased by a uniform dollar amount based on actual utilization of network contracted services.

MANAGED CARE PUBLIC HOSPITAL EPP
REGULAR POLICY CHANGE NUMBER: 62

Prior to implementation of a directed payment program, the Centers for Medicare & Medicaid Services (CMS) requires states seek pre-approval of any requested directed payment program through the standard CMS “pre-print” form. This “pre-print” is typically submitted on an annual basis.

As a result of the COVID-19 national public health emergency, increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year (CY) 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase due to updated CY 2023 EPP Capitated sub-pool amounts that are higher than previous projections. The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to larger pooled amounts for CY 2024.

Methodology:
1. The value of the entire public hospital EPP pool is $1,878,640,000 TF for the CY 2022 rating period on an accrual basis.

2. The value of the entire public hospital EPP pool is $1,982,550,000 TF for the CY 2023 rating period on an accrual basis.

3. The value of the entire public hospital EPP pool is $2,478,190,000 TF for the CY 2024 rating period on an accrual basis.

4. The July 1, 2022, through December 31, 2022, FFS sub-pool payments were made in September 2024. The January 1, 2023, through June 30, 2023, FFS sub-pool payments are anticipated to be made in March 2025. The July 1, 2023, through December 31, 2023, FFS sub-pool payments are anticipated to be made in September 2025. The January 1, 2024, through June 30, 2024, FFS sub-pool payments are anticipated to be made in March 2026.

5. The January 1, 2023, through June 30, 2023, Capitated sub-pool payments were made in September 2024. The July 1, 2023, through December 31, 2023, Capitated sub-pool payments are anticipated to be made in March 2025. The January 1, 2024, through June 30, 2024, Capitated sub-pool payments are anticipated to be made in September 2025. The July 1, 2024, through December 31, 2024, Capitated sub-pool payments are anticipated to be made in March 2026.

6. The Title XIX and Title XXI COVID-19 increased FMAP is assumed for expenditures for the CY 2022 and CY 2023 rating periods.

MANAGED CARE PUBLIC HOSPITAL EPP
REGULAR POLICY CHANGE NUMBER: 62

7. On a cash basis, the estimated payments are:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF	ACA FF
Title XIX	$635,950	$317,975	$317,975	$0
Title XXI 65/35	$64,208	$22,473	$41,735	$0
UIS State Only	$139,444	$139,444	$0	$0
ACA 2020 90/10	$1,105,099	$110,510	$0	$994,589
COVID-19 Tile XIX Increased FMAP	$0	($30,324)	$30,324	$0
COVID-19 Tile XXI Increased FMAP	$0	($2,162)	$2,162	$0
Total FY 2024-25	**$1,944,701**	**$557,916**	**$392,196**	**$994,589**

*Totals may differ due to rounding.

(Dollars in Thousands)

FY 2025-26	TF	GF	FF	ACA FF
Title XIX	$764,425	$382,213	$382,213	$0
Title XXI 65/35	$77,091	$26,982	$50,109	$0
UIS State Only	$170,930	$170,930	$0	$0
ACA 2020 90/10	$1,357,280	$135,728	$0	$1,221,552
COVID-19 Tile XIX Increased FMAP	$0	($3,428)	$3,428	$0
COVID-19 Tile XXI Increased FMAP	$0	($249)	$249	$0
Total FY 2025-26	**$2,369,726**	**$712,176**	**$435,999**	**$1,221,552**

*Totals may differ due to rounding.

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX ACA FF / 10% GF (4260-101-0001/0890)
65% Title XXI FF / 35% GF (4260-101-0001/0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)
COVID-19 Title XIX GF (4260-101-0001)
COVID-19 Title XXI Increased FFP (4260-101-0890)
COVID-19 Title XXI GF (4260-101-0001)
100% GF (4260-101-0001)

WORKFORCE & QUALITY INCENTIVE PROGRAM

REGULAR POLICY CHANGE NUMBER: 64
IMPLEMENTATION DATE: 3/2024
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2388

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$297,468,000	$309,967,000
- STATE FUNDS	$148,777,250	$155,548,350
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$297,468,000	$309,967,000
STATE FUNDS	$148,777,250	$155,548,350
FEDERAL FUNDS	$148,690,750	$154,418,650

Purpose:
This policy change estimates the cost providing Workforce & Quality Incentive Program (WQIP) directed payments to Freestanding Skilled Nursing Facilities, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facilities, Level-B (FSSA/NF-B).

Authority:
AB 186 (Chapter 46, Statutes of 2022)

Interdependent Policy Changes:
Not Applicable

Background:
AB 186 established the WQIP for calendar years 2023 through 2026 to provide nursing facilities which meet workforce and quality benchmarks directed payments through the Medi-Cal managed care delivery system. The WQIP succeeds the former Quality & Accountability Supplemental Payment program. AB 186 requires the Department to develop the methodology, parameters and eligibility criteria for receipt of WQIP directed payments in consultation with stakeholders.

Statute requires the Department to set the amount of performance-based directed payments to target an aggregate amount of $280 million for the 2023 calendar year (CY) and to increase the targeted amount in subsequent years by an amount equal to one percent of facilities' non-labor costs.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is an increase due to the addition of CY 2023 reconciliation final payment calculation cost amounts being paid in FY 2024-25.

WORKFORCE & QUALITY INCENTIVE PROGRAM

REGULAR POLICY CHANGE NUMBER: 64

The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase based on higher annual projections associated with CY 2025 cost amounts and CY 2024 reconciliation final payment calculation amounts being paid in FY 2025-26.

Methodology:

1. Assume CY 2023 directed payments were $280 million total fund on an accrual basis, in FY 2023-24. Reconciliations associated with CY 2023 are anticipated to pay in FY 2024-25.

2. Assume the CY 2024 directed payments will be $295.3 million total fund, on an accrual basis, in FY 2024-25. Reconciliations associated with CY 2024 are anticipated to pay in FY 2025-26.

3. Assume CY 2025 directed payments will be $310.7 million total fund, on an accrual basis, in FY 2025-26. Reconciliations associated with CY 2025 are anticipated to pay in FY 2026-27.

(Dollars in Thousands)

FY 2024-25	TF	GF	FFP
WQIP Directed Payments	$297,468	$148,777	$148,691
Total	**$297,468**	**$148,777**	**$148,691**

(Dollars in Thousands)

FY 2025-26	TF	GF	FFP
WQIP Directed Payments	$309,967	$155,548	$154,419
Total	**$309,967**	**$155,548**	**$154,419**

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX / 10% GF (4260-101-0001/0890)
65% Title XXI / 35% GF (4260-101-0001/0890)
100% GF (4260-101-0001)

MANAGED CARE PUBLIC DP-NF PASS-THROUGH PYMT PROG

REGULAR POLICY CHANGE NUMBER: 65
IMPLEMENTATION DATE: 9/2024
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 2448

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$281,681,000	$74,666,000
- STATE FUNDS	$133,563,300	$36,168,700
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$281,681,000	$74,666,000
STATE FUNDS	$133,563,300	$36,168,700
FEDERAL FUNDS	$148,117,700	$38,497,300

Purpose:
This policy change estimates costs for the distinct part nursing facility (DP-NF) pass-through payment program that transitions supplemental payments for qualifying days at publicly owned/operated DP-NFs formerly covered in the Medi-Cal fee-for-service (FFS) delivery system.

Authority:
Welfare & Institutions Code 14184.201(b)(c)
42, Code of Federal Regulations 438.6(d)(6)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Change:
Not Applicable

Background:
Historically, public owned/operated DP-NFs were allowed to claim federal financial participation (FFP) payments based on the difference between their actual costs and the amount Medi-Cal currently pays. The acute care hospital must be owned and operated by a public entity, such as a city, city and county, or health care district. In addition, the acute care hospital must meet specified requirements and provide skilled nursing services to Medi-Cal members.

Effective January 1, 2023, the managed care delivery system included a temporary DP-NF pass-through payment program that transitioned supplemental payments for DP-NF days formerly covered under FFS. This program applies to DP-NFs for designated public hospitals (DPHs) and district and municipal public hospital (DMPHs) in counties that transitioned from FFS to managed care for CY 2023 through CY 2025.

As a result of the Coronavirus Disease 2019 (COVID-19) national public health emergency, increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased FMAP was only available through the end of Calendar

MANAGED CARE PUBLIC DP-NF PASS-THROUGH PYMT PROG
REGULAR POLICY CHANGE NUMBER: 65

Year 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is an increase due to updated payment timing, which now reflects payments for CY 2023, CY 2024, and a part of CY 2025 service periods paying in FY 2024-25. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due to the program ending after the CY 2025 service period.

Methodology:
1. Assume the total value of the CY 2023 service period, on an accrual basis, is $107.3 million total fund. These program payments are expected to pay as a lump sum in FY 2024-25.

2. Assume the total value of the CY 2024 service period, on an accrual basis, is $121 million total fund. These program payments are expected to pay as a lump sum in FY 2024-25.

3. Assume the total value of the CY 2025 service period, on an accrual basis, is $128 million total fund. These program payments are expected to pay monthly beginning in February 2025, with five-months' worth of payments expected to pay in FY 2024-25 and seven-months' worth of payments expected to pay in FY 2025-26.

4. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

5. On a cash basis, the estimated payments are:

FY 2024-25	TF	GF	FF	ACA FF	FFCRA
Title XIX 50/50	$230,300,000	$115,150,000	$115,150,000	$0	$0
ACA 2020 90/10	$33,223,000	$3,322,000	$0	$29,901,000	$0
100% State GF	$17,796,000	$17,796,000	$0	$0	$0
Title XIX 50/50 - UIS	$362,000	$181,000	$181,000	$0	$0
COVID-19 Tile XIX Increased FMAP	$0	($2,886,000)	$0	$0	$2,886,000
Total FY 2024-25	**$281,681,000**	**$133,563,000**	**$115,331,000**	**$29,901,000**	**$2,886,000**

FY 2025-26	TF	GF	FF	ACA FF
Title XIX 50/50	$61,046,000	$30,523,000	$30,523,000	$0
ACA 2020 90/10	$8,807,000	$881,000	$0	$7,926,000
100% State GF	$4,717,000	$4,717,000	$0	$0
Title XIX 50/50 - UIS	$96,000	$48,000	$48,000	$0
Total FY 2025-26	**$74,666,000**	**$36,169,000**	**$30,571,000**	**$7,926,000**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX ACA FF / 10% GF (4260-101-0001/0890)
100% State GF (4260-101-0001)
COVID-19 Title XIX Increased FFP (4260-101-0890)

MANAGED CARE DISTRICT HOSPITAL DIRECTED PAYMENTS

REGULAR POLICY CHANGE NUMBER: 68
IMPLEMENTATION DATE: 3/2025
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 2437

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$100,000,000	$203,645,000
- STATE FUNDS	$29,241,000	$66,246,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$100,000,000	$203,645,000
STATE FUNDS	$29,241,000	$66,246,000
FEDERAL FUNDS	$70,759,000	$137,399,000

Purpose:
This policy change estimates the managed care District Hospital Directed Payments (DHDP) to district hospitals through enhanced capitation payments to managed care plans (MCPs).

Authority:
Title 42, Code of Federal Regulations (CFR) 438.6(c)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Change:
N/A

Background:
Title 42, CFR 438.6(c) provides states authority to implement a delivery system and provider payment initiatives under MCP contracts based on allowable directed payment mechanisms.

Under the DHDP, base payments will be enhanced by a uniform dollar increment (uniform unit cost add-on) and promote hospitals providing adequate access to service, including primary, specialty, and inpatient (both tertiary and quaternary) care.

The total funding available for the enhanced contracted payments will be limited to a predetermined amount (pool). Upon determination of actual utilization, the Department will direct the MCPs to make enhanced payments to public hospitals for contracted services. The Department will adjust MCP's per-member-per-month rates to appropriately fund MCPs for the enhanced payment obligation.

District and Municipal Public Hospital (DMPH) pass-through payments, previously budgeted in the Hospital Quality Assurance Fee program policy change, for the Calendar Year (CY) 2025 rating period and onward will be transitioned to the DHDP and reflected in this policy change.

MANAGED CARE DISTRICT HOSPITAL DIRECTED PAYMENTS

REGULAR POLICY CHANGE NUMBER: 68

Reason for Change:
There is no change in total funds for FY 2024-25. The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to larger pool amounts associated with the directed payments occurring in FY 2025-26.

Methodology:
1. The total value of the funding for the DHDP pool on an accrual basis is $200 million total fund for the CY 2023 rating period and $207.3 million total fund for the CY 2024 rating period.

2. Within each managed care rating period, payments are calculated and issued separately for each 6-month service period.

3. Payment for the January through June 2023 service period is anticipated to occur in March 2025. Payment for the July through December 2023 service period is anticipated to occur in September 2025. Payment for the January through June 2024 service period is anticipated to occur in March 2026.

4. The Title XIX and Title XXI COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

5. On a cash basis, the estimated payments are:

(Dollars in Thousands)

FY 2024-25	TF	IGT*	FF	ACA FF
Title XIX 50/50	$52,366	$26,183	$26,183	$0
Title XXI 65/35	$4,208	$1,473	$2,735	$0
ACA 2020 90/10	$43,426	$4,342	$0	$39,084
COVID-19 Title XIX Increased FMAP	$0	($2,610)	$2,610	$0
COVID-19 Title XXI Increased FMAP	$0	($147)	$147	$0
Total FY 2024-25	**$100,000**	**$29,241**	**$31,675**	**$39,084**

FY 2025-26	TF	IGT*	FF	ACA FF
Title XIX 50/50	$108,182	$54,091	$54,091	$0
Title XXI 65/35	$13,937	$4,878	$9,059	$0
ACA 2020 90/10	$81,526	$8,153	$0	$73,373
COVID-19 Tile XIX Increased FMAP	$0	($829)	$829	$0
COVID-19 Tile XXI Increased FMAP	$0	($47)	$47	$0
Total FY 2025-26	**$203,645**	**$66,246**	**$64,026**	**$73,373**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX ACA FF / 10% GF (4260-101-0001/0890)
65% Title XXI FF / 35% GF (4260-101-0001/0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)
COVID-19 Title XXI Increased FFP (4260-101-0890)
*Reimbursement GF (4260-601-0995)

CYBHI - STUDENT BH INCENTIVE PROGRAM

REGULAR POLICY CHANGE NUMBER: 70
IMPLEMENTATION DATE: 1/2022
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2260

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$94,202,000	$0
- STATE FUNDS	$47,101,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$94,202,000	$0
STATE FUNDS	$47,101,000	$0
FEDERAL FUNDS	$47,101,000	$0

Purpose:
This policy change estimates expenditures related to implementing an incentive program through Medi-Cal managed care plans, in coordination with county behavioral health departments and schools, to build infrastructure, partnerships, and capacity statewide to increase access to preventive and early intervention behavioral health services for students.

Authority:
AB 133 (Chapter 143, Statutes of 2021)
SB 154 (Chapter 43, Statutes of 2022)

Interdependent Policy Changes:
Not Applicable

Background:
The Children and Youth Behavioral Health Initiative (CYBHI) is a multiyear package of investments as part of the FY 2021-22 budget agreement. The CYBHI is intended to transform California's behavioral health system for children and youth aged 0-25 into a world-class, innovative, up-stream focused, ecosystem where all children and young adults are routinely screened, supported, and served for emerging behavioral health needs.

Schools are a critical point of access for preventive and early intervention behavioral health services, as children are in school for many hours a day, for approximately half the days of the year. The consequences of not addressing child and adolescent mental health conditions often extend to adulthood. Early identification and treatment through school-based or school-linked services can reduce emergency room visits, crisis situations, inpatient stays and placement in high-cost special education settings and/or out of home placement. Schools often lack on-campus behavioral health resources and find it challenging to recognize and respond appropriately to children's mental health needs, particularly in the absence of school-based mental health professionals.

In order to build infrastructure, partnerships, and capacity statewide, the Department implemented incentive payments to qualifying Medi-Cal managed care plans for a variety of

CYBHI - STUDENT BH INCENTIVE PROGRAM
REGULAR POLICY CHANGE NUMBER: 70

interventions for a maximum period of three calendar years commencing with the rating period beginning January 1, 2022. The first 50% of the Student Behavioral Health Incentive assessment funds were paid out to plans in Program Year 1 (Calendar Year 2022), and the remaining 50% of assessment funds were paid in Program Year 2 (Calendar Year 2023). For the program milestones and performance metrics successfully completed during Program Years 2 and 3 (CY 2023 and 2024), Medi-Cal managed care plans will receive bi-annual incentive payments from the Department.

Reason for Change:
There is no change from the prior estimate for FY 2024-25. The change in the current estimate, from FY 2024-25 to FY 2025-26, is a decrease due to the program ending in December 2024.

Methodology:
1. Assume expenditures of $94,202,000 TF ($47,101,000 GF) in FY 2024-25.

2. A total of $388,986,000 TF ($194,493,000 GF) is available for the local assistance portion of this program, available for expenditure through June 30, 2025. The table below displays the estimated spending and remaining funds by Appropriation Year:

	TF	GF	FF
Appropriation Year 2021-22			
Prior Years	$294,784,000	$147,392,000	$147,392,000
Estimated in FY 2024-25	$94,202,000	$47,101,000	$47,101,000
Total Estimated Remaining	$0	$0	$0

3. The estimated costs in FY 2024-25 are as follows:

FY 2024-25	TF	GF	FF
50% Title XIX / 50%GF	$94,202,000	$47,101,000	$47,101,000
Total	**$94,202,000**	**$47,101,000**	**$47,101,000**

*Totals may differ due to rounding

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

NON-HOSPITAL 340B CLINIC DIRECTED PAYMENTS

REGULAR POLICY CHANGE NUMBER: 71
IMPLEMENTATION DATE: 2/2025
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 2499

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$43,750,000	$105,000,000
- STATE FUNDS	$21,875,000	$52,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$43,750,000	$105,000,000
STATE FUNDS	$21,875,000	$52,500,000
FEDERAL FUNDS	$21,875,000	$52,500,000

Purpose:
This policy change estimates the cost of managed care directed payments for non-hospital 340B community clinic services.

Authority:
SB 159 (Chapter 40, Statutes of 2024)
Welfare and Institutions (W&I) Code 14105.468

Interdependent Policy Change:
Medi-Cal Provider Payment Increases 2025 & Later

Background:
SB 159 (Chapter 40, Statutes of 2024) authorized the Department to implement a payment methodology to provide directed payments from contracted Medi-Cal managed care plans to qualifying non-hospital 340B community clinics to secure, strengthen, and support the community clinic and health center delivery system for Medi-Cal members, effective January 1, 2025.

Beginning with dates of service on or after January 1, 2026, the amount of directed payments will be increased with $50 million (state funds) annually allocated from the Medi-Cal Provider Payment Reserve Fund plus matching federal funds. These increases are budgeted in the Medi-Cal Provider Payment Increases 2025 & Later policy change.

Reason for Change:
This is a new policy change.

Methodology:
1. The estimated non-hospital 340B clinic directed payments annual cost is $105,000,000 TF.

2. Assume the managed care payments will begin February 2025.

NON-HOSPITAL 340B CLINIC DIRECTED PAYMENTS
REGULAR POLICY CHANGE NUMBER: 71

3. . The estimated payments on a cash basis are:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
Non-Hospital 340B Clinic Directed Payments	$43,750	$21,875	$21,875
Total	**$43,750**	**$21,875**	**$21,875**

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
Non-Hospital 340B Clinic Directed Payments	$105,000	$52,500	$52,500
Total	**$105,000**	**$52,500**	**$52,500**

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

CCI-QUALITY WITHHOLD REPAYMENTS

REGULAR POLICY CHANGE NUMBER: 73
IMPLEMENTATION DATE: 5/2017
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2031

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$13,886,000	$17,414,000
- STATE FUNDS	$6,943,000	$8,707,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$13,886,000	$17,414,000
STATE FUNDS	$6,943,000	$8,707,000
FEDERAL FUNDS	$6,943,000	$8,707,000

Purpose:
This policy change estimates the repayment of the quality withholds for the Coordinated Care Initiative (CCI).

Authority:
SB 1008 (Chapter 33, Statutes of 2012)
SB 1036 (Chapter 45, Statutes of 2012)

Interdependent Policy Changes:
Not Applicable.

Background:
In coordination with Federal and State Government, the CCI provided the benefits of coordinated care models to persons eligible for Medi-Cal. By enrolling these eligibles into coordinated care delivery models, the CCI aligned financial incentives, streamlined member-centered care delivery, and rebalanced the current health care system away from avoidable institutionalized services.

The CCI mandatorily enrolled dual and Medi-Cal only eligibles into managed care for their Medi-Cal benefits. Those benefits included Long Term Care (LTC) institutional services, In-Home Supportive Services (IHSS), Community-Based Adult Services, Multi-Purpose Senior Services Program, and other Home and Community-Based Services. Savings were generated from a reduction in inpatient and LTC institutional services. Beginning January 1, 2018, IHSS was no longer included in the CCI.

The CCI was implemented in seven pilot counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

As part of the CCI, a quality withhold was applied to the Cal MediConnect (CMC) capitation rate. The withheld amounts are repaid subject to plan performance consistent with established quality thresholds. The quality withholds started at 1% in CY 2014 and CY 2015, increased to 2% in CY

CCI-QUALITY WITHHOLD REPAYMENTS
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2016, increased to 3% in CY 2017 through CY 2019, and increased to 4% in CY 2020 through CY 2022. Repayments of withholds are based on performance measures.

The 2017 Budget extended the CMC program and the mandatory enrollment of dual eligibles and integration of long-term services and support, except IHSS, into managed care. IHSS was removed from capitation rate payments effective January 1, 2018.

As part of the California Advancing and Innovating Medi-Cal Initiative's standardized mandatory enrollment of dual eligibles and statewide integration of long-term care into managed care, the CCI pilot program sunset December 31, 2022.

Reason for Change:
There is no change from the prior estimate for FY 2024-25. The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to FY 2024-25 being based on the withhold amounts for CY 2021 and FY 2025-26 being based on the withhold amounts for CY 2022.

Methodology:
1. Withheld amounts are 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. The CMS and the State 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. Assume quality withholds for CY 2021 will be repaid in FY 2024-25.

4. Assume quality withholds for CY 2022 will be repaid in FY 2025-26.

FY 2024-25	TF	GF	FF
Quality Withhold Repayment (CY 2021)	**$13,886,000**	$6,943,000	$6,943,000

FY 2025-26	TF	GF	FF
Quality Withhold Repayment (CY 2022)	**$17,414,000**	$8,707,000	$8,707,000

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

CAPITATED RATE ADJUSTMENT FOR FY 2025-26

REGULAR POLICY CHANGE NUMBER: 77
IMPLEMENTATION DATE: 7/2025
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1338

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$0	$2,976,538,000
- STATE FUNDS	$0	$1,210,639,450
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$2,976,538,000
STATE FUNDS	$0	$1,210,639,450
FEDERAL FUNDS	$0	$1,765,898,550

Purpose:
The policy change estimates the increase for the managed care capitation rates for fiscal year (FY) 2025-26.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
Managed care capitation rates are typically rebased each rating period. After actuarial analysis, upward/downward adjustments are applied to historical data to develop a reasonable “base” for rate development. Additional adjustments such as trends and program changes are applied to the base data to inform the final capitated rates. This policy change shows the increase in capitation rates from FY 2024-25 to FY 2025-26.

Reason for Change:
The change in capitation rates from FY 2024-25 to FY 2025-26 is a 5.11% average rate increase on a cash basis, primarily due to:

- Updated Calendar Year (CY) 2024 rates and enrollment, in addition to updated CY 2025 rate growth projections in the range of 3.2% to 6.5% annually, depending on managed care model and year.

Methodology:
1. Assume the following dollars for all managed care expenditures:

Managed Care Model	FY 2024-25 Estimated Cost	Rate Adjustment	Dollar Adjustment
Total Statewide	$58,272,959,950	5.11%	$2,976,538,123

CAPITATED RATE ADJUSTMENT FOR FY 2025-26

REGULAR POLICY CHANGE NUMBER: 77

Funding:

FY 2025-26	TF	GF	FF
SIS Title XIX 50/50	$1,436,795,000	$718,397,500	$718,397,500
SIS Title XXI 65/35	$117,249,000	$41,037,150	$76,211,850
ACA SIS 90/10	$895,248,000	$89,524,800	$805,723,200
UIS 100% State GF	$275,924,000	$275,924,000	$0
UIS Pregnancy 65/35	$23,850,000	$8,347,500	$15,502,500
UIS Emergency Title XIX 50/50	$130,022,000	$65,011,000	$65,011,000
ACA UIS Emergency 90/10	$81,015,000	$8,101,500	$72,913,500
UIS Emergency 65/35	$10,610,000	$3,713,500	$6,896,500
Family Planning 90/10	$5,825,000	$582,500	$5,242,500
Total	**$2,976,538,000**	**$1,210,639,450**	**$1,765,898,550**

MEDI-CAL MANAGED CARE QUALITY WITHHOLD RELEASE

REGULAR POLICY CHANGE NUMBER: 78
IMPLEMENTATION DATE: 12/2025
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2504

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$0	$250,577,000
- STATE FUNDS	$0	$103,007,550
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$250,577,000
STATE FUNDS	$0	$103,007,550
FEDERAL FUNDS	$0	$147,569,450

Purpose:
This policy change estimates the cost of releasing the withheld portion of Medi-Cal managed care plan (MCP) capitation payments that were withheld as part of the Quality Withhold and Incentive program.

Authority:
Title 42, Code of Federal Regulations (CFR), Section 438.6(b)

Interdependent Policy Changes:
Not Applicable

Background:
Commencing with the calendar year (CY) 2024 rating period, subject to the Centers for Medicare and Medicaid Services approval, the Department implemented a hybrid Quality Withhold and Incentive program for contracted MCPs. This program withholds a percentage of the lower bound capitation rates; the related savings are accounted for in the managed care base policy changes. The capitation rate withhold percentage may change across rating periods, subject to actuarial soundness and quality goals.

Reason for Change:
This is a new policy change.

Methodology:
1. Assume the CY 2024 performance results will be calculated and earned withhold dollars will be distributed back to MCPs in FY 2025-26. Unearned withhold dollars will roll over into a separate incentive program to pay MCPs for meeting specified performance metrics.

2. CY 2024 Quality Withhold amounts are estimated to be:

MEDI-CAL MANAGED CARE QUALITY WITHHOLD RELEASE

REGULAR POLICY CHANGE NUMBER: 78

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
Title XIX 50/50	$131,456	$65,728	$65,728
Title XXI 65/35	$8,418	$2,946	$5,472
ACA 90/10	$69,954	$6,995	$62,959
100% State GF	$21,475	$21,475	$0
UIS Emergency Title XIX 50/50	$8,908	$4,454	$4,454
UIS Pregnancy Title XXI 65/35	$1,171	$410	$761
ACA UIS Emergency 90/10	$8,877	$888	$7,989
ACA UIS Pregnancy 65/35	$318	$111	$207
Total FY 2025-26	**$250,577**	**$103,007**	**$147,570**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX ACA FF / 10% GF (4260-101-0001/0890)
65% Title XXI FF / 35% GF (4260-101-0001/0890)
100% GF (4260-101-0001)

CHILDREN'S HOSPITAL DIRECTED PAYMENT

REGULAR POLICY CHANGE NUMBER: 79
IMPLEMENTATION DATE: 7/2025
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 2474

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$0	$115,000,000
- STATE FUNDS	$0	$57,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$115,000,000
STATE FUNDS	$0	$57,500,000
FEDERAL FUNDS	$0	$57,500,000

Purpose:
This policy change estimates costs related to new directed payments to children’s hospitals.

Authority:
Budget Act of 2024
Title 42, Code of Federal Regulations (CFR) 438.6(c)

Interdependent Policy Changes:
Not Applicable

Background:
Title 42, Code of Federal Regulations, section 438.6 (c) provides authority to implement delivery system and provider payment initiatives under managed care plan (MCP) contracts based on allowable directed payment mechanisms. The Department implemented new directed payments to the following children’s hospitals pursuant to Section 14197.6 of the Welfare and Institutions Code, effective for dates of service commencing July 1, 2024:

- Children’s Hospital of Orange County
- Children’s Hospital Los Angeles, Los Angeles
- MemorialCare Miller Children’s & Women’s Hospital, Long Beach
- Rady Children's Hospital–San Diego
- University of California, San Francisco (UCSF) Benioff Children's Hospital, Oakland
- Valley Children’s Hospital, Madera
- Lucile Packard Children’s Hospital Stanford, Palo Alto
- Loma Linda University Children’s Hospital, Loma Linda

The directed payments enhance reimbursement received by eligible children’s hospitals for qualifying network hospital inpatient and outpatient services provided in the Medi-Cal managed care delivery system.

CHILDREN'S HOSPITAL DIRECTED PAYMENT

REGULAR POLICY CHANGE NUMBER: 79

Reason for Change:
The change from the prior estimate, for FY 2024 25, is a decrease due to delayed program start and payment dates. The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to FY 2024-25 expenditures shifting to FY 2025-26.

Methodology:

1. Subject to finalization and federal approval of program design, payments for the July through December 2024 program period are anticipated to be made in March 2026. Payments for subsequent program periods are anticipated to be made 15 months after the end of each 6-month service (calculation) period consistent with other, utilization-based hospital directed payments.

2. Costs are expected to be $230,000,000 total funds ($115,000,000 Children’s Hospital Directed Payment Fund and $115,000,000 Federal Funds) each rating period.

3. Program was effective July 1, 2024.

4. The estimated costs for FY 2025-26 are $115,000,000 TF ($57,500,000 GF).

Funding:
100% Title XIX FFP (4260-101-0890)
General Fund for Children’s Hospital Directed Payment (4260-603-0001)

MANAGED CARE DIRECTED PAYMENTS MLK COMM HOSPITAL

REGULAR POLICY CHANGE NUMBER: 80
IMPLEMENTATION DATE: 7/2025
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 2507

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$0	$28,905,000
- STATE FUNDS	$0	$8,083,150
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$28,905,000
STATE FUNDS	$0	$8,083,150
FEDERAL FUNDS	$0	$20,821,850

Purpose:
This policy change estimates the cost of Medi-Cal managed care directed payments to Martin Luther King, Jr. Community Hospital (MLKCH) for contracted inpatient and outpatient hospital services.

Authority:
Welfare & Institutions Code, section 14165.51

Interdependent Policy Changes:
Not applicable

Background:
Section 14165.51 of the Welfare and Institutions Code provides authority to the Department for dates of service commencing no later than January 1, 2026, to establish a Medi-Cal managed care directed payment methodology applicable to MLKCH. The methodology will: (1) replace historical pass-through payments to the hospital pursuant to Section 14165.50 of the Welfare and Institutions Code; and (2) provide additional payments to MLKCH that are projected to total $25,000,000 annually in addition to the historical pass-through payments. The directed payment methodology will align with the goals and objectives of the Department's comprehensive quality strategy, link payments to value and outcomes as appropriate, and be developed with consideration of the stability of the MLKCH's cash flow, and in consultation with the hospital.

The Department will develop the methodology for MLKCH to receive directed payments on an ongoing or periodic basis that support the stability of the hospital's cash flow. The Department anticipates payments will flow to Medi-Cal managed care health plans in February 2026 and to MLKCH pending final program design and federal approval.

Reason for Change:
This is a new policy.

MANAGED CARE DIRECTED PAYMENTS MLK COMM HOSPITAL

REGULAR POLICY CHANGE NUMBER: 80

Methodology:

1. Program is anticipated to be effective January 1, 2026.

2. The estimated costs for FY 2025-26 are $28,905,000 TF ($8,083,000 GF).

3. FY 2025-26 will include five months of capitated expenditures, equivalent to historical pass-through requirements which otherwise would have been budgeted in the Retro Manage Care Rate Adjustments policy change and the $25 million in additional payments.

Funding:

50% Title XIX FF / 50% GF (4260-101-0001/0890)
65% Title XXI FF / 35% GF (4260-101-0001/0890)
ACA 90/10 (4260-101-0890)
ACA 65/35 (4260-101-0890)

2023 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ

REGULAR POLICY CHANGE NUMBER: 81
IMPLEMENTATION DATE: 3/2024
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2406

	FY 2024-25	FY 2025-26
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

Purpose:
This policy change estimates the transfer of funds collected from the tax on managed care organizations (MCOs) to the General Fund (GF) to be used by the Department to fund related managed care capitation rate increases.

Authority:
AB 119 (Chapter 13, Statutes of 2023)

Interdependent Policy Changes:
2023 MCO Enrollment Tax Mgd. Care Plans-Incr. Cap. Rates
2023 MCO Enrollment Tax Managed Care Plans

Background:
Effective April 1, 2023, the Department enacted a multi-year renewal of the MCO provider tax that provides for a statewide tax on managed care plans based on reported enrollment into these plans during the 12-month calendar year (CY) 2022 period. The tax is tiered based on whether the enrollee is a Medi-Cal enrollee or other enrollee.

This policy change estimates the offset of GF costs for the capitated rate increases.

In November 2024, voters approved the Protect Access to Health Care Act of 2024 (Proposition 35), which makes the MCO tax permanent, subject to continued federal approval for future tax periods, and specifies how revenues from the current period tax as it existed on July 1, 2023, are to be allocated, beginning with taxes collected in calendar year 2025. Proposition 35 allocates revenues to cover the non- federal share of costs for increased capitation costs to Medi-Cal managed care plans that pay the tax, increases payments to Medi-Cal providers, and supports existing Medi-Cal costs. Proposition 35 creates additional funds into which MCO tax revenues are deposited, appropriated, and spent.

Reason for Change:
The change from the prior estimate, FY 2024-25, is an increase in GF reimbursements due to changes in the MCO tax model which impose a higher tax for CY 2024 and subsequent years.

2023 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ

REGULAR POLICY CHANGE NUMBER: 81

The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease in GF reimbursements due to six months of CY 2024 retroactive payments occurring in FY 2024-25. Additionally, funding from the Health Care Oversight & Accountability (HCO&A) Subfund has been incorporated pursuant to the passage of Proposition 35.

Methodology:

1. Total revenues for Medi-Cal managed care plans are based on the number of Medi-Cal enrollees and “all-other” enrollees.

2. Only tax relating to Medi-Cal enrollees are budgeted in this PC.

3. The Managed Care Enrollment (MCE) Fund is assumed to cover the non-federal share of all MCO-tax related capitated rate increases through December 31, 2024. Beginning January 1, 2025, the Managed Care Enrollment Fund is assumed to cover the non-federal share of capitated rate increases related to amendments to the MCO tax approved in SB 136 (Chapter 6, Statutes of 2024) and AB 160 (Chapter 39, Statutes of 2024).

4. The values below are reflective of the recently approved Proposition 35. Proposition 35 provides for the non-federal share of capitation payments related to the MCO tax as approved in AB 119 (Chapter 13, Statutes of 2023) to be covered from the HCO&A Subfund beginning January 1, 2025.

5. The Managed Care Enrollment Fund and HCO&A shifts to the GF are expected to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	MCE Fund	HCO&A Subfund
FY 2024-25	$0	($5,638,327)	$4,482,026	$1,156,301
FY 2025-26	$0	($5,069,228)	$1,569,490	$3,499,738

Funding:

100% GF (4260-101-0001)
Managed Care Enrollment Fund (4260-101-3428)
Health Care Oversight & Accountability Subfund (4260-601-3443)

2023 MCO ENROLLMENT TAX MANAGED CARE PLANS

REGULAR POLICY CHANGE NUMBER: 82
IMPLEMENTATION DATE: 3/2024
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2407

	FY 2024-25	FY 2025-26
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

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 April 1, 2023.

Authority:
AB 119 (Chapter 13, Statutes of 2023)
SB 136 (Chapter 6, Statutes of 2024)
AB 160 (Chapter 39, Statutes of 2024)

Interdependent Policy Changes:
2023 MCO Enrollment Tax Mgd. Care Plans-Incr. Cap. Rates
2023 MCO Enrollment Tax Mgd. Care Plans-Funding Adj.

Background:
Effective April 1, 2023, the Department enacted a multi-year renewal of the MCO provider tax that provides for a statewide tax on managed care plans based on reported enrollment into these plans during the 12-month calendar year (CY) 2022 period. The tax is tiered based on whether the enrollee is a Medi-Cal enrollee or other enrollee.

This policy change estimates GF savings resulting from the imposition of the 2023 MCO Enrollment Tax.

In November 2024, voters approved the Protect Access to Health Care Act of 2024 (Proposition 35), which makes the MCO tax permanent, subject to continued federal approval for future tax periods, and specifies how revenues from the current period tax as it existed on July 1, 2023, are to be allocated, beginning with taxes collected in calendar year 2025. Proposition 35 allocates specified revenues to cover the non- federal share of costs for increased capitation costs to Medi-Cal managed care plans that pay the tax, increases payments to Medi-Cal providers, and supports existing Medi-Cal costs. Proposition 35 creates additional funds into which MCO tax revenues are deposited, appropriated, and spent.

2023 MCO ENROLLMENT TAX MANAGED CARE PLANS

REGULAR POLICY CHANGE NUMBER: 82

Reason for Change:
The change from the prior estimate, FY 2024-25, is an increase in dollars transferred to the GF due to changes in the MCO tax model which impose a higher tax for CY 2024 and subsequent years and reflect updated assumptions around the timing of revenue collection and capitation payments. Additionally, funding from the Health Care Oversight & Accountability (HCO&A) Subfund has been incorporated pursuant to the passage of Proposition 35. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease in dollars transferred to the GF due to six months of CY 2024 retroactive payments occurring in FY 2024-25 and the passage of Proposition 35, which specifies a lower amount of MCO tax revenue for support of the Medi-Cal program relative to the 2024 Budget Act.

Methodology:
1. The 2023 MCO Enrollment Tax is based on the cumulative enrollment of health plans during the 12-month CY 2022 period.

2. Different rates are assessed to Medi-Cal and non-Medi-Cal health plans.

3. The impact of the increase in capitation payments related to the tax is included in the 2023 MCO Enrollment Tax Mgd. Care Plans-Incr. Cap. Rates policy change.

4. The values below are reflective of the recently approved Proposition 35. Proposition 35 provides for $2 billion from the HCO&A to support the Medi-Cal program in each of calendar year 2025 and 2026. On a cash basis, the estimated amounts shifted from the HCO&A Subfund to the GF are $833.3 million in FY 2024-25 and $2 billion in FY 2025-26.

5. The Budget includes the net benefit of funding associated with the 2024 MCO Tax amendments (SB 136 and AB 160) to entirely support the Medi-Cal program.

6. The Managed Care Enrollment (MCE) Fund and HCO&A Subfund shifts to the GF are expected to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	MCE Fund	HCO&A Subfund
FY 2024-25	$0	($7,941,724)	$7,108,391	$833,333
FY 2025-26	$0	($4,373,496)	$2,373,496	$2,000,000

Funding:
100% GF (4260-101-0001)
Managed Care Enrollment Fund (4260-101-3428)
Health Care Oversight & Accountability Subfund (4260-601-3443)

MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND

REGULAR POLICY CHANGE NUMBER: 83
IMPLEMENTATION DATE: 2/2019
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2063

	FY 2024-25	FY 2025-26
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

Purpose:
This policy change estimates reimbursements to the General Fund (GF) by Intergovernmental Transfer (IGT) from allowable public entities for Medi-Cal payment contributions and administration and processing fees.

Authority:
Welfare & Institution Code 14164 and 14301.4
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
Effective July 1, 2017, rating period, this policy change consolidates voluntary IGT reimbursements to the GF and administration and processing fees from allowable public entities servicing Medi-Cal managed care members.

As a result of the COVID-19 national public health emergency, increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year (CY) 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase in GF reimbursements due to updated CY 2023 enrollment and rates, as well as the assessment of IGT administrative fees associated with the District Hospital Directed Payment (DHDP), Enhanced Payment Program (EPP), and Quality Incentive Pool (QIP) as of January 2025.The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase in GF reimbursements due to a full year of the new IGT administrative fees associated with DHDP, EPP, and QIP in FY 2025-26.

MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND

REGULAR POLICY CHANGE NUMBER: 83

Methodology:

1. Data from CY 2022, CY 2023, and CY 2024 are used to estimate the annual commitment from allowable public entities.

2. The Title XIX and Title XXI COVID-19 increased FMAP is assumed for expenditures for the CY 2022 and CY 2023 rating periods and has already been adjusted for in the corresponding GF expenditure payments and expected GF reimbursement levels.

3. On a cash basis, the estimated reimbursements to the General Fund are:

(Dollars in Thousands)

Reimbursement	GF
CY 2022	$130,305
CY 2023	$2,126,979
CY 2024	$11,029
Total	$2,268,313
CY 2023 Support Cost to GF	($251)
GF	($2,268,062)
FY 2024-25 Net Impact	**$0**

(Dollars in Thousands)

Reimbursement	GF
CY 2023	$162,756
CY 2024	$2,606,293
CY 2025	$11,581
Total	$2,780,629
CY 2024 Support Cost to GF	($251)
GF	($2,780,378)
FY 2025-26 Net Impact	**$0**

Funding:

Reimbursement (4260-601-0995)
100% State GF (4260-101-0001)

COORDINATED CARE INITIATIVE RISK MITIGATION

REGULAR POLICY CHANGE NUMBER: 84
IMPLEMENTATION DATE: 12/2024
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2135

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	-$27,380,000	-$83,880,000
- STATE FUNDS	-$13,690,000	-$41,940,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$27,380,000	-$83,880,000
STATE FUNDS	-$13,690,000	-$41,940,000
FEDERAL FUNDS	-$13,690,000	-$41,940,000

Purpose:
This policy change estimates additional payments to and recoveries from managed care plans (MCPs) who participated in the Coordinated Care Initiative (CCI) related to the risk mitigation strategies applicable to Cal MediConnect (CMC) and non-CMC full-benefit dual-eligible members, partial-benefit dual eligible members, and non-dual-eligible members.

Authority:
Welfare and Institutions (W&I) Code section 14182.18
CMC Three-Way Contract

Interdependent Policy Changes:
Not Applicable

Background:
Risk mitigation strategies were put in place for CMC and non-CMC full-benefit dual eligible members. Risk mitigation strategies were also put in place for partial-benefit dual eligible members and non-dual-eligible members enrolled in managed care in the CCI counties.

There was a limited up-side risk corridor and a limited down-side risk corridor for CMC full-benefit dual eligible members, as specified in the CMC Three-Way Contract, for all demonstration years (DYs) through December 31, 2017. This two-sided risk corridor allowed for additional recoveries from MCPs in the event of profit (up-side) above a specific threshold, and additional payments to MCPs in the event of loss (down-side) greater than a specified threshold.

There was also a one-sided (up-side) risk corridor in place for the period of January 1, 2020, through December 31, 2022, for CMC members. The necessary data to perform the calculation for this risk corridor is not currently available, thus an estimated net recoupment is unable to be determined at this time.

For non-CMC full-benefit dual eligible members, partial-benefit dual eligible members, and non-dual-eligible members, there was a separate 24-month symmetrical down-side and up-side risk corridors, as specified in W&I Code, section 14182.18 and existing Medi-Cal MCP contracts.

COORDINATED CARE INITIATIVE RISK MITIGATION

REGULAR POLICY CHANGE NUMBER: 84

Capitation payments for CMC and non-CMC full-benefit dual eligible members were subject to an additional risk mitigation requirement. This requirement is applicable to periods for which capitation payments are based on a projected mix of members of varying acuity levels. If there is a difference between the projected member mix and the actual member mix that would result in a greater than 2.5 percent impact to the capitation rates, the Department and MCPs will equally share any increases or decreases beyond the 2.5 percent threshold (independent of the MCPs' actual gains or losses).

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a decrease in recoupments due to previously budgeted recoupments shifting from FY 2024-25 to FY 2025-26. The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase in recoupments due to a larger number of recoupments anticipated to occur in FY 2025-26 than in FY 2024-25.

Methodology:
1. Assume all payments and recoupments attributable to CMC eligibles for the 2.5 percent member mix threshold for 2014 through 2022 will occur in FY 2024-25. The payments and recoupments attributable to non-CMC eligibles for the 2.5 percent member mix threshold for 2014 through 2022 will occur no sooner than FY 2025-26. Estimates are not available at this time for 2018 and beyond.

2. Assume all CMC payments and recoupments for DY one through three will occur in FY 2024-25 while payments and recoupments for DY six through eight will occur no sooner than FY 2025-26. Estimates are not available at this time for DY six through eight.

3. Assume all payments and recoupments for the first 24-month period, for the non-CMC full-benefit dual eligibles, partial-benefit dual eligibles, and non-dual-eligibles will occur no sooner than FY 2025-26.

4. Total recoupments are estimated to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2024-25	($27,380)	($13,690)	($13,690)
FY 2025-26	($83,880)	($41,940)	($41,940)

*Totals may differ due to rounding.

Funding:
50/50 FFP Title XIX (4260-101-0890)

PROP 56 - DIRECTED PAYMENT RISK MITIGATION

REGULAR POLICY CHANGE NUMBER: 85
IMPLEMENTATION DATE: 7/2024
ANALYST: Whitney Li
FISCAL REFERENCE NUMBER: 2333

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	-$600,000,000	$0
- STATE FUNDS	-$181,601,400	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$600,000,000	$0
STATE FUNDS	-$181,601,400	$0
FEDERAL FUNDS	-$418,398,600	$0

Purpose:
This policy change budgets additional payments owed to managed care plans (MCPs), or recoupment of payments due from managed care plans, as determined by risk corridor calculations applicable to Proposition 56 payments.

Authority:
All Plan Letter (APL) 19-015
APL 19-016
APL 19-018
APL 20-013
APL 20-014

Interdependent Policy Changes:
Proposition 56 Funding

Background:
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56, 2016) increased the excise tax rate on cigarettes and tobacco products and allocates a portion of the tobacco tax revenue to the Department for use as the nonfederal share of health care expenditures.

Proposition 56 funds are used to fund various payments to Medi-Cal providers through both the fee-for-service and managed care delivery systems.

CMS instituted the Medicaid Managed Care Final Rule in May 2016, which modernized Medicaid managed care regulations. The result is changes in the usage of managed care delivery systems, 42 CFR section 438.6(c) provides states flexibility to implement delivery system and provider payment initiatives under Medicaid managed care plans (MCPs) contracts based on allowable directed payments.

Beginning with the July 1, 2017 rating period, the state has directed MCPs to make enhanced supplemental payments to eligible provider types for specified CPT codes upon approval from

PROP 56 - DIRECTED PAYMENT RISK MITIGATION
REGULAR POLICY CHANGE NUMBER: 85

CMS and availability of federal funding. The enhanced supplemental payment is contingent upon the MCPs' receipt of providers' actual utilization for these codes reported through encounter data.

For the calendar year (CY) 2022 rating period there are a subset of Proposition 56 directed payment programs that were subject to one of three two-sided risk corridors. The first risk corridor applies to the Proposition 56 Physicians Services, Proposition 56 Developmental Screening Services, and Proposition 56 Adverse Childhood Experiences Screening Services programs. The second risk corridor applies to the Proposition 56 Family Planning Services program. The third risk corridor applies to the Proposition 56 Value-Based Payment program.

Reason for Change:
There is no change in FY 2024-25 from the prior estimate.

The change in FY 2024-25 to FY 2025-26, in the current estimate, is a decrease in recoupments due to no calculations being available for the CY 2023 risk corridor.

Methodology:
1. For the CY 2022 rating period, $600 million TF ($181.6 million state funds) are estimated to be recouped in FY 2024-25.

2. This policy change identifies the use of the General Fund for these Proposition 56 adjustments. See the Proposition 56 Funding policy change for the Proposition 56 offset to the GF.

3. Total impacts related to this policy change are summarized below:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
CY 2022 recoupments	($600,000)	($181,602)	($418,398)
Total	**($600,000)**	**($181,602)**	**($418,398)**

Funding:
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)
ACA 90% Title XIX FF / 10% GF (4260-101-0001 / 0890)
65% Title XXI FF / 35% GF (4260-101-0001 / 0890)
100% Title XXI FF (4260-101-0890)
100% State GF (4260-101-0001)
COVID-19 Title XIX Increased FMAP
COVID-19 Title XXI Increased FMAP

RETRO MC RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 86
IMPLEMENTATION DATE: 1/2016
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1788

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	-$1,169,110,000	$284,245,000
- STATE FUNDS	-$643,195,100	$159,836,550
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,169,110,000	$284,245,000
STATE FUNDS	-$643,195,100	$159,836,550
FEDERAL FUNDS	-$525,914,900	$124,408,450

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:
- Retro Managed Care Rate Adjustments,
- Managed care pass through payments, and
- Managed care funding adjustments.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase in recoupments due to:
- Rate adjustments (net recoupments) associated with Calendar Year (CY) 2023 and CY 2024 amended rates occurring in FY 2024-25, and
- A shift in the SB 78 MCO tax reconciliation from Fund 3156 to GF from FY 2023-24 to FY 2024-25.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase in total fund expenditures due to no significant recoupments related to retroactive managed care rate adjustments are expected to occur in FY 2025-26.

RETRO MC RATE ADJUSTMENTS
REGULAR POLICY CHANGE NUMBER: 86

Methodology:
1. The Department estimates the following retroactive managed care capitation rate adjustments and retroactive pass-through payments in FY 2024-25 and FY 2025-25:

(Dollars in Thousands)

FY 2024-25	TF	GF	Fund 3156	State-Only	FF
Retro MC Rate Adjustments Payments	($1,244,156)	($726,267)	$0	$59,192	($577,080)
Retro Pass-Through Payments	$75,046	$23,879	$0	$1	$51,166
SB 78 MCO Tax Reconciliation	$0	($144,464)	$144,464	$0	$0
Total FY 2024-25	**($1,169,110)**	**($846,853)**	**$144,464**	**$59,193**	**($525,914)**

(Dollars in Thousands)

FY 2025-26	TF	GF	State-Only	FF
Retro MC Rate Adjustment Payments	$208,304	$72,870	$62,565	$72,870
Retro Pass-Through Payments	$75,940	$24,400	$2	$51,539
Total FY 2025-26	**$284,245**	**$97,269**	**$62,567**	**$124,408**

Funding:
50% Title XIX FF / 50% GF (4260-101-0001/0890)
65% Title XXI FF / 35% GF (4260-101-0001/0890)
ACA 90/10 (2019) (4260-101-0890)
100% GF (4260-101-0001)
Title XIX 100% FF (4260-101-0890)
3156 MCO Tax (Non-GF) (4260-601-3156 MCO Tax)
90% Family Planning FFP / 10% GF (4260-101-0001/0890)
COVID-19 Title XIX Increased FMAP (4260-101-0890/0001)
COVID-19 Title XXI Increased FMAP (4260-113-0890/0001)

RATE INCREASE FOR FQHCS/RHCS/CBRCS

REGULAR POLICY CHANGE NUMBER: 87
IMPLEMENTATION DATE: 10/2005
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 88

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$653,011,000	$1,134,117,000
- STATE FUNDS	$235,344,650	$408,734,550
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	35.76 %	20.59 %
APPLIED TO BASE		
TOTAL FUNDS	$419,494,300	$900,602,300
STATE FUNDS	$151,185,400	$324,576,110
FEDERAL FUNDS	$268,308,860	$576,026,200

Purpose:
This policy change estimates the rate increase for all Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) under the prospective payment system (PPS) reimbursement methodology and the rate increase for Cost-Based Reimbursement Clinics (CBRCs).

Authority:
Section 1833 of the Social Security Act
Welfare & Institutions Code, section 14170 and 14132.100

Interdependent Policy Changes:
Not Applicable

Background:
The Benefits Improvement and Protection Act of 2000 required the Department to reimburse FQHCs and RHCs based on the PPS reimbursement methodology. Clinics chose a PPS rate based on either 1) the average of the clinic's 1999 and 2000 cost-based rate or, 2) the clinic's 2000 cost-based rate. The clinic receives an annual rate adjustment based on the percentage increase in the Medicare Economic Index and is effective October 1st of each year.

The Department reimburses the CBRCs, owned or operated by Los Angeles County, at 100% of reasonable and allowable costs. The Department pays an interim rate to the clinics, which is adjusted once the audit reports are finalized. The interim rate is adjusted July 1 of each year.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase due to updated actuals and a projected increase in rates and visits. The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to a projected increase in rates and visits.

Methodology:
1. The projected visits are based on the average percent increase of the last three years of actual visit counts.

RATE INCREASE FOR FQHCS/RHCS/CBRCS

REGULAR POLICY CHANGE NUMBER: 87

2. The rate increase will be used as a trend factor to calculate the estimated cost per visit rate. The rate increase percent was 8.44% for calendar year (CY) 2023 and 5.88% for CY 2024 and CY 2025.

Rate Year	Projected Visits	Current Rate	Rate with Increase
2023	24,600,988	$197.88	$197.88 x (1+8.44%) = $214.59
2024	26,431,464	$214.59	$214.59 x (1+5.88%) = $227.21
2025	28,398,141	$227.21	$227.21 x (1+5.88%) = $240.58

*Totals may differ due to rounding.

3. The estimated expenditures are the increased rate multiplied by the number of projected visits. The projected annual expenditures due to the rate increase are:

(Dollars in Thousands)

Federal Rate Year	Expenditures	Exp. with Increase	Rate Increase
2023	$4,868,043	$5,279,126	$411,083
2024	$5,671,928	$6,005,493	$333,565
2025	$6,452,342	$6,832,025	$379,683

4. The FY 2024-25 CBRC rate increase of $30,908,000 is based on the FY 2022-23 reported rates and a three year average of visits. The estimated payment increase is determined by the difference between the calculated estimated payments and the total three year average payments per the Paid Claims Summary Reports for FY 2021-22, FY 2022-23, and FY 2023-24.

5. The FY 2025-26 CBRC rate increase of $36,619,000 is based on the FY 2022-23 reported rates. FY 2022-23 reported rates utilized a three year average of payment data from the Paid Claims Summary Reports for FY 2022-23 and FY 2023-24 and the FY 2024-25 estimates. The estimated payment increase is determined by the difference between the calculated estimated payments and the total three year average of visits and payments.

6. The estimated expenditures in FY 2024-25 and FY 2025-26 are:

(Dollars in Thousands)

FY 2024-25	TF
CY 2024 Increase	$326,505
CY 2025 Increase	$326,505
FY 2024-25 Total	**$653,011**

RATE INCREASE FOR FQHCS/RHCS/CBRCS

REGULAR POLICY CHANGE NUMBER: 87

FY 2025-26	TF
CY 2025 Increase	$567,059
CY 2026 Increase	$567,059
FY 2025-26 Total	**$1,134,117**

Funding:

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF	$409,647,000	$204,824,000	$204,823,000
90% Title XIX ACA / 10% GF	$218,625,000	$21,863,000	$196,762,000
65% Title XXI / 35% GF	$24,739,000	$8,659,000	$16,080,000
FY 2024-25 Total	**$653,011,000**	**$235,346,000**	**$417,665,000**

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF	$711,454,000	$355,727,000	$355,727,000
90% Title XIX ACA / 10% GF	$379,698,000	$37,970,000	$341,728,000
65% Title XXI / 35% GF	$42,965,000	$15,038,000	$27,927,000
FY 2025-26 Total	**$1,134,117,000**	**$408,735,000**	**$725,382,000**

*Totals may differ due to rounding.

PP-GEMT IGT PROGRAM

REGULAR POLICY CHANGE NUMBER: 88
IMPLEMENTATION DATE: 1/2023
ANALYST: Ryan Woolsey
FISCAL REFERENCE NUMBER: 2267

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$321,745,000	$319,405,000
- STATE FUNDS	$110,632,000	$111,486,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	3.37 %	2.61 %
APPLIED TO BASE		
TOTAL FUNDS	$310,902,200	$311,068,500
STATE FUNDS	$106,903,700	$108,576,220
FEDERAL FUNDS	$203,998,490	$202,492,310

Purpose:
This policy change estimates reimbursements to the General Fund (GF) by intergovernmental transfer (IGT) from AB 1705 Intergovernmental Transfer Program revenues, and the supplemental reimbursement payments for Ground Emergency Medical Transportation (GEMT) services provided by public GEMT providers.

Authority:
AB 1705 (Chapter 544, Statutes of 2019)
State Plan Amendment (SPA) 22-0015

Interdependent Policy Changes:
Ground Emergency Medical Transportation QAF

Background:
AB 1705 requires the Department to implement the Public Provider GEMT Intergovernmental Transfer (PP-GEMT IGT) Program no sooner than July 1, 2021. Currently, the Department administers the GEMT Quality Assurance Fee (QAF) program under Welfare and Institutions Code § 14129 et seq. for private and public providers, which is budgeted in the GEMT QAF policy change. Pursuant to AB 1705, the GEMT Supplemental Payment Program for public governmental entities had a sunset date on December 31, 2022. The reimbursements made to public providers previously enrolled in the GEMT QAF program have transitioned into the new PP-GEMT IGT Program. The Department has implemented the PP-GEMT IGT program effective January 1, 2023. As of January 1, 2023, public providers are no longer eligible to participate in the GEMT QAF program.

Pending CMS approval, a 10% fee will be assessed on the IGTs in order to support health care coverage costs and costs associated with administering the program. Fees assessed in excess of the costs will result in a savings to the GF. Eligible emergency medical transport providers will be required to receive an add-on increase to their Medi-Cal Fee-for-Service (FFS) payment schedule for certain procedure codes. The Department developed the add-on increase based on specific standards, including eligible providers' average costs directly associated with providing Medi-Cal emergency medical transports under the Medi-Cal program.

PP-GEMT IGT PROGRAM
REGULAR POLICY CHANGE NUMBER: 88

The Centers for Medicare and Medicaid Services (CMS) approved SPA 22-0015 on December 21, 2022, authorizing the add-on increase of $946.92 to the Medi-Cal FFS fee schedule rates for eligible GEMT services when provided by qualified public providers in Calendar Year (CY) 2023.

The Department submitted SPA 24-0002 to CMS on March 21, 2024, to continue the PP GEMT IGT add-on program in CY 2024 and update the add-on increase.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is an increase due to amended CY 2024 rates and increased enrollment projections. Additionally, FY 2024-25 no longer assumes any offset to the General Fund related to the 10% fee to support health care coverage costs and administrative costs, pending CMS approval.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is a slight decrease due to lower projected enrollment in CY 2025 and 2026.

Methodology:
1. The PP-GEMT IGT program was implemented on January 1, 2023.

2. The total payments in FY 2024-25 on a cash basis are expected to be $321,745,000 Total Fund (TF), of which $10,846,000 TF is FFS and $310,899,000 is for managed care.

3. The total payments in FY 2025-26 on a cash basis are expected to be $319,405,000 TF, of which $8,333,000 is FFS and $311,072,000 is for managed care.

4. CMS has not yet approved the 10% fee assessment to support health care coverage costs and administrative costs, so no offset to the General Fund is assumed for FY 2024-25 or FY 2025-26.

5. FY 2024-25 and FY 2025-26 are summarized as follows:

FY 2024-25	TF	GF	IGT*	FF
GF Offset	$0	$0	$0	$0
FFS Payments	$10,846,000	$0	$3,638,000	$7,208,000
Managed Care Payments	$310,899,000	$0	$106,994,000	$203,905,000
Total:	**$321,745,000**	**$0**	**$110,632,000**	**$211,113,000**

FY 2025-26	TF	GF	IGT*	FF
GF Offset	$0	$0	$0	$0
FFS Payments	$8,333,000	$0	$2,795,000	$5,538,000
Managed Care Payments	$311,072,000	$0	$108,691,000	$202,381,000
Total:	**$319,405,000**	**$0**	**$111,486,000**	**$207,919,000**

PP-GEMT IGT PROGRAM

REGULAR POLICY CHANGE NUMBER: 88

Funding:

FY 2024-25	TF	GF	IGT*	FF
100% GF (4260-101-0001)	$0	$0	$0	$0
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	$191,806,000	$0	$95,903,000	$95,903,000
90%Title XIX FF / 10% GF (4260-101-0001 / 0890)	$122,999,000	$0	$12,300,000	$110,699,000
65% Title XXI FF / 35% GF (4260-101-0890)	$6,940,000	$0	$2,429,000	$4,511,000
Total	**$321,745,000**	**$0**	**$110,632,000**	**$211,113,000**

FY 2025-26	TF	GF	IGT*	FF
100% GF (4260-101-0001)	$0	$0	$0	$0
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	$194,506,000	$0	$97,253,000	$97,253,000
90%Title XIX FF / 10% GF (4260-101-0001 / 0890)	$117,926,000	$0	$11,793,000	$106,133,000
65% Title XXI FF / 35% GF (4260-101-0001 / 0890)	$6,973,000	$0	$2,440,000	$4,533,000
Total	**$319,405,000**	**$0**	**$111,486,000**	**$207,919,000**

*Reimbursement GF (4260-601-0995)

MEDI-CAL PROVIDER PAYMENT INCREASES 2025 & LATER

REGULAR POLICY CHANGE NUMBER: 89
IMPLEMENTATION DATE: 2/2025
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2458

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$153,980,000	$7,417,883,000
- STATE FUNDS	$61,592,000	$2,967,153,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$153,980,000	$7,417,883,000
STATE FUNDS	$61,592,000	$2,967,153,000
FEDERAL FUNDS	$92,388,000	$4,450,730,000

Purpose:
This policy change reflects the costs associated with increasing provider payments, pursuant to Proposition 35.

This policy change was previously titled "Medi-Cal Provider Rate Increase 2025."

Authority:
Protect Access to Health Care Act of 2024 (Proposition 35)

Interdependent Policy Changes:
Not Applicable

Background:
In November 2024, voters approved the Protect Access to Health Care Act of 2024 (Proposition 35), which makes the managed care organization (MCO) tax permanent, subject to continued federal approval for future tax periods, and specifies how revenues from the tax for current periods, as it existed on July 1, 2023, are to be allocated beginning with taxes collected in calendar year 2025. Proposition 35 allocates revenues to cover the non-federal share of costs for increased capitation costs to Medi-Cal managed care plans that pay the tax, increases payments to Medi-Cal providers, and supports existing Medi-Cal costs. Proposition 35 creates additional funds into which MCO tax revenues are deposited, appropriated, and spent.

Pursuant to Chapter 40, Statutes of 2024 (SB 159), additional rate increases in various specified domains with effective dates of January 1, 2025, and January 1, 2026, that were included in the 2024 Budget Act MCO Tax package are inoperative due to the passage of Proposition 35.

The non-federal share of Proposition 35 provider payment increases will be borne by the Health Care Oversight & Accountability Subfund, item 4260-601-3443. The total amount of these provider payment increases will include matching federal funds for eligible services. This policy change identifies the use of General Fund (GF) for the payment increases. See the Prop 35 –

MEDI-CAL PROVIDER PAYMENT INCREASES 2025 & LATER

REGULAR POLICY CHANGE NUMBER: 89

Provider Payment Increase Funding policy change for the shift from the GF to item 4260-601-3443.

Reason for Change:
The change for FY 2024-25, from the prior estimate, is due to updates made for the estimated impact of Proposition 35.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to an increase in total funds and state funds from a full year of the 2025 provider payment increases being reflected in FY 2025-26.

Methodology:
1. For this Estimate cycle, preliminary cash basis amounts are based on placeholder assumption of January 1, 2025 implementation. However, cash basis amounts will be revised following finalization and approval of program specifications including payment mechanisms and timing, subject to consultation with the Protect Access for Health Care Act Stakeholder Advisory Committee, as specified in Proposition 35.

2. Preliminary estimates on a cash basis for FY 2024-25 and FY 2025-26 costs are estimated to be:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
Medi-Cal Provider Payment Increases 2025 & Later	$153,980	$61,592	$92,388
Total	**$153,980**	**$61,592**	**$92,388**

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
Medi-Cal Provider Payment Increases 2025 & Later	$7,417,883	$2,967,153	$4,450,730
Total	**$7,417,883**	**$2,967,153**	**$4,450,730**

Funding:
100% GF (4260-101-0001)
100% Title XIX FFP (4260-101-0890)

DPH INTERIM & FINAL RECONS

REGULAR POLICY CHANGE NUMBER: 90
IMPLEMENTATION DATE: 10/2007
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1152

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$208,277,000	$17,839,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$208,277,000	$17,839,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$208,277,000	$17,839,000

Purpose:
This policy change estimates the funds for the reconciliation of Designated Public Hospital (DPH) interim payments to their finalized hospital inpatient costs.

Authority:
State Plan Amendment (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 members will be reconciled to its filed Medi-Cal cost report for the respective fiscal year. The reconciliations, interim and final, are based on the hospitals' Certified Public Expenditures (CPE).

This reconciliation process may result in an overpayment or underpayment to a DPH and will be handled as follows:

- For DPHs that have been determined to be overpaid, the Department will recoup any overpayments.
- For DPHs that have been determined to be underpaid, the Department will make a payment equal to the difference between the DPH's computed Medi-Cal cost, and a DPH's payments consisting of: share of cost, third party liability, other health coverage, Medicare, Medi-Cal administrative days, crossovers, and interim payments.

Final payment reconciliation will be completed when the Department has audited the hospitals' cost reports.

DPH INTERIM & FINAL RECONS

REGULAR POLICY CHANGE NUMBER: 90

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to shifting the FY 2017-18 final reconciliations for non-Los Angeles (non-LA) County DPHs from FY 2023-24 to FY 2024-25.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to varying reconciliation estimates from 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 2024-25	TF	FF	ACA FF
2015-16 Final Reconciliation (LA County)	$10,342	$8,538	$1,804
2016-17 Final Reconciliation (LA County)	($1,848)	($275)	($1,573)
2017-18 Final Reconciliation	$57,912	$30,518	$27,394
2018-19 Final Reconciliation	$21,548	$24,849	($3,301)
2019-20 Final Reconciliation	$120,323	$97,808	$22,515
Total	**$208,277**	**$161,438**	**$46,839**

(Dollars in Thousands)

FY 2025-26	TF	FF	ACA FF
2020-21 Final Reconciliation	$17,839	$56,415	($38,576)
Total	**$17,839**	**$56,415**	**($38,576)**

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

GROUND EMERGENCY MEDICAL TRANSPORTATION QAF

REGULAR POLICY CHANGE NUMBER: 91
IMPLEMENTATION DATE: 4/2019
ANALYST: Ryan Woolsey
FISCAL REFERENCE NUMBER: 2081

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$161,216,000	$160,424,000
- STATE FUNDS	$49,784,000	$50,015,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	5.44 %	5.46 %
APPLIED TO BASE		
TOTAL FUNDS	$152,445,800	$151,664,800
STATE FUNDS	$47,075,750	$47,284,180
FEDERAL FUNDS	$105,370,100	$104,380,670

Purpose:
This policy change estimates the Quality Assurance Fee (QAF) revenues and the cost of rate increases for certain Ground Emergency Medical Transportation (GEMT) services.

Authority:
SB 523 (Chapter 773, Statutes of 2017)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023
AB 1705 (Chapter 544, Statutes of 2019)
State Plan Amendment (SPA) 20-0009
SPA 21-0017
SPA 22-0040
SPA 23-0020

Interdependent Policy Changes:
PP-GEMT IGT Program

Background:
SB 523 requires the Department to impose a GEMT QAF on all ground emergency medical transports. The QAF revenues will be used 1) to pay for Department staffing and administrative costs to implement the QAF program, 2) to pay for health care coverage in each fiscal year (FY) in the amount of 10% of the annual QAF collection amount, and 3) to be used, along with a federal match, to provide an add-on to the reimbursement rates for base ground emergency transport services.

The Department collects gross transport and revenue data from GEMT providers in order to calculate an annual QAF amount. The QAF is assessed on each GEMT transport for base ground emergency medical services, effective July 1, 2018. The revenue generated by the QAF collections is deposited directly into the Medi-Cal Emergency Medical Transportation Fund (MEMTF).

GROUND EMERGENCY MEDICAL TRANSPORTATION QAF

REGULAR POLICY CHANGE NUMBER: 91

For FY 2018-19, the Department was required to provide an add-on to the Medi-Cal Fee-for-Service (FFS) reimbursements for codes A0427 Advanced Life Support (ALS) Emergency, A0429 Basic Life Support (BLS) Emergency, and A0433 ALS2 using available QAF revenue, effective July 1, 2018.

Effective July 1, 2018, the add-on was calculated to be $220.80 and authorized by SPA 18-004. SPA 19-0020 authorizes for the add-on to be provided for codes A0225 Neonatal Emergency Transport and A0434 Specialty Care Transport, effective July 1, 2019. SPA 20-0009 was approved to continue providing the add-on in FY 2020-21. SPA 21-0017, for the FY 2021-22 add-on, was approved on August 20, 2021. SPA 22-0040, for the FY 2022-23 add-on, was approved on December 16, 2022. SPA 23-0020, for the FY 2023-24 add-on, was approved on November 16, 2023. The Department will submit SPA 24-0025 in Quarter 3 to continue the add-on payment in FY 2024-25.

AB 1705 requires the Department to implement a public provider GEMT intergovernmental transfer (PP-GEMT IGT) program, utilizing intergovernmental transfers. The public providers previously enrolled in the GEMT QAF program were transitioned into the new AB 1705 PP-GEMT IGT Program. As of January 1, 2023, these providers are no longer able to participate in the GEMT QAF program and funds associated with AB 1705 (public providers) have shifted into the PP-GEMT IGT Program policy change.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is an increase due to updated enrollment projections.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is a slight decrease due to a projected decline in enrollment.

Methodology:

1. The effective date for the GEMT QAF is July 1, 2018 with the approved add-on amount of $220.80.

2. Assume the GEMT QAF revenue will be $59,883,000 in FY 2024-25 and $60,159,000 in FY 2025-26.

3. For FY 2018-19, $1,003,000 will be transferred from the MEMTF to the GF for administration costs. Beginning FY 2019-20 and every year after, $374,000 will be transferred.

4. The transfer from the MEMTF to the GF for the 10% set aside for health care coverage is estimated to be $26,000,000 for FY 2024-25, including amounts from prior years, and $5,800,000 for FY 2025-26.

5. From the remaining GEMT QAF revenue available, total annual GEMT add-on payments for FY 2024-25 are estimated to be $161,216,000 TF, of which $8,765,000 TF is for FFS and $152,451,000 TF is for Managed Care GEMT transport services.

6. From the remaining GEMT QAF revenue available, total annual GEMT add-on payments for FY 2025-26 are estimated to be $161,216,000 TF, of which $8,764,000 TF is for FFS and $151,660,000 TF is for Managed Care GEMT transport services.

GROUND EMERGENCY MEDICAL TRANSPORTATION QAF

REGULAR POLICY CHANGE NUMBER: 91

8. Managed Care Payments:
   a. FY 2024-25 is expected to include 7 months of the CY 2024 rates and 5 months of the CY 2025 rates.
   b. FY 2025-26 is expected to include 7 months of the CY 2025 rates and 5 months of the CY 2026 rates.

10. The cash basis estimate is summarized as follows:

FY 2024-25	TF	GF	MEMTF	FF
FFS Payments	$8,765,000	$0	$2,939,000	$5,826,000
Managed Care Payments	$152,451,000	$0	$46,845,000	$105,606,000
General Fund Offset	$0	($26,000,000)	$26,000,000	$0
Total	**$161,216,000**	**($26,000,000)**	**$75,784,000**	**$111,432,000**

FY 2025-26	TF	GF	MEMTF	FF
FFS Payments	$8,764,000	$0	$2,939,000	$5,825,000
Managed Care Payments	$151,660,000	$0	$47,076,000	$104,584,000
General Fund Offset	$0	($5,800,000)	$5,800,000	$0
Total	**$160,424,000**	**($5,800,000)**	**$55,815,000**	**$110,409,000**

Funding:

FY 2024-25	TF	GF	MEMTF	FF
100% General Fund (4260-101-0001)	($26,000,000)	($26,000,000)	$0	$0
MEMTF (4260-601-3323)	$75,784,000	$0	$75,784,000	$0
ACA Title XIX FF (4260-101-0890)	$67,658,000	$0	$0	$67,658,000
Title XIX FF (4260-101-0890)	$40,511,000	$0	$0	$40,511,000
Title XXI FF (4260-101-0890)	$3,263,000	$0	$0	$3,263,000
Total	**$161,216,000**	**($26,000,000)**	**$75,784,000**	**$111,432,000**

GROUND EMERGENCY MEDICAL TRANSPORTATION QAF

REGULAR POLICY CHANGE NUMBER: 91

FY 2025-26	TF	GF	MEMTF	FF
100% General Fund (4260-101-0001)	($5,800,000)	($5,800,000)	$0	$0
MEMTF (4260-601-3323)	$55,815,000	$0	$55,815,000	$0
ACA Title XIX FF (4260-101-0890)	$66,233,000	$0	$0	$66,233,000
Title XIX FF (4260-101-0890)	$40,884,000	$0	$0	$40,884,000
Title XXI FF (4260-101-0890)	$3,292,000	$0	$0	$3,292,000
Total	**$160,424,000**	**($5,800,000)**	**$55,815,000**	**$110,409,000**

FQHC/RHC/CBRC RECONCILIATION PROCESS

REGULAR POLICY CHANGE NUMBER: 92
IMPLEMENTATION DATE: 7/2008
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 1329

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$128,915,000	$133,942,000
- STATE FUNDS	$46,460,900	$48,272,700
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	5.57 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$121,734,400	$133,942,000
STATE FUNDS	$43,873,030	$48,272,700
FEDERAL FUNDS	$77,861,410	$85,669,300

Purpose:
This policy change estimates the reimbursement of participating Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) according to the prospective payment system (PPS), Indian Health Services/Memorandum of Agreement (IHS/MOA), and the reimbursement to Cost-Based Reimbursement Clinics (CBRCs).

Authority:
Welfare & Institutions Code, sections 14132 and 14170
Social Security Act, 1902 (bb)(5)

Interdependent Policy Changes:
Not Applicable

Background:
Annually, each FQHC/RHC submits a reconciliation request for full reimbursement. The Department must provide payment to the clinics equal to the difference between each clinic's final PPS rate and the expenditures already reimbursed by an interim payment and third party payors (i.e. managed care entities, Medicare, etc.) in order to calculate the final settlement with the clinic.

The Department reimburses the CBRCs, owned or operated by Los Angeles County, at 100% of reasonable and allowable costs. The Department pays an interim rate to the clinics, which is adjusted once the audit reports are finalized. The adjusted interim rate is used for subsequent fiscal year claims.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a net decrease due to updated Erroneous Payment Corrections (EPCs) and actual settlement recoveries. The change from FY 2024-25 to FY 2025-26, in the current estimate, is an overall net increase due to FY 2025-26 being based on actual settlement recoveries and the FY 2024-25 estimated amounts.

FQHC/RHC/CBRC RECONCILIATION PROCESS

REGULAR POLICY CHANGE NUMBER: 92

Methodology:

1. FY 2024-25 FQHC and RHC reconciliations are based on a three-year average of actual settlements from July 2021 through June 2024. The FY 2025-26 reconciliations are based on a three-year average of actual settlements from July 2022 through June 2024 and the FY 2024-25 estimated amounts. The FQHC reconciliation amount includes settlements for IHS.

2. The estimated FQHC retroactive rate adjustment of $51,365,000 for FY 2024-25 is based on paid EPCs from July 2023 through June 2024. For FY 2025-26, the amount of $61,383,000 is based on a three-year average of paid EPCs from July 2021 through June 2024. Currently, the fiscal intermediary processes EPCs quarterly.

3. The LA CBRC reconciliation for FY 2024-25 is based on a three-year average of actual settlements from July 2021 through June 2024. The FY 2025-26 reconciliation is based on a three-year average of actual settlements from July 2022 through June 2024 and the FY 2024-25 estimated amount.

Reconciliations and Adjustments	FY 2024-25	FY 2025-26
FQHCs Reconciliation	$20,076,000	$18,398,000
RHCs Reconciliation	$1,115,000	($2,143,000)
FQHC Retroactive Rate Adjustment	$51,365,000	$61,383,000
LA CBRCs Reconciliation	$56,359,000	$56,304,000
Total	**$128,915,000**	**$133,942,000**

FY 2024-25	TF	GF	FF
90% Title XIX ACA / 10% GF	$43,160,000	$4,316,000	$38,844,000
65% Title XXI / 35% GF	$4,884,000	$1,709,000	$3,175,000
50% Title XIX / 50% GF	$80,871,000	$40,436,000	$40,435,000
Total	**$128,915,000**	**$46,461,000**	**$82,454,000**

*Totals may differ due to rounding.

FY 2025-26	TF	GF	FF
90% Title XIX ACA / 10% GF	$44,843,000	$4,484,000	$40,359,000
65% Title XXI / 35% GF	$5,074,000	$1,776,000	$3,298,000
50% Title XIX / 50% GF	$84,025,000	$42,013,000	$42,012,000
Total	**$133,942,000**	**$48,273,000**	**$85,669,000**

*Totals may differ due to rounding.

Funding:

50% Title XIX / 50% GF (4260-101-0890/0001)
90% Title XIX ACA / 10% GF (4260-101-0890/0001)
65% Title XXI / 35% GF (4260-101-0001/0890)

NURSING FACILITY RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 93
IMPLEMENTATION DATE: 1/2023
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2181

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$763,290,000	$783,416,000
- STATE FUNDS	$361,799,400	$371,339,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	91.85 %	88.02 %
APPLIED TO BASE		
TOTAL FUNDS	$62,208,100	$93,853,200
STATE FUNDS	$29,486,650	$44,486,440
FEDERAL FUNDS	$32,721,480	$49,366,800

Purpose:
This policy change estimates the cost of extending the skilled nursing facility rate methodology and Quality Assurance Fee (QAF).

Authority:
AB 186 (Chapter 46, Statutes of 2022)

Interdependent Policy Changes:
Not Applicable

Background:
AB 1629 (Chapter 875, Statutes of 2004), most recently extended by AB 186 (Chapter 46, Statutes of 2022) through 2026, requires the Department to implement a facility-specific rate methodology on Freestanding Skilled Nursing Facilities, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facilities, Level-B (FSSA/NF-B). For calendar years (CYs) 2023 through 2026, annual rate increase for labor costs will be limited to 5 percent and annual rate increases for non-labor costs will be limited to 2 percent. Beginning in CY 2026, half of the annual increase for non-labor costs will be allocated to base rates and half to increasing Workforce & Quality Incentive Program (WQIP) directed payments. The WQIP directed payments are budgeted in the Workforce & Quality Incentive Program policy change.

The methodology also imposes a Quality Assurance Fee (QAF) equivalent to 6% of all facility revenue, which is used to increase rates and offset a portion of the General Fund cost for the rate increases. Receipts from the extended QAF are budgeted in the Long-Term Care Quality Assurance Fund Expenditures policy change.

Workforce Standards and Base Rate Augmentation
For CY 2024 through CY 2026, AB 186 authorized the Workforce Standards Program (WSP). The WSP will provide an enhanced Medi-Cal per diem rate, including a workforce rate adjustment, to facilities that maintain a collective bargaining agreement, participate in a statewide multi-employer labor management committee (LMC), or meet basic wages and benefit standards established by the Department.

NURSING FACILITY RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 93

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to:

- Updated total Medi-Cal days,
- Updated split of FFS and managed care days, and
- The CY 2024 FFS rates implementation is delayed to October 2024, with the retroactive rate adjustment in January 2025.
- The CY 2025 FFS rates implementation is delayed to July 2025, with the retroactive rate adjustment in October 2025.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to:

- Including the full impact of the CY 2024 FFS rates in FY 2024-25,
- Implementation of the CY 2025 FFS rates and FFS retroactive adjustments for CY 2025 in FY 2025-26, and
- Including a partial year of the CY 2026 rate impact in FY 2025-26.

Methodology:

1. The fee-for-service (FFS) CY 2023 rates were implemented in November 2023. The retroactive correction for the period from January 2023 to October 2023 was implemented in January 2024.

2. Assume the CY 2024 FFS rates will be implemented in October2024. The retroactive correction for the period from January 2024 to September 2024 is expected to be implemented in January 2025.

3. Assume the CY 2025 FFS rates will be implemented in July 2025. The retroactive correction for the period from January 2024 to June 2024 is expected to be implemented in October 2025.

4. Assume the CY 2026 FFS rates will be implemented in January 2026.

5. Assume the managed care rate impacts are budgeted in the managed care base capitation rates.

6. Assume a 5% base rate increase for Labor costs and 1% base rate increase for non-Labor costs effective January 2024. Additionally, assume a workforce standards rate adjustment effective January 2024 assuming all facilities meet the specified workforce standards.

7. The cash basis FFS and managed care rate adjustment impact for FY 2024-25 and FY 2025-26 are estimated to be:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
FFS (Lagged)	$155,595	$73,752	$81,843
Managed Care (In MC Base)	$607,695	$288,047	$319,648
Total	**$763,290**	**$361,799**	**$401,491**

NURSING FACILITY RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 93

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
FFS (Lagged)	$193,867	$91,893	$101,974
Managed Care (In MC Base)	$589,549	$279,446	$310,103
Total	**$783,416**	**$371,339**	**$412,077**

Funding:
50% Title XIX / 50% GF (4260-101-0001/ 0890)
90% Title XIX / 10% GF (4260-101-0001/ 0890)

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 94
IMPLEMENTATION DATE: 8/2007
ANALYST: Ryan Woolsey
FISCAL REFERENCE NUMBER: 1046

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$207,853,000	$203,731,000
- STATE FUNDS	$99,686,200	$97,709,250
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	88.12 %	91.97 %
APPLIED TO BASE		
TOTAL FUNDS	$24,692,900	$16,359,600
STATE FUNDS	$11,842,720	$7,846,050
FEDERAL FUNDS	$12,850,220	$8,513,550

Purpose:
This policy change estimates the annual long-term care (LTC) rate adjustment for Nursing Facility-A (NF-A), Distinct Part (DP) Nursing Facility-B (DP/NF-B), Rural Swing Bed, DP Adult Subacute, DP Pediatric Subacute (DP/PSA), Freestanding Pediatric Subacute, Intermediate Care Facility – Developmentally Disabled (ICF/DD), Intermediate Care Facility – Habilitative (ICF/DD-H), and Intermediate Care Facility – Nursing (ICF/DD-N) facilities. Additionally, it estimates the rate increases due to the assessment of Quality Assurance (QA) fees for ICF/DDs. Finally, it 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)
AB 81 (Chapter 13, Statutes of 2020)
AB 133 (Chapter 143, Statutes of 2021)
SB 184 (Chapter 47, Statutes of 2022)
AB 118 (Chapter 42, Statutes of 2023)
SB 525 (Chapter 890, Statutes of 2023)
SB 159 (Chapter 40, Statutes of 2024)

Interdependent Policy Changes:
Not Applicable

Background:
Prior to rate year 2009-10, Medi-Cal rates for LTC facilities were adjusted after completion of an annual rate study for specified provider types. ABX4 5 froze rates for rate year 2009-10 and every year thereafter at the 2008-09 levels. On February 24, 2010, in the case of *CHA v. David Maxwell-Jolly*, the court enjoined the Department from continuing to implement the freeze in

LTC RATE ADJUSTMENT
REGULAR POLICY CHANGE NUMBER: 94

reimbursement at the 2008-09 rate levels for DP/NF-Bs, Rural Swing Beds, DP Adult Subacute, and DP/PSA.

Effective June 1, 2011, AB 97 required the Department to freeze rates and reduce payments by up to 10% for the facilities enjoined from the original rate freeze, which was required by ABX4 5. In addition, 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%.

Effective September 1, 2013, State Plan Amendment (SPA) 13-034 exempted Rural Swing Beds in DP/NF-B facilities located in designated rural and frontier areas from the AB 97 rate freeze and rate reduction. All other bed types in DP/NF-B facilities were exempted October 1, 2013.

The Department also received CMS approval to exempt DP Adult Subacute and DP/PSA from the rate freeze based on access and utilization analyses.

AB 119 extends the FS/PSA QA fee sunset from July 31, 2015 to July 31, 2020. Pursuant to AB 81, FS/PSA are exempt from the QA fee, effective August 1, 2020.

Effective August 1, 2016, ABX2 1 requires the Department to forgo the AB 97 retroactive recoupment for the rate reduction and rate freeze that would have been applied to the reimbursement for services provided by DP/NF-Bs between June 1, 2011 and September 30, 2013. ABX2 1 also required the Department to restore the AB 97 payment reduction and reimburse ICF/DD facilities at the 2008-09 levels, increased by 3.7%.

The reimbursement rates for DP Adult Subacute and DP Pediatric Subacute types are described in the State Plan and are currently not subject to any rate reductions.

AB 133 removes reductions or limitations for FS/PSA or ICF/DD rate setting effective August 1, 2021, including the rate freeze imposed by AB 97 and related legislation. Beginning with RY 2021-22, ICF/DD facilities shall receive an unfrozen reimbursement rate inclusive of any Proposition 56 supplemental payments. However, for RY 2021-22, the reimbursement rate may not be less than the rate authorized by the California Medicaid State Plan, plus any Proposition 56 supplemental payment, in effect for that facility on July 31, 2021.

For FS/PSAs, as defined in Section 51215.8 of Title 22 of the California Code of Regulations, reimbursement rates shall be determined without applying the rate freeze and limitations imposed by AB 97 and related legislation. Beginning with RY 2021-22, the unfrozen reimbursement rates for these facilities shall be inclusive of any Proposition 56 supplemental payments.

The Budget Act of 2022 transitioned Proposition 56 supplemental payments for ICF/DDs and FS-PSAs to ongoing rate increase funded from the General Fund. SPA 22-0061 will incorporate amounts equivalent to the former Proposition 56 supplemental payment amounts into the facility's base rates. For RY 2022-23, Proposition 56 supplemental payment amounts are included in the annual base rate build up.

SB 184 established a hold harmless provision for ICF/DDs for dates of service after the declared end of the federal COVID-19 public health emergency (PHE). The hold harmless provision provides that after the last day of the PHE, facilities will receive the greater of the

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unfrozen reimbursement or the total reimbursement rate in effect on the last day of the PHE, inclusive of a temporary rate increase that was provided during the PHE.

For all other LTC facilities the COVID-19 increased reimbursement ceased effective May 12, 2023, and reimbursement rates for room and board services reverted to the regular annual per diem rates.

In accordance with AB 118, pending federal approval and effective January 1, 2024, the Department will align rate years with the calendar year for the following facility types: NF-A, DP/NF-B, DP/PSA, FS/PSA, and ICF/DD, including ICF/DD-N and ICF/DD-H. The Department will calculate new rates for the August 1, 2023 to December 31, 2023 period (referred to hereafter as the “bridge period” and for the January 1, 2024 to December 31, 2024 period utilizing the same underlying cost reports and by adjusting the months of inflation applied in the rate study.

Additionally, pending federal approval, for dates of service July 1, 2023, through December 31, 2023, FS/PSA reimbursement rates will be set at the total per diem rate in effect on August 1, 2022, inclusive of an amount equivalent to the COVID-19 PHE rate increase then in effect. For dates of service on or after January 1, 2024, FS/PSA rates shall be the greater of: (1) the reimbursement rate established by the applicable State Plan reimbursement methodology or (2) the reimbursement rate in effect for the facility on December 31, 2023, inclusive of the amount equivalent to the COVID-19 PHE rate increase.

SB 525, as amended by SB 159, enacts a phased-in multi-tiered statewide minimum wage increase schedule for health care workers employed by covered healthcare facilities, including licensed skilled nursing facilities that are distinct parts of hospitals.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is an increase due to:

- Revised days assumptions that better reflect the shift of services, particularly ICF/DD, into managed care.
- Revised rate increase assumptions.
- Retroactive adjustments for the FY 2023-24 bridge period shifted from FY 2023-24 to FY 2024-25.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is a minor net decrease due to:

- The FY 2023-24 bridge period rate adjustment retroactive payments ending.
- Smaller projected rate increases in the calendar year (CY) 2025 period compared to the FY 2023-24 period.

Methodology:
1. Beginning in CY 2024, the effect date for rate adjustments is January 1st of each calendar year. The assumed implementation dates are as follows:

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Facility	CY 2024	CY 2025	CY 2026
DP/NF-B	4/19/2024	1/1/2025	1/1/2026
Rural Swing Beds (non-exempt)	4/19/2024	1/1/2025	1/1/2026
Rural Swing Beds (exempt)	4/19/2024	1/1/2025	1/1/2026
DP Adult Subacute	4/19/2024	1/1/2025	1/1/2026
NF-A	3/27/2024	1/1/2025	1/1/2026
ICF/DDs	4/15/2024	1/1/2025	1/1/2026
DP Pediatric Subacute	4/19/2024	1/1/2025	1/1/2026
FS Pediatric Subacute	4/19/2024	1/1/2025	1/1/2026

2. The costs below reflect the estimated impact, before accounting for payment lags, of incremental rate adjustments for each facility type in the FFS delivery system:

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Unlagged Fee-for-Service	FY 2024-25	FY 2025-26
Rate Adjustment (23-24, Bridge Period)		
DP/NF-B	$4,249,000	
Rural Swing Beds (non-exempt)	$0	
Rural Swing Beds (exempt)	$4,000	
DP Adult Subacute	$2,294,000	
NF-A	$1,000	
ICF/DDs	$24,089,000	
DP Pediatric Subacute	$132,000	
FS Pediatric Subacute	$697,000	
Rate Adjustment (CY 2024)		
DP/NF-B	$1,079,000	$1,079,000
Rural Swing Beds (non-exempt)	$0	$0
Rural Swing Beds (exempt)	$2,000	$2,000
DP Adult Subacute	$3,077,000	$3,077,000
NF-A	$1,000	$1,000
ICF/DDs	$1,680,000	$1,680,000
DP Pediatric Subacute	$393,000	$393,000
FS Pediatric Subacute	$0	$0
Rate Adjustment (CY 2025)		
DP/NF-B	$3,267,000	$6,534,000
Rural Swing Beds (non-exempt)	$0	$0
Rural Swing Beds (exempt)	$3,000	$6,000
DP Adult Subacute	$1,362,000	$2,723,000
NF-A	$1,000	$1,000
ICF/DDs	$485,000	$971,000
DP Pediatric Subacute	$197,000	$393,000
FS Pediatric Subacute	$0	$0
Rate Adjustment (CY 2026)		
DP/NF-B		$3,101,000
Rural Swing Beds (non-exempt)		$0
Rural Swing Beds (exempt)		$3,000
DP Adult Subacute		$1,039,000
NF-A		$0
ICF/DDs		$442,000
DP Pediatric Subacute		$139,000
FS Pediatric Subacute		$4,000
Retro FFS Rate Adjustments		
DP/NF-B	$2,130,000	$0
Rural Swing Beds (non-exempt)	$0	$0
Rural Swing Beds (exempt)	$2,000	$0
DP Adult Subacute	$1,982,000	$0
NF-A	$0	$0
ICF/DDs	$10,597,000	$0
DP Pediatric Subacute	$186,000	$0
FS Pediatric Subacute	$290,000	$0
Total FFS	**$58,200,000**	**$21,588,000**

LTC RATE ADJUSTMENT
REGULAR POLICY CHANGE NUMBER: 94

3. The costs below reflect the estimated impact, before accounting for payment lags, of incremental rate adjustments in the managed care delivery system. These impacts are fully reflected in managed care base policy changes.

Unlagged Managed Care	FY 2024-25	FY 2025-26
Rate Adjustment (23-24, Bridge Period)	$74,231,000	
Rate Adjustment (CY 2024)	$32,710,000	$32,710,000
Rate Adjustment (CY 2025)	$53,711,000	$107,421,000
Rate Adjustment (CY 2026)		$52,731,000
Total Managed Care	**$160,652,000**	**$192,862,000**

4. The estimated impact of SB 525 on LTC facility payments is roughly estimated to be $3.4 million total funds ($1.6 million General Fund) in FY 2024-25 and $8.5 million total funds ($4.1 million General Fund) in FY 2025-26. These amounts are included in the FFS and managed care totals shown above.

5. Payment lag factors of 0.9497 for FY 2024-25 and 0.9500 for FY 2025-26 are applied to the FFS and managed care costs to account for payment timing. Lagged amounts are displayed below.

Lagged Amounts	FY 2024-25	FY 2025-26
Fee-for-Service	$56,153,000	$19,657,000
Managed Care	$151,700,000	$184,074,000
Total Lagged Costs	**$207,853,000**	**$203,731,000**

Funding:

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	$192,621,000	$96,311,000	$96,310,000
90% Title XIX / 10% GF (4260-101-0001 / 0890)	$7,822,000	$782,000	$7,040,000
65% Title XXI / 35% GF (4260-101-0001 / 0890)	$7,410,000	$2,594,000	$4,816,000
Total	**$207,853,000**	**$99,687,000**	**$108,166,000**

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	$188,801,000	$94,401,000	$94,400,000
90% Title XIX / 10% GF (4260-101-0001 / 0890)	$7,667,000	$766,000	$6,901,000
65% Title XXI / 35% GF (4260-101-0001 / 0890)	$7,263,000	$2,542,000	$4,721,000
Total	**$203,731,000**	**$97,709,000**	**$106,022,000**

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 95
IMPLEMENTATION DATE: 10/2006
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 96

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$14,142,000	$16,934,000
- STATE FUNDS	$5,623,850	$6,734,100
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	8.03 %	8.18 %
APPLIED TO BASE		
TOTAL FUNDS	$13,006,400	$15,548,800
STATE FUNDS	$5,172,260	$6,183,250
FEDERAL FUNDS	$7,834,140	$9,365,550

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 – Centers for Medicare & Medicaid Services (CMS) Final Rule

Interdependent Policy Changes:
Not Applicable

Background:
1. **Hospice Services**
   Medi-Cal hospice service rates are established in accordance with Section 1902(a)(13), (42 USC 1396 a(a)(13)) of the federal Social Security Act. This act requires annual rate increases for hospice care services based on corresponding Medicare rates effective October 1st of each year.

   Effective January 1, 2016, the CMS final hospice rule changed the payment methodology for Routine Home Care (RHC) rates to implement two rates that will result in a higher base payment for the first 60 days of hospice care and a reduced payment rate for days thereafter. Additionally, the CMS final hospice rule established a Service Intensity Add-On (SIA) payment for services provided by a registered nurse or social worker during the last seven days of a member's life for a maximum of four hours a day.

HOSPICE RATE INCREASES
REGULAR POLICY CHANGE NUMBER: 95

2. **Hospice Room and Board**
   The Department reimburses each hospice facility's room and board rate at 95% of the individual facility's per diem rates for Nursing Facility – Level B (NF-B), which include Distinct Part (DP) or Freestanding; Nursing Facility – Level A (NF-A); Intermediate Care Facility – Developmentally Disabled (ICF/DD), Intermediate Care Facility for the Developmentally Disabled – Nursing (ICF/DD-N), and Intermediate Care Facility for the Developmentally Disabled – Habilitative (ICF/DD-H).

On March 4, 2020, Governor Newsom declared a state of emergency in response to the developing pandemic of COVID-19. A statewide stay at home order was introduced on March 19, 2020. The federal government declared a national public health emergency (PHE) on January 31, 2020, and a national emergency on March 13, 2020. The public health emergency for the COVID-19 outbreak expired on May 11, 2023.

The Department received federal approval for State Plan Amendment (SPA) 20-0024, which authorizes a temporary additional 10% reimbursement for eligible Long-Term Care (LTC) facilities during the PHE. For Freestanding Skilled Nursing facilities – Level B (FS/NF-B) and Freestanding Adult Subacute (FSSA), the 2022 Budget Act extended the PHE rate increase through December 31, 2023 and established a new Workforce Augmentation effective January 1, 2024 which is intended to succeed the PHE rate increase for these facilities. For Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), the 2022 Budget Act provided that after the last day of the PHE, rates would be held harmless at the rate in effect on the last day of the PHE until the unfrozen rate calculated pursuant to the State Plan exceeds the hold harmless rate. For all other LTC facilities the COVID-19 increased reimbursement ceased effective May 12, 2023, and reimbursement rates for room and board services reverted to the regular annual per diem rates.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to:
- Revised estimate of the RY 2023-24 and RY 2024-25 rate adjustments based on more recent data,
- Delayed implementation of the RY 2023-24 rates,
- Addition of Hospice Room & Board Calendar Year (CY) 2024 and 2025 impacts, and
- Including the retroactive rate adjustment for RY 2023-24 Hospice rates in September 2024.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to assuming a full year's impact for RY 2023-24 and RY 2024-25 rates and including RY 2025-26 impacts in FY 2025-26
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Methodology:
1. Hospice Services:
   a. The weighted increase for hospice service rates, excluding RHC and SIA, is estimated to be 2.82% for RY 2024-25 and 2.83% for RY 2025-26.

   b. The RY 2023-24 hospice rates, including RHC rates, implemented on June 24, 2024. The retroactive payment for the period from October 2023 through June 23, 2024 implemented in September 2024.

HOSPICE RATE INCREASES
REGULAR POLICY CHANGE NUMBER: 95

c. The RY 2024-25 hospice rates, including RHC rates, are expected to implement in December 2024. The retroactive payment for the period from October 2024 through November 2024 is expected to be implemented in March 2025.

d. The RY 2025-26 hospice rates, including RHC rates, are expected to implement in December 2025. The retroactive payment for the period from October 2025 through November 2025 is expected to be implemented in March 2026.

2. Hospice room and board rates will continue at 95% of the facility's rates, whether frozen or unfrozen. The weighted increase for hospice room and board rates is assumed to be 3.28% for RY 2024-25 and RY 2025-26.

3. Managed care costs for hospice rate adjustments are included in the base capitation rates, and currently budgeted in the following policy changes: County Organized Health Systems, Two Plan Model, Regional Model, and Geographic Managed Care.

4. The estimated Fee-for-Service (FFS) payments on a cash basis are:

Cash Basis - Lagged	**FY 2024-25**	**FY 2025-26**
Hospice Services (23-24)	$21,000	$21,000
RHC & SIA Payments (23-24)	$5,320,000	$5,330,000
Room & Board (CY 2024)	$1,119,000	$1,129,000
Hospice Services (23-24) Retro	$16,000	$0
RHC & SIA Payments (23-24) Retro	$3,990,000	$0
Hospice Services (24-25)	$10,000	$23,000
RHC & SIA Payments (24-25)	$2,533,000	$5,493,000
Room & Board (CY 2025)	$406,000	$1,155,000
Hospice Services (24-25) Retro	$3,000	$0
RHC & SIA Payments (24-25) Retro	$724,000	$0
Hospice Services (25-26)	$0	$11,000
RHC & SIA Payments (25-26)	$0	$2,616,000
Room & Board (CY 2026)	$0	$406,000
Hospice Services (25-26 Retro	$0	$3,000
RHC & SIA Payments (25-26) Retro	$0	$747,000
TOTAL	**$14,142,000**	**$16,934,000**

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 95

Funding:

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	$10,521,000	$5,260,000	$5,261,000
90% Title XIX / 10% GF (4260-101-0001 / 0890)	$3,616,000	$362,000	$3,254,000
65% Title XXI / 35% GF (4260-101-0001 / 0890)	$5,000	$2,000	$3,000
Total	**$14,142,000**	**$5,624,000**	**$8,518,000**

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	$12,598,000	$6,299,000	$6,299,000
90% Title XIX / 10% GF (4260-101-0001 / 0890)	$4,330,000	$433,000	$3,897,000
65% Title XXI / 35% GF (4260-101-0001 / 0890)	$6,000	$2,000	$4,000
Total	**$16,934,000**	**$6,734,000**	**$10,200,000**

MEDI-CAL PROVIDER PAYMENT INCREASE

REGULAR POLICY CHANGE NUMBER: 96
IMPLEMENTATION DATE: 1/2024
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2417

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$727,000,000	$727,000,000
- STATE FUNDS	$291,000,000	$291,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	98.35 %	98.35 %
APPLIED TO BASE		
TOTAL FUNDS	$11,995,500	$11,995,500
STATE FUNDS	$4,801,500	$4,801,500
FEDERAL FUNDS	$7,194,000	$7,194,000

Purpose:
This policy change estimates the costs associated with increasing provider rates for Primary Care, non-specialty mental health services, and Obstetric Care (including doulas) services to at least 87.5% of Medicare rates, pursuant to AB 118 (Chapter 42, Statutes of 2023).

This policy change was previously titled “Medi-Cal Provider Rate Increase”.

Authority:
California Advancing and Innovating Medi-Cal (CalAIM) Section 1115(a) Medicaid Demonstration
Title 42, Code of Federal Regulations (CFR), 438.6(c)
Budget Act of 2023 [AB 118 (Chapter 42, Statutes of 2023)]
State Plan Amendment 23-0035

Interdependent Policy Changes:
Not Applicable

Background:
Provider rate increases to 87.5% of Medicare
Provider rates for Primary Care, non-specialty mental health services, and Obstetric Care services, including mid-level practitioners and doula services, will be increased to at least 87.5% of Medicare rates effective for dates of service beginning January 1, 2024. In the Fee-for-Service (FFS) delivery system, the rate increases will be implemented as increases to the applicable FFS base rates for eligible providers. In the Managed Care delivery system, the rate increases will be implemented via a directed payment arrangement requiring Medi-Cal managed care plans (MCPs) to pay eligible providers at no less than the increased FFS base rates for qualifying services.

Services identified as Primary/General Care are reimbursed at the increased rate if the service is billed and provided by the following eligible provider types:

- Physicians
- Physician Assistants

MEDI-CAL PROVIDER PAYMENT INCREASE
REGULAR POLICY CHANGE NUMBER: 96

- Nurse Practitioners
- Podiatrists
- Certified Nurse Midwives
- Licensed Midwives
- Doula Providers
- Psychologists
- Licensed Professional Clinical Counselor
- Licensed Clinical Social Workers
- Marriage and Family Therapists

Other providers will continue to be reimbursed at the existing Medi-Cal rate for services identified as Primary/General Care.

Services identified as Obstetric and Non-Specialty Mental Health Services are reimbursed at the increased rate for all eligible providers.

On December 19, 2023, the Centers for Medicare & Medicaid Services (CMS) approved State Plan Amendment 23-0035 authorizing the Department to provide targeted rate increases for primary/general care, obstetric and doula, and non-specialty mental health services effective January 1, 2024.

The non-federal share of these provider rate increases will be borne by the Medi-Cal Provider Payment Reserve Fund, item 4260-101-3431, for services through December 31, 2024. This policy change identifies the use of General Fund (GF) for the rate increases. See the Medi-Cal Provider Payment Reserve Fund policy change for the shift from the GF to item 4260-101-3431.

Proposition 35
In November 2024, voters approved the Protect Access to Health Care Act of 2024 (Proposition 35), which makes the MCO tax permanent, subject to continued federal approval for future tax periods, and specifies how revenues from the current period tax, as it existed on July 1, 2023, are to be allocated, beginning with taxes collected in calendar year 2025. Proposition 35 allocates revenues to cover the non-federal share of costs for increased capitation costs to MCPs that pay the tax, increases payments to Medi-Cal providers, and supports existing Medi-Cal costs. Proposition 35 creates additional funds into which MCO tax revenues are deposited, appropriated, and spent.

The non-federal share of these provider rate increases will be borne by the Health Care Oversight & Accountability Subfund, created by Proposition 35, for services beginning January 1, 2025. See the Prop 35 – Provider Payment Increase Funding policy change for the shift from GF to item 4260-601-3443.

Reason for Change:
There is no change from the prior estimate for FY 2024-25.

There is no change from FY 2024-25 to FY 2025-26 in the current estimate.

Methodology:
1. The effective date for the rate increases in both the Fee-for-Service and Managed Care delivery systems is January 1, 2024.

MEDI-CAL PROVIDER PAYMENT INCREASE
REGULAR POLICY CHANGE NUMBER: 96

2. Assume the annual impact is $727,000,000 TF ($291,000,000 GF).

3. On a cash basis, the estimated costs are:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
Primary Care, OB, MH	$602,000	$241,000	$361,000
Specialty Care	$125,000	$50,000	$75,000
Total	**$727,000**	**$291,000**	**$436,000**

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
Primary Care, OB, MH	$602,000	$241,000	$361,000
Specialty Care	$125,000	$50,000	$75,000
Total	**$727,000**	**$291,000**	**$436,000**

Funding:
100% GF (4260-101-0001)
100% Title XIX FFP (4260-101-0890)

GDSP NBS & PNS FEE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 97
IMPLEMENTATION DATE: 1/2023
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2184

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$5,543,000	$6,747,000
- STATE FUNDS	$2,178,900	$2,652,050
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$5,543,000	$6,747,000
STATE FUNDS	$2,178,900	$2,652,050
FEDERAL FUNDS	$3,364,100	$4,094,950

Purpose:
This policy change estimates the costs associated with a fee increase for newborn screening (NBS) and prenatal screening (PNS) provided to Medi-Cal members under the California Department of Public Health (CDPH) Genetic Disease Screening Program (GDSP).

Authority:
Health & Safety Code, Division 106, Part 5, Chapter 1, Article 1, Section 124977
SB 1095 (Chapter 393, Statutes of 2016)
State Plan Amendment (SPA) 22-0021
SPA 22-0054
SPA 22-0063
SPA 22-0064

Interdependent Policy Changes:
Not Applicable

Background:
Pursuant to Health & Safety Code, Division 106, Part 5, Chapter 1, Article 1, Section 124977, the Newborn Screening (NBS) Program fee shall be periodically adjusted to fully support GDSP. Section 124977(d)(1) outlines the GDSP's ability to adopt emergency regulations surrounding newborn and prenatal screening.

CDPH administers California's GDSP, which includes the 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.

GDSP NBS & PNS FEE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 97

Newborn Screening Program

SB 1095 requires GDSP to expand statewide newborn screening to include any disease that is detectable in blood samples as soon as practicable, but no later than two years after the disease is adopted by the federal Recommended Uniform Screening Panel (RUSP).

The Department plans to submit SPA 24-0034 in September 2024, to obtain federal approval to update the NBS rates to $226 to align with CDPH participation fees effective July 1, 2024.

On August 2, 2022, newborn screening for mucopolysaccharidosis type II (MPS II) was added to the federal RUSP. On January 4, 2023, guanidinoacetate methyltransferase (GAMT) deficiency was added to the federal RUSP. By August 2024, CDPH will incorporate screening for MPS II and GAMT deficiency into the Newborn Screening panel. A fee increase of $15 will be proposed for the NBS program starting July 1, 2024 to cover the costs of the adding the two conditions.

Prenatal Screening Program

CDPH replaced GDSP's conventional biochemical screening for chromosome abnormalities with a Cell-free DNA (cfDNA) screening that screen for chromosomal abnormalities. GDSP's screening for Maternal Serum Alpha-Fetoprotein (MSAFP) screening remains as part of the overall screening process. A total fee increase of $95.40 was proposed beginning September 2022 and the components are as follows:

1. CDPH charges a fee increase of $10.40 ($221.60 to $232.00) for the GDSP PNS cfDNA test, with Current Procedural Terminology (CPT) code 81420 and Proprietary Laboratory Analyses (PLA) Code 0327U.
2. Additionally, the MSAFP screening test in the second trimester, which is currently included in the GDSP PNS biochemical screening fees, requires a new separate fee of $85.00, with CPT code 82105.
3. These fee structure changes will generate sufficient ongoing revenue to offset CDPH's additional laboratory screening costs.

Additionally, the Department plans to submit SPA 24-0034, which proposes to increase rate reimbursement from $232 to $344 for codes 0327U and 81420 effective July 1, 2024.

Medi-Cal have published on April 2023 on their website the New Billable Codes for CDPH Genetic Disease Screening Program and Presumptive Eligibility for Pregnant Women (PE4PW).

Effective retroactively for dates of service on or after September 19, 2022, the following CPT® codes are billable under the CDPH GDSP:

Code	Description	Rates
0327U	Fetal aneuploidy (trisomy 13, 18, and 21), DNA sequence analysis of selected regions using maternal plasma, algorithm reported as a risk score for each trisomy, includes sex reporting, if performed	$232
81420	Fetal chromosomal aneuploidy (e.g., trisomy 21, monosomy X) genomic sequence analysis panel, circulating cell-free fetal DNA in maternal blood, must include analysis of chromosomes 13, 18, and 21	$232
82105	Alpha-fetoprotein (AFP); serum	$85

GDSP NBS & PNS FEE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 97

Effective July 1, 2024, CDPH proposes to implement fee increases totaling $112 for:

- A $38 fee increase due to updates to the caseload methodology, and
- A $74 fee increase for the addition of prenatal screenings for Sex Chromosome Aneuploidies (SCAs).

Reason for Change:

The change in FY 2024-25, from the prior estimate, is due to:

- This policy change only included the GDSP NBS rate changes in the prior estimate. For the current estimate, the rate changes for the GDSP Prenatal Screening Program are now included with the GDSP NBS Program fee changes in this policy change.
- Rate changes prior to July 1, 2024 are now fully captured in the fee-for-service base estimates and no longer estimated in this policy change,
- NBS and PNS estimates were updated based on the updated GDSP caseload projections,
- Implementation of the July 1, 2024 NBS and July 1, 2024 PNS rate changes were delayed to February 2025, and
- The retroactive rate adjustments for the October 1, 2022 PNS rates, the July 1, 2024 NBS rates, and July 1, 2024 PNS rates are included in FY 2024-25.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to:

- A full year's impact of the July 1, 2024 NBS and July 1, 2024 PNS rate changes are included in FY 2025-26, and
- No retroactive rate adjustments are expected in FY 2025-26.

Methodology:

Newborn Screening Program

1. The CDPH implemented a $15.00 fee increase for the GDSP NBS program to add MPS II and GAMT to the NBS program, effective July 1, 2024. The Department will implement corresponding Medi-Cal FFS GDSP NBS rate increases based on the CDPH fee increases.

2. The Department will implement the $15 fee increase in February 2025. The Erroneous Payment Correction (EPC) for the July 1, 2024 through January 31, 2025 period is expected to implement February 2025.

3. Assume approximately 60% of newborns screened are from the Medi-Cal population. Of the percentage Medi-Cal newborn population, assume approximately 36.4% are in Medi-Cal FFS.

4. Assume approximately 99% of newborns will be screened by the NBS program each year.

5. The Medi-Cal managed care impact is assumed in the managed care base capitation rates; therefore, there are no managed care costs included in this policy change.

6. Assume 99% of Medi-Cal FFS claims submitted are paid.

GDSP NBS & PNS FEE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 97

Prenatal Screening Program

7. The Department implemented a $375.24 fee adjustment for CPT 81420, reducing the current FFS rate from $607.24 to $232.00 to reflect CDPH's new participation fee of $232.00 for the cfDNA screening, effective October 1, 2022. This adjustment was implemented on May 22, 2023 and the Erroneous Payment Correction (EPC) for the October 1, 2022 through May 21, 2023 period was implemented on August 2, 2023, occurring over 12 months.

8. CDPH has proposed a fee increase for CPT codes 81420 and 0327U, increasing the rate by $112 from $232.00 to $344.00, effective July 1, 2024. The Department will implement a corresponding Medi-Cal Fee-for-Service (FFS) GDSP PNS rate adjustment based on the CDPH fee increase and new fee structure. This adjustment is expected to be implemented in February 2025. The EPC for the July 1, 2024 through January 31, 2025 period is expected to implement February 2025.

9. The estimated Medi-Cal FFS costs for the NBS and PNS rate changes in FY 2024-25 and FY 2025-26 are:

FY 2024-25	TF	GF	FF
NBS FFS Prospective Rate Change	$452,000	$178,000	$274,000
PNS FFS Prospective Rate Change	$1,910,000	$750,000	$1,160,000
NBS FFS Retroactive Rate Change	$633,000	$249,000	$384,000
PNS FFS Retroactive Rate Change	$2,548,000	$1,002,000	$1,546,000
Total	**$5,543,000**	**$2,179,000**	**$3,364,000**

FY 2025-26	TF	GF	FF
NBS FFS Prospective Rate Change	$1,292,000	$508,000	$784,000
PNS FFS Prospective Rate Change	$5,455,000	$2,144,000	$3,311,000
Total	**$6,747,000**	**$2,652,000**	**$4,095,000**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX / 10% GF (4260-101-0001/0890)
65% Title XXI / 35% GF (4260-101-0001/0890)

SKILLED NURSING FACILITY (SNF) BACK-UP POWER

REGULAR POLICY CHANGE NUMBER: 98
IMPLEMENTATION DATE: 1/2026
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2446

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$0	$249,603,000
- STATE FUNDS	$0	$98,231,400
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$249,603,000
STATE FUNDS	$0	$98,231,400
FEDERAL FUNDS	$0	$151,371,600

Purpose:
This policy change estimates the costs to reimburse long-term care (LTC) facilities for the costs of securing an alternative source of power for no fewer than 96 hours during any type of power outage by January 1, 2026.

Authority:
SB 1511 (Chapter 492, Statutes of 2024)
Health & Safety Code (HSC) section 1418.22
Welfare and Institutions Code (WIC) sections 14105.194, 14169.81, 14126.023, and 14126.033

Interdependent Policy Changes:
Not Applicable

Background:
SB 1511 (Chapter 492, Statutes of 2024) requires Skilled Nursing Facilities (SNFs) to have an alternative source of power for no fewer than 96 hours during any type of power outage by January 1, 2026, and these requirements are assumed to increase costs incurred by SNFs. The Medi-Cal Long-Term Care facility rate setting methodologies require Medi-Cal Fee-for-Service (FFS) rates to reimburse LTC facilities for the Medi-Cal share of projected costs of complying with new state or federal mandates by providing a rate add-on to per diem rates of facilities. The Department will calculate a facility-specific one-time rate add-on to reimburse facilities for the cost of complying with SB 1511, based on each facility's reasonable projected contracting costs reported to the Department of Health Care Access & Information. Medi-Cal managed care plans are required to pay SNF FFS rates, including add-ons, to network providers.

Reason for Change:
This is a new policy change.

SKILLED NURSING FACILITY (SNF) BACK-UP POWER

REGULAR POLICY CHANGE NUMBER: 98

Methodology:

1. The Department estimates a one-time fiscal impact to Medi-Cal of approximately $600 million Total Fund (TF), assuming approximately 1,000 facilities will require a $1 million upgrade and Medi-Cal's proportional share will be 66% of days. The Medi-Cal impacts will include both FFS and managed care costs. Facilities will be reimbursed through a one-time rate add-on.

2. Payments are assumed to begin January 2026 for FFS and February 2026 for managed care.

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
FFS	$2,103	$997	$1,106
Managed Care	$247,500	$97,234	$150,266
Total	**$249,603**	**$98,231**	**$151,372**

Funding:

50% Title XIX / 50% GF (4260-101-0001 / 0890)
90% Title XIX / 10% GF (4260-101-0001 / 0890)
Title XXI 65% / 35% GF (4260-101-0001 / 0890)
100% GF (4260-101-0001)
100% Title XIX (4260-101-0890)

DPH INTERIM RATE GROWTH

REGULAR POLICY CHANGE NUMBER: 99
IMPLEMENTATION DATE: 7/2025
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1162

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$0	$39,818,000
- STATE FUNDS	$0	$13,055,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$39,818,000
STATE FUNDS	$0	$13,055,800
FEDERAL FUNDS	$0	$26,762,200

Purpose:
This policy change estimates the cost of increases in payments to Designated Public Hospitals (DPHs) due to interim rate growth.

Authority:
SPA 05-21

Interdependent Policy Changes:
DPH Interim Rate

Background:
As approved on April 25, 2006 through SPA 05-21, effective July 1, 2005, DPHs receive interim per diem rates based on estimated costs using the hospitals' prior Medi-Cal costs trended forward. The DPHs' interim rate receives a growth percent increase to reflect an increase in the hospitals' costs. The interim per diem rate consists of 100% federal funding.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to DPH county and DPH community growth rates for FY 2024-25 are included in the Fee-for-Service (FFS) base and no longer reflected in the policy change.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to including the estimated DPH county and DPH community growth rates for FY 2025-26.

Methodology:
1. The FY 2024-25 interim rates were implemented July 2024.

2. For FY 2024-25:
   - The county-based and community-based DPH interim rate growths are considered in the FFS base and are not included in this policy change

DPH INTERIM RATE GROWTH
REGULAR POLICY CHANGE NUMBER: 99

3. For FY 2025-26:
   - Assume a 5.6% interim rate increase for county-based DPHs and 4.35% for community-based DPHs.
   - An additional cost of $39,818,000 TF is estimated for the FY 2025-26 interim rates.

4. The interim payments are 100% federal funds, after the Department's adjustment. The rate growth policy change estimates the increased DPH payments at 50% FFP/ 50% GF and 90% FFP/ 10% GF newly funding. The full adjustment to 100% FFP is shown in the DPH Interim Rate policy change.

Funding:
50% Title XIX / 50% GF (4260-101-0890/0001)
90% Title XIX ACA / 10% GF (4260-101-0890/0001)

DPH INTERIM RATE

REGULAR POLICY CHANGE NUMBER: 100
IMPLEMENTATION DATE: 7/2005
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1161

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$347,999,700	-$363,298,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$347,999,700	-$363,298,300
FEDERAL FUNDS	$347,999,700	$363,298,300

Purpose:
This policy change estimates the technical adjustment in funding to reimburse Designated Public Hospitals (DPHs) at 100% federal financial participation (FFP).

Authority:
SPA 05-21

Interdependent Policy Changes:
DPH Interim Rate Growth

Background:
As approved on April 25, 2006 through SPA 05-21, effective July 1, 2005, DPHs receive interim per diem rates based on estimated costs using the hospitals' two years prior Medi-Cal costs trended forward. These interim payments are 100% federal funds based on the hospitals' certified public expenditures (CPEs), resulting in 50% FFP and 50% CPE.

The Medi-Cal Estimate FFS base expenditures are calculated at 50% FFP and 50% GF. Since the DPH interim rate receives a 100% FFP, an adjustment to shift from 50% GF to 100% FFP is made.

In addition, the Medi-Cal Estimate makes funding adjustments to inpatient services for the applicable Federal Medical Assistance Percentage (FMAP) for the Affordable Care Act (ACA) optional population. As a result, this policy change will also make adjustments for the ACA optional population to shift from 5% GF / 95% FFP to 100% FFP beginning January 2017 through December 2017, 6% GF / 94% FFP to 100% FFP beginning January 2018 through December 2018, 7% GF / 93% FFP to 100% FFP beginning January 2019, and 10% GF / 90% FFP to 100% FFP beginning January 2020.

DPH INTERIM RATE
REGULAR POLICY CHANGE NUMBER: 100

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to:
- Updated DPH actual data through July 2024, and
- Lower projected expenditures in FY 2024-25.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to higher projected expenditures in FY 2025-26.

Methodology:
1. The funding adjustment is estimated at:

(Dollars in Thousands)

	Expenditures	GF to FF Shift
FY 2024-25	**$1,050,941**	**$348,000**
FY 2025-26	**$1,099,771**	**$363,298**

Funding:
(Dollars in Thousands)

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890 / 0001)	($607,264)	($303,632)	($303,632)
100% Title XIX FF (4260-101-0890)	$1,050,941	$0	$1,050,941
90% Title XIX ACA / 10% GF (4260-101-0890 / 0001)	($443,677)	($44,368)	($399,309)
Total Funds	**$0**	**($348,000)**	**$348,000**

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890 / 0001)	($633,303)	($316,651)	($316,652)
100% Title XIX FF (4260-101-0890)	$1,099,771	$0	$1,099,771
90% Title XIX ACA / 10% GF (4260-101-0890 / 0001)	($466,468)	($46,647)	($419,821)
Total Funds	**$0**	**($363,298)**	**$363,298**

*Totals may differ due to rounding.

LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES

REGULAR POLICY CHANGE NUMBER: 101
IMPLEMENTATION DATE: 8/2013
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1784

	FY 2024-25	FY 2025-26
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

Purpose:
This policy change budgets the funding adjustment from the Long Term Care Quality Assurance Fund (LTCQAF) to the state General Fund (GF) to partially offset GF costs associated with providing Long Term Care (LTC) Services.

Authority:
AB 1762 (Chapter 230, Statutes of 2003)
AB 1629 (Chapter 875, Statutes of 2004)
ABX1 19 (Chapter 4, Statutes of 2011)
AB 1467 (Chapter 23, Statutes of 2012)
AB 119 (Chapter 17, Statutes of 2015)
SB 833 (Chapter 30, Statutes of 2016)
AB 81 (Chapter 13, Statutes of 2020)
AB 186 (Chapter 46, Statutes of 2022)

Interdependent Policy Changes:
Not Applicable

Background:
AB 1762 (Chapter 230, Statutes of 2003) imposed a Quality Assurance (QA) fee for certain LTC provider types. AB 1629 (Chapter 875, Statutes of 2004) and ABX1 19 (Chapter 4, Statutes of 2011) imposed a QA fee, in conjunction with a facility specific reimbursement program, for additional LTC providers. The revenue generated from the fee is used to draw down a federal match to partially offset LTC rate reimbursement. The following LTC providers are subject to a QA fee:

- Freestanding Nursing Facilities Level-B (FS/NF-Bs)
- Freestanding Subacute Nursing Facilities level-B (FSSA/NF-Bs)
- Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs)

LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES

REGULAR POLICY CHANGE NUMBER: 101

AB 1467 established the LTCQAF. Effective August 1, 2013, the QA fees collected by LTC and ICF-DD facilities are deposited into the fund, rather than the state GF, which are used for LTC provider reimbursement rate expenditures.

AB 119 extended the AB 1629 facility-specific rate methodology, QAF, and Quality and Accountability Supplemental Payments (QASP) Program through July 31, 2020.
SB 833 established a continuous appropriation for the LTCQAF to allow moneys from the fund to be appropriated without further legislative action.

A withhold process was developed to collect past due AB 1629 QAF assessed on specified Skilled Nursing Facilities. The withheld portion is transferred to the LTCQAF, and subsequently to the GF. The withheld QAF payments are budgeted in the QAF Withhold Transfer policy change.

AB 81 (Chapter 13, Statutes of 2020) extends the QAF and AB 1629 methodology through December 31, 2022, and exempts Freestanding Pediatric Subacute Care Facilities (FS-PSAs) from the QAF, effective August 1, 2020.

AB 186 (Chapter 46, Statutes of 2022) extends the QAF and AB1629 methodology through December 31, 2026.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is a net increase in GF transfers due to:

- Delayed FY 2023-24 transfers will now occur in FY 2024-25,
- Higher actual QAF collections through June 2024,
- Higher monthly projections for QAF collections in FY 2024-25,
- Fewer collection months estimated to be transferred in FY 2024-25 than previously estimated, and
- Lower actual FY 2023-24 withhold amount to be transferred in FY 2024-25.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is an estimated decrease in GF transfers, due to:

- Actual collections estimated to be transferred in FY 2024-25 were higher than projected monthly transfers in FY 2025-26, and
- Lower estimated QAF withhold transfers in FY 2025-26.

Methodology:

1. Based on collections data through June 2024 and transfer data through July 2024; assume $604.9 million will be transferred to the GF in FY 2024-25 and $577.4 million in FY 2025-26.

2. The estimated withhold transfers for the AB 1629 QAF and QAF assessed on ICF-DDs expected to occur are $35.48 million in FY 2024-25 and $18.97 million in FY 2025-26.

LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES
REGULAR POLICY CHANGE NUMBER: 101

3. The estimated fund adjustment from the LTCQAF to the GF is:

(Dollars in Thousands)

FY 2024-25	TF	GF	LTCQAF
FY 2023-24	$0	($196,982)	$196,982
FY 2024-25	$0	($372,443)	$372,443
Subtotal	$0	($569,425)	$569,425
Withhold Transfers	$0	($35,475)	$35,475
Total	**$0**	**($604,900)**	**$604,900**

(Dollars in Thousands)

FY 2025-26	TF	GF	LTCQAF
FY 2024-25	$0	($186,221)	$186,221
FY 2025-26	$0	($372,443)	$372,443
Subtotal	$0	($558,664)	$558,664
Withhold Transfers	$0	($18,973)	$18,973
Total	**$0**	**($577,637)**	**$577,637**

Funding:
Long Term Care Quality Assurance Fund (4260-601-3213)
100% GF (4260-101-0001)

MEDI-CAL PROVIDER PAYMENT RESERVE FUND

REGULAR POLICY CHANGE NUMBER: 102
IMPLEMENTATION DATE: 7/2024
ANALYST: Erik Stacey
FISCAL REFERENCE NUMBER: 2421

	FY 2024-25	FY 2025-26
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

Purpose:
This policy change estimates funding to be spent from the Medi-Cal Provider Payment Reserve Fund (Fund 3431).

Authority:
Welfare & Institutions (W&I) Code Section 14105.200
W&I Code Section 14199.82
Budget Act of 2024

Interdependent Policy Changes:
Medi-Cal Provider Payment Increase

Background:
The Medi-Cal Provider Payment Reserve Fund receives revenues from the Managed Care Enrollment Fund (Fund 3428) to be used to support various provider payments and other investments, subject to appropriation by the Legislature.

In November 2024, voters approved the Protect Access to Health Care Act of 2024 (Proposition 35), which makes the managed care organization (MCO) tax permanent, subject to continued federal approval for future tax periods, and specifies how revenues from the current period tax as it existed on July, 1, 2023, are to be allocated, beginning with taxes collected in calendar year 2025. Proposition 35 allocates revenues to cover the non-federal share of costs for increased capitation costs to Medi-Cal managed care plans that pay the tax, increases payments to Medi-Cal providers, and supports existing Medi-Cal costs. Proposition 35 creates additional funds into which MCO tax revenues are deposited, appropriated, and spent.

Beginning January 1, 2025, the Medi-Cal Provider Payment Reserve Fund will not be used to support provider payment increases and other investments.

MEDI-CAL PROVIDER PAYMENT RESERVE FUND
REGULAR POLICY CHANGE NUMBER: 102

Starting on January 1, 2025, the Health Care Accountability & Oversight Subfund will support the non-federal share of increasing provider rates for Primary Care, non-specialty mental health services, and Obstetric Care services, including mid-level practitioners and doula services, to at least 87.5% of Medicare rates effective for dates of service beginning on January 1, 2024. Pursuant to Chapter 40, Statutes of 2024 (SB 159), additional rate increases in various specified domains with effective dates of January 1, 2025, and January 1, 2026, that were included in the 2024 Budget Act MCO Tax package are inoperative due to the passage of Proposition 35.

Reason for Change:
The change for FY 2024-25, from the prior estimate, is to reduce estimated spending from the fund to only cover costs for increases through December 31, 2024.

The change from FY 2024-24 to FY 2025-26, in the current estimate, is due to no further expenditures from the fund.

Methodology:

1. The Medi-Cal Provider Payment Reserve Fund is supporting the non-federal share of increasing provider rates for Primary Care, non-specialty mental health services, and Obstetric Care services, including mid-level practitioners and doula services, to at least 87.5% of Medicare rates effective for dates of services beginning January 1, 2024. These costs are budgeted in the Medi-Cal Provider Payment Increase policy change using General Fund as the non-federal share. This policy change replaces General Fund spending on these rate increases with spending from the Medi-Cal Provider Payment Reserve Fund for services through December 31, 2024.

2. Allocations from the Medi-Cal Provider Payment Reserve Fund in FY 2024-25 are summarized below:

(Dollars in Thousands)

FY 2024-25	TF	GF	SF
Medi-Cal Provider Payment Increase	$0	-$166,449	$166,449
Total	**$0**	**-$166,449**	**$166,449**

Funding:
Medi-Cal Provider Payment Reserve Fund (4260-101-3431)
100% General Fund (4260-101-0001)

REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER: 103
IMPLEMENTATION DATE: 8/2015
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1505

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	-$1,678,000	-$16,004,000
- STATE FUNDS	-$739,900	-$6,731,700
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,678,000	-$16,004,000
STATE FUNDS	-$739,900	-$6,731,700
FEDERAL FUNDS	-$938,100	-$9,272,300

Purpose:
This policy change estimates savings resulting from adjustments made to certain radiology reimbursement rates.

Authority:
SB 853 (Chapter 717, Statutes of 2010)
State Plan Amendment (SPA) 22-0006

Interdependent Policy Changes:
Not Applicable

Background:
SB 853 mandates that Medi-Cal rates for radiology services not exceed 80% of Medicare rates for dates of service on or after October 1, 2010. In light of the AB 97 (Chapter 3, Statutes of 2011) 10% payment reduction, and that a lengthy retroactive recoupment would likely create access to care issues for radiology services, the effective date for retroactive savings shifted from October 1, 2010 to October 1, 2012.

The Centers for Medicare and Medicaid Services (CMS) requires SPA approval for all rate reductions. SPA 22-0006 was approved on April 29, 2022 for rate adjustments effective January 1, 2022, and the Department submitted SPA 23-0004 on March 20, 2023 to adjust rates effective January 1, 2023.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to:

- Delayed implementation of the January 2023 rate adjustments from July 2024 to April 2025.
- Updated estimate of the January 2024 rate adjustments and delayed implementation from July 2024 to April 2025.
- Including the estimated January 2025 rate adjustments to be implemented April 2025.
- Retroactive recoupments for the January 2023 and January 2024 rate adjustments have been delayed from October 2024 to start in July 2025.

REDUCTION TO RADIOLOGY RATES
REGULAR POLICY CHANGE NUMBER: 103

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to:
- Including a full year impact of the January 2023, January 2024, and January 2025 rate adjustments in FY 2025-26.
- Including the estimated January 2026 rate adjustments to be implemented April 2026.
- Including the retroactive recoupments for the January 2023, January 2024, and January 2025 rate adjustments starting in July 2025.

Methodology:
1. The Medi-Cal rate reductions will apply to radiology services reimbursement rates exceeding 80% of Medicare rates.

2. Any managed care impact would be captured through the current rate setting process and included in the applicable base policy changes in future years.

3. The annual FFS savings for the rate adjustments effective January 1, 2023 is expected to be $1,612,000 TF. These adjustments are expected to be implemented in April 2025.

   The total recoupment of retroactive savings from January 1, 2023 through March 31, 2025 is expected to be implemented July 1, 2015, with recoupments occurring over 12 months.

4. The annual FFS savings for the rate adjustments effective January 1, 2024 is expected to be $3,004,000 TF. These adjustments are expected to be implemented in April 2025.

   The total recoupment of retroactive savings from January 1, 2024 through March 31, 2024 is expected to be implemented July 1, 2025, with recoupments occurring over 12 months.

5. The annual FFS savings for the rate adjustments effective January 1, 2025 is expected to be $3,004,000 TF. These adjustments are expected to be implemented in April 2025.

   The total recoupment of retroactive savings from January 1, 2025 through March 31, 2025 is expected to be implemented July 1, 2025, with recoupments occurring over 12 months.

6. The annual FFS savings for the rate adjustments effective January 1, 2026 is expected to be $3,004,000 TF. These adjustments are expected to be implemented in April 2026.

   The total recoupment of retroactive savings from January 1, 2026 through March 31, 2026 is expected to be implemented July 1, 2026, with recoupments occurring over 12 months.

7. The estimated savings for the reduction to radiology reimbursement rates are:

FY 2024-25	TF	GF	TITLE XIX FF	TITLE XXI FF	ACA FF
Prospective Savings	($1,678,000)	($740,000)	($627,000)	($183,000)	($128,000)
Total	**($1,678,000)**	**($740,000)**	**($627,000)**	**($183,000)**	**($128,000)**

REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER: 103

FY 2025-26	TF	GF	TITLE XIX FF	TITLE XXI FF	ACA FF
Prospective Savings	($8,124,000)	($3,476,000)	($3,036,000)	($609,000)	($1,003,000)
Recoupment of Retro Savings	($7,880,000)	($3,256,000)	($2,945,000)	($292,000)	($1,387,000)
Total	**($16,004,000)**	**($6,732,000)**	**($5,981,000)**	**($901,000)**	**($2,390,000)**

Funding:
50% Title XIX FF / 50% GF (4260-101-0001/0890)
65% Title XXI FF / 35% GF (4260-101-0001/0890)
90% Title XIX FF / 10% GF (4260-101-0001/0890)

LABORATORY RATE METHODOLOGY CHANGE

REGULAR POLICY CHANGE NUMBER: 104
IMPLEMENTATION DATE: 2/2016
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1703

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	-$14,148,000	-$10,345,000
- STATE FUNDS	-$6,001,300	-$4,388,100
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	34.72 %	60.46 %
APPLIED TO BASE		
TOTAL FUNDS	-$9,235,800	-$4,090,400
STATE FUNDS	-$3,917,650	-$1,735,060
FEDERAL FUNDS	-$5,318,170	-$2,355,360

Purpose:
This policy change estimates savings and loss of savings from adjustments made to certain clinical laboratories or laboratory services rates.

Authority:
AB 1467 (Chapter 23, Statutes of 2012)
AB 1494 (Chapter 28, Statutes of 2012)
AB 1124 (Chapter 8, Statutes of 2014)
AB 659 (Chapter 346, Statutes of 2017)
AB 133 (Chapter 143, Statutes of 2021)
Welfare and Institutions (W&I) Code 14105.22
State Plan Amendment (SPA) 15-015
SPA 21-0052
SPA 22-0053
SPA 23-0019

Interdependent Policy Changes:
Not Applicable

Background:
AB 1494 required the Department to develop a new rate methodology for clinical laboratories or laboratory services, as part of the overall reimbursement methodology. In addition to 10% payment reductions pursuant to AB 97 (Chapter 3, Statutes of 2011), AB 1494 allowed for payments to be reduced by 10% for clinical laboratories or laboratory services for dates of service on and after July 1, 2012, through June 30, 2015. The Family Planning, Access, Care, and Treatment Program (FPACT) and outpatient hospital services were exempt from the 10% provider payment reductions per AB 1494.

Effective July 1, 2015, the new reimbursement methodology is applicable to certain clinical laboratory or laboratory service codes, which may include FPACT and outpatient hospital services. AB 659 changed the frequency of data collection and rate development from once a year to once every three years, with the new rates being effective July 1, 2020.

LABORATORY RATE METHODOLOGY CHANGE
REGULAR POLICY CHANGE NUMBER: 104

Annual Rate Adjustment to 100% of Medicare
Effective July 1, 2022, clinical laboratory rates will be established in accordance with W&I Code Section 14105.22, which provides that reimbursement for clinical laboratory or laboratory services may not exceed 100% of the lowest maximum allowance established by the federal Medicare program for the same or similar services. SPA 22-0053 was approved on December 16, 2022, which adjusts the clinical laboratory rates exceeding 100% of the corresponding Medicare rates, for dates of service on or after July 1, 2022.

Triennial Rate Adjustment
Every three years, rates for certain services will be adjusted using a weighted reimbursement methodology that is based on an average of the lowest prices other third-party payers are paying for similar services.

On January 12, 2021, the Department received federal approval for SPA 20-0010 to adjust clinical laboratory or laboratory services reimbursement rates based on the triennial reimbursement methodology, effective July 1, 2020. On November 8, 2023, the Department received federal approval for SPA 23-0019 to adjust clinical laboratory or laboratory services reimbursement rates based on the Triennial reimbursement methodology, effective July 1, 2023.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to updated funding splits.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to:
- Including 12 months of the July 2025 rate adjustment in FY 2025-26, and
- No retroactive savings are estimated in FY 2025-26.

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. **Annual rate adjustment:** The annual Medi-Cal rate adjustments will apply to clinical laboratory or laboratory services reimbursement rates exceeding 100% of corresponding Medicare rates.
    a. The 2024 annual rate adjustment is effective July 1, 2024. No fiscal impact is assumed.
    b. The 2025 annual rate adjustment is effective July 1, 2025, and assumes a total fund savings of $1.4 million TF. The 2025 annual rate adjustment is estimated to be implemented in July 2025.

4. **Triennial rate adjustment:** The CMS approved the new laboratory rate methodology in July 2015.

    a. The savings resulting from the July 2023 rate adjustment are estimated to be $9.1 million TF and was implemented on February 26, 2024. The retroactive recoupment for July 1, 2023 through February 25, 2024 implemented in May 2024 and will be recouped over 12 months.

LABORATORY RATE METHODOLOGY CHANGE
REGULAR POLICY CHANGE NUMBER: 104

5. The expected adjustments are as follows:

FY 2024-25	TF	GF	FF
Prospective Savings			
2023 Triennial Rate Adjustment	($9,095,000)	($3,858,000)	($5,237,000)
Retroactive Adjustments			
2023 Triennial Rate Adjustment	($5,053,000)	($2,143,000)	($2,910,000)
Total	**($14,148,000)**	**($6,001,000)**	**($8,147,000)**

FY 2025-26	TF	GF	FF
Prospective Savings			
2023 Triennial Rate Adjustment	($9,095,000)	($3,858,000)	($5,237,000)
July 1, 2025 Rate Adjustment	($1,250,000)	($530,000)	($720,000)
Total	**($10,345,000)**	**($4,388,000)**	**($5,957,000)**

Funding:
50% Title XIX/ 50% GF (4260-101-0001/0890)
90% Title XIX/ 10% GF (4260-101-0001/0890)
65% Title XXI/ 35% GF (4260-101-0001/0890)

MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS

REGULAR POLICY CHANGE NUMBER: 105
IMPLEMENTATION DATE: 9/2019
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 2055

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$4,550,530,000	$6,289,994,000
- STATE FUNDS	$1,512,896,150	$2,273,458,900
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$4,550,530,000	$6,289,994,000
STATE FUNDS	$1,512,896,150	$2,273,458,900
FEDERAL FUNDS	$3,037,633,850	$4,016,535,100

Purpose:
This policy change estimates the managed care Private Hospital Directed Payments (PHDP) to private hospitals through enhanced capitation payments to managed care plans (MCPs).

For more information about the Hospital QAF, see the Hospital QAF - FFS Payments, Hospital QAF - Managed Care Payments, and Hospital QAF – Children's Health Care policy changes.

Authority:
Proposition 52 (2016)
Title 42, Code of Federal Regulations (CFR) 438.6(c)

Interdependent Policy Changes:
Not Applicable

Background:
Title 42, Code of Federal Regulations, section 438.6 (c) provides states authority to implement delivery system and provider payment initiatives under MCP contracts based on allowable directed payment mechanisms.

Effective July 1, 2017, for the FY 2017-18 rating period, the Department directed MCPs to reimburse private hospitals as defined in WIC 14169.51 for PHDP based on actual utilization of contracted services. Base payments will be enhanced by a uniform dollar increment (uniform unit cost add on) and promote hospitals providing adequate access to service, including primary, specialty, and inpatient (both tertiary and quaternary) care.

The total funding available for the enhanced contracted payments will be limited to a predetermined amount (pool). Upon determination of actual utilization, the Department will direct the MCPs to make enhanced payments to private hospitals for contracted services. The Department will adjust MCP's per-member-per-month rates to appropriately fund MCPs for the enhanced payment obligation.

MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS

REGULAR POLICY CHANGE NUMBER: 105

Prior to implementation of a directed payment program, the Centers for Medicare & Medicaid Services (CMS) requires states to seek pre-approval of any requested directed payment program through the standard CMS “pre-print” form.

As a result of the COVID-19 national public health emergency, increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year (CY) 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

Reason for Change:
There is no change in the total fund in FY 2024-25 from the prior estimate. The funding splits have been updated based on actual utilization data months from July 2022 to December 2022 of the CY 2022 rating period, and from January 2023 to June 2023 of the CY 2023 rating period.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to growth of the total pool size.

Methodology:
1. The total value of the funding for the private hospital directed payment pool on an accrual basis is $3.71 billion total fund for the CY 2022 rating period, $5.39 billion total fund for the CY 2023 rating period, and $7.19 billion total fund for the CY 2024 rating period.

2. The non-federal share will be supported by the Hospital Quality Assurance Revenue Fund (HQARF).

3. Enhanced payments will be issued to MCPs based on actual utilization of qualifying, contracted private hospital services.

4. Within each managed care rating period, separate payments are calculated and issued for each 6-month service period.

5. Payments are anticipated to occur in September and March of each fiscal year.

6. The final six months of the CY 2022 rating period (July 1, 2022, through December 31, 2022) payments are expected to occur in September 2024. The first six months of the CY 2023 rating period (January 1, 2023, through June 30, 2023) payments are expected to occur in March 2025.

7. The final six months of the CY 2023 rating period (July 1, 2023, though December 31, 2023) payments are expected to occur in September 2025. The first six months of the CY 2024 rating period (January 1, 2024, through June 30, 2024) payments are expected to occur in March 2026.

MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS
REGULAR POLICY CHANGE NUMBER: 105

8. On a cash basis, the estimated payments are:

(Dollars in Thousands)

FY 2024-25	TF	SF (HQARF)	FF (Title 19)	FF (Title 21)	ACA FF	COVID-19 FF
CY 2022 P2 (July - Dec 2022) +CY 2023 P1 (Jan - June 2023)	$4,550,530	$1,512,896	$1,270,321	$194,259	$1,422,386	$150,668
Total FY 2024-25	**$4,550,530**	**$1,512,896**	**$1,270,321**	**$194,259**	**$1,422,386**	**$150,668**

(Dollars in Thousands)

FY 2025-26	TF	SF (HQARF)	FF (Title 19)	FF (Title 21)	ACA FF	COVID-19 FF
CY 2023 P2 (July - Dec 2023) +CY 2024 P1 (Jan - June 2024)	$6,289,994	$2,273,459	$1,755,187	$269,453	$1,966,100	$25,796
Total FY 2025-26	**$6,289,994**	**$2,273,459**	**$1,755,187**	**$269,453**	**$1,966,100**	**$25,796**

Funding:
Hospital Quality Assurance Revenue Fund (4260-611-3158)
SCHIP HQARF 65/35 (4260-101-0890/4260-611-3158)
Title XIX FFP (4260-101-0890)
ACA Title XIX FFP (4260-101-0890)
Title XXI FFP (4260-101-0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)
COVID-19 Title XXI Increased FFP (4260-101-0890)
COVID-19 SCHIP 4.34% FFP (4260-101-0890)

HOSPITAL QAF - FFS PAYMENTS

REGULAR POLICY CHANGE NUMBER: 106
IMPLEMENTATION DATE: 7/2017
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 1475

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$3,530,277,000	$2,744,188,000
- STATE FUNDS	$1,925,369,000	$1,319,076,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,530,277,000	$2,744,188,000
STATE FUNDS	$1,925,369,000	$1,319,076,000
FEDERAL FUNDS	$1,604,908,000	$1,425,112,000

Purpose:
This policy change estimates the fee-for-service (FFS) payments that hospitals will receive from the hospital quality assurance fee (HQAF) program.

For more information about the HQAF, see the Hospital QAF - Managed Care Payments, Managed Care Private Hospital Directed Payments, and Hospital QAF – Children's Health Care policy changes.

Authority:
Proposition 52 (2016)

Interdependent Policy Changes:
Not Applicable

Background:
Proposition 52, approved by California voters on November 8, 2016, permanently extended the HQAF program.

The Department received federal approval for the HQAF V program period (January 1, 2017, to June 30, 2019) in December 2017. This HQAF program period is referred to as HQAF V.

The Department received federal approval for the HQAF VI program period (July 1, 2019, through December 31, 2021) in February 2020. This HQAF program period is referred to as HQAF VI.

The Department received federal approval for the HQAF VII program period (January 1, 2022, through December 31, 2022) in September 2022. This HQAF program period is referred to as HQAF VII.

The Department received federal approval for the HQAF VIII program period (January 1, 2023, through December 31, 2024) in December 2023. This HQAF program period is referred to as HQAF VIII.

HOSPITAL QAF - FFS PAYMENTS
REGULAR POLICY CHANGE NUMBER: 106

The Department will begin developing the subsequent program period (HQAF IX) in FY 2024-25 Q1 which will include payments for the period beginning January 1, 2025. The Department is proposing a one-year program period for dates of service January 1, 2025, through December 31, 2025, which will be submitted to the Centers for Medicare and Medicaid Services (CMS) before April 1, 2025, via State Plan Amendments (SPAs) 24-0048 and 24-0049.

As a result of the COVID-19 national public health emergency (PHE), increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year (CY) 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to:
- Including the HQAF V Subacute Overage payment for FY 2024-25.
- HQAF VIII Cycles 2 and 3 ACA adjustments reflected in FY 2024-25 have been updated with actual data.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to:
- FY 2024-25 includes HQAF V Subacute Overage payment.
- FY 2020-21 and FY 2021-22 Upper Payment Limit (UPL) Overage backlog will be paid by FY 2024-25 and program will be current.
- HQAF IX CY 2025 payments are lower than the HQAF VIII CY 2023 and CY 2024 payments.
- FY 2024-25 includes additional ACA adjustments for prior program periods (CY 2023 and 2024).
- FY 2025-26 includes the HQAF VIII CY 2023 Disproportionate Share Hospital (DSH) reduction payment.

Methodology:
HQAF V-HQAF IX
1. The HQAF V Subacute Overage payment for FY 2018-19 will take place in FY 2024-25. This was calculated in accordance with SPA 18-0012.

2. The ACA claiming methodology for the FFS supplemental payments was approved in FY 2017-18. The Hospital Quality Assurance Revenue Fund (HQARF) will be reimbursed for the SF portion (non-federal share) and an adjustment will be made for the federal share processed at the applicable FMAP.

3. HQAF VI payments are based on the HQAF VI model that was approved by CMS in February 2020. Exact payment timings are subject to change.

4. The HQAF VI inpatient (IP) UPL overages payback for FY 2020-21 and FY 2021-22 will take place in FY 2024-25. This was calculated in accordance with State Medicaid Director Letter (SMDL) #13-003 and assumes additional room from the HQAF VI outpatient (OP) UPLs can be offset with the paybacks.

5. HQAF VIII payments are based on the HQAF VIII model that was approved by CMS.

HOSPITAL QAF - FFS PAYMENTS
REGULAR POLICY CHANGE NUMBER: 106

6. Reductions to DHS replacement payments were initially anticipated to take effect during the Federal Fiscal Year 2024 (October 1, 2023, through September 30, 2024) based on Federal Statute. The Department included the DSH Replacement reductions in the federal upper payment limit demonstration, which effectively increased HQAF VIII total payments for calendar year 2023. CMS conditionally approved the CY 2023 UPL calculations on the condition that if the DSH reductions were further delayed, that the Department would repay any FFP that was overpaid for CY 2023. Pursuant to H.R.4366 (2024), the DSH reductions were postponed to January 2025, so providers were overpaid HQAF payments for CY 2023. The Department will repay the federal funds for the overpayment resulting from the DSH reduction delay. The HQAF VIII DSH reduction payment for CY 2023 will take place in FY 2025 26. This was calculated using the HQAF VI IP FFP rate. This is subject to change when CY 2023 data becomes available.

7. HQAF IX estimated payments are based on the HQAF VIII model for CY 2024 that was approved by CMS in December 2023. The amounts for HQAF IX will begin development in FY 2024-25 Q1 which will include payments for the period beginning January 1, 2025. Payment timing and amounts are subject to change.

8. For the duration of the PHE period, the FFS supplemental payments will claim for the COVID-19 increased FMAP. The additional COVID-19 increased FFP claimed during the PHE will be transferred to the HQARF to be expended at a later time.

HOSPITAL QAF - FFS PAYMENTS
REGULAR POLICY CHANGE NUMBER: 106

9. On a cash basis, the estimated HQAF V- HQAF IX payments are:

(Dollars in Thousands)

FY 2024-25	TF	SF (HQARF)	FF	ACA FF	COVID-19 FF	*Return to Fund 3158
HQAF V						
FY 2018-19 Subacute Overage	$0	$69,423	($37,427)	($31,996)	$0	$0
HQAF VI						
FY 2020-21 UPL Overage	$0	$255,809	($102,964)	($131,050)	($21,795)	$0
FY 2021-22 UPL Overage	$0	$93,127	($37,485)	($47,707)	($7,935)	$0
HQAF VIII						
CY 2023	$786,089	$405,046	$369,945	$0	$11,098	$0
CY 2024	$2,744,188	$1,464,104	$1,280,084	$0	$0	$0
CY 2023 ACA FFCRA Adjustment	$0	($223,760)	($302,604)	$544,687	($18,323)	$223,760
CY 2024 ACA Adjustment	$0	($138,380)	($172,975)	$311,355	$0	$138,380
Total FY 2024-25	**$3,530,277**	**$1,925,369**	**$996,574**	**$645,289**	**($36,955)**	$362,140

(Dollars in Thousands)

FY 2025-26	TF	SF (HQARF)	FF	ACA FF	COVID-19 FF	*Return to Fund 3158
HQAF VIII						
CY 2023 DSH Reduction Payment	$0	$131,732	($66,101)	($60,607)	($5,024)	$0
CY 2024 ACA Adjustment	$0	($138,380)	($172,975)	$311,355	$0	$138,380
HQAF IX						
CY 2025	$2,744,188	$1,464,104	$1,280,084	$0	$0	$0
CY 2025 ACA Adjustment	$0	($138,380)	($172,975)	$311,355	$0	$138,380
Total FY 2025-26	**$2,744,188**	**$1,319,076**	**$868,033**	**$562,103**	**($5,024)**	$276,760

*The Return to Fund 3158 column is for display purposes only (see HQAF V-HQAF IX Methodology #2 and #8).

Funding:
100% GF (4260-101-0001)
Hospital Quality Assurance Revenue Fund (4260-611-3158)
ACA Title XIX FFP (4260-101-0890)
Title XIX FFP (4260-101-0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)

HOSPITAL QAF - MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 107
IMPLEMENTATION DATE: 3/2015
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 1761

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$1,297,400,000	$1,200,000,000
- STATE FUNDS	$414,058,400	$382,973,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,297,400,000	$1,200,000,000
STATE FUNDS	$414,058,400	$382,973,500
FEDERAL FUNDS	$883,341,600	$817,026,500

Purpose:
This policy change estimates the Managed Care payments hospitals will receive from the extension of the hospital quality assurance fee (HQAF) program.

For more information about the HQAF, see the Hospital QAF – FFS Payments, Managed Care Private Hospital Directed Payments, and Hospital QAF – Children's Health Care policy changes.

Authority:
Proposition 52 (2016)
Title 42, Code of Federal Regulations (CFR) 438.6(d)(3)

Interdependent Policy Changes:
Not Applicable

Background:
Proposition 52, approved by California voters on November 8, 2016, permanently extended the HQAF program. The program period from January 1, 2017, to June 30, 2019, is referred to as HQAF V.

The Department received federal approval for the HQAF VI program period (July 1, 2019, through December 31, 2021) in February 2020. This HQAF program period is referred to as HQAF VI.

The Department received federal approval for the HQAF VII program period (January 1, 2022, through December 31, 2022) in September 2022. This HQAF program period is referred to as HQAF VII.

The Department received federal approval for the HQAF VIII program period (January 1, 2023, through December 31, 2023) in December 2023. This HQAF program is referred to as HQAF VIII.

HOSPITAL QAF - MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 107

As payments start to transition away from Pass-Through payments, the dollars attributable to the District and Municipal Public Hospitals (DMPHs) in the HQAF Pass-Through will transition to the District Hospital Directed Payment program. This creates more room for those hospitals still receiving funding through the HQAF Pass-Through and move towards fully transitioning away from the Pass-Through payments. The DMPH Intergovernmental Transfer (IGT) portion of payments is budgeted in the Managed Care District Hospital Directed Payments policy change as of the Calendar Year 2025 rating period.

Reason for Change:
There is no change in total fund for FY 2024-25 from the prior estimate, but the funding assumptions have been updated.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due to the DMPH IGTs are now budgeted in the Managed Care District Hospital Directed Payments policy change.

Methodology:
1. CY 2024 HQAF payments are anticipated to occur in FY 2024-25 while the CY 2025 HQAF payments are anticipated to occur in FY 2025-26.

2. The Department will collect IGTs from the District and Municipal Public Hospitals, and payments will be made from the Hospital Quality Assurance Revenue Fund.

3. Effective January 1, 2025, expenses related to the DMPH program will be captured in the Managed Care District Hospital Directed Payments policy change.

4. The CY 2024 total amounts are within the approved HQAF VIII model.

HOSPITAL QAF - MANAGED CARE PAYMENTS
REGULAR POLICY CHANGE NUMBER: 107

5. On a cash basis, the estimated QAF payments are:

(Dollars in Thousands)

FY 2024-25	TF	SF (HQARF)	FF (TITLE 19)	FF (TITLE 21)	ACA FF
Managed Care					
Calendar Year 2024	$1,200,000	$382,973	$314,337	$29,910	$472,780
Total MC	$1,200,000	$382,973	$314,337	$29,910	$472,780
DMPH IGT					
Calendar Year 2024	$97,400	$31,085	$25,514	$2,427	$38,374
Total DMPH IGT	$97,400	$31,085	$25,514	$2,427	$38,374
Total FY 2024-25	**$1,297,400**	**$414,058**	**$339,851**	**$32,337**	**$511,154**

(Dollars in Thousands)

FY 2025-26	TF	SF (HQARF)	FF (TITLE 19)	FF (TITLE 21)	ACA FF
Managed Care					
Calendar Year 2025	$1,200,000	$382,973	$314,337	$29,910	$472,780
Total MC	$1,200,000	$382,973	$314,337	$29,910	$472,780
Total FY 2025-26	**$1,200,000**	**$382,973**	**$314,337**	**$29,910**	**$472,780**

Funding:
Hospital Quality Assurance Revenue Fund (4260-611-3158)
SCHIP HQARF 65/35 (4260-101-0890/4260-611-3158)
Title XIX FFP (4260-101-0890)
Title XXI FFP (4260-101-0890)

GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS

REGULAR POLICY CHANGE NUMBER: 108
IMPLEMENTATION DATE: 6/2020
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 2024

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$850,473,000	$925,573,000
- STATE FUNDS	$355,705,000	$405,198,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$850,473,000	$925,573,000
STATE FUNDS	$355,705,000	$405,198,000
FEDERAL FUNDS	$494,768,000	$520,375,000

Purpose:
This policy change estimates direct and indirect graduate medical education (GME) payments to the Designated Public Hospitals (DPHs) participating in the Medi-Cal managed care program in recognition of the Medi-Cal managed care share of graduate medical education costs.

Authority:
Title 42, Code of Federal Regulations (CFR), Section 438.60
SB 97 (Chapter 52, Statutes of 2017)
State Amendment Plan (SPA) 17-0009

Interdependent Policy Changes:
IGT Admin. & Processing Fee

Background:
The Medicare enactment of direct and indirect GME identified the importance of paying the extra costs of teaching hospitals to ensure seniors' ability to access the care they require. According to the Balanced Budget Act of 1997, Medicare capped the levels of funding for both direct and indirect GME costs when the number of allopathic and osteopathic medical residents exceeded the expected limit. In accordance with Title 42, CFR, Section 438.60, the Department is authorized to make new GME payments to DPH systems.

GME is the supervised, hands-on training after medical school that all physicians complete to become independent and licensed practitioners. The length of this training varies depending on specialty, but generally lasts three to five years. Residents and supervising physicians at teaching hospitals are available around the clock and are prepared to care for the nation's most critically ill or injured patients, with hospitals often absorbing the cost of training.

On March 19, 2020, Centers for Medicare and Medicaid Services approved SPA 17-0009 with a January 1, 2017, effective date, allowing the Department to make new Medi-Cal GME payments to DPH systems. 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: 108

- 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

Intergovernmental transfers (IGTs) will fund the nonfederal share of the cost. The Department will assess a 5% administrative fee on IGTs related to the GME payments to reimburse the Department for support costs associated with administering the program. The 5% administrative fee will be assessed in addition to the IGT funding the nonfederal share of the cost. The IGT savings will be budgeted in the IGT Admin. & Processing Fee policy change.

As a result of the COVID-19 national public health emergency, increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to:
- FY 2022-23 Q1-Q2 Affordable Care Act (ACA) Adjustments shifted from date of payment FY 2023-24 to FY 2024-25.
- Revised FY 2022-23 Q3-Q4 ACA Adjustments based on updated data.
- Revised FY 2023-24 Final Settlement based on updated data.
- Revised FY 2023-24 Q1-Q2 ACA Adjustments based on updated data.
- Revised FY 2024-25 Interim Payments based on updated data.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to:
- Higher volume of ACA Adjustments and final settlements are expected to occur in FY 2024-25 compared to FY 2025-26.
- Increased interim payment and final settlement expenditures are estimated in FY 2025-26 compared to FY 2024-25 due to higher direct and indirect graduate medical costs.

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.

2. The indirect medical education (IME) payments include costs incurred by DPHs due to teaching activities. Such indirect costs will be calculated by determining the hospital's adjusted Medi-Cal IME payment per inpatient day and multiplying by the total Medi-Cal managed care days.

3. The GME and IME annual distribution amounts are calculated based on the methodologies outlined in SPA 17-0009.

    - FY 2024-25 payments were calculated based on FY 2022-23 cost report data and are estimated at $598 million Total Funds (TF).
    - FY 2025-26 payments assumed an increase from FY 2024-25 estimated payments based on the percent change average from FY 2020-21, FY 2021-22, FY 2022-23,

GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS
REGULAR POLICY CHANGE NUMBER: 108

FY 2023-24, and FY 2024-25. FY 2025-26 payments are estimated to provide $672.5 million TF.

4. Payments will be made on a lump-sum quarterly basis throughout the fiscal year and will not be paid as individual increases to current reimbursement rates for specific services.

5. The IGTs referenced in this policy change are not the basis for the 5% administrative fee for GME supplemental payments. The administrative fees are reflected in the IGT Admin & Processing Fee policy change and will be 5% of the aggregate nonfederal share that is calculated at 50% FMAP of the TF.

6. The ACA allows for 100% FMAP for calendar year 2016 for newly eligible Medi-Cal members. Beginning January 1, 2017, the ACA optional population FMAP reduces to 95%, 94% beginning January 1, 2018, 93% beginning January 1, 2019, and 90% beginning January 1, 2020. The ACA reimbursement methodology was approved in the fourth quarter of FY 2022-23.

7. ACA adjustments are anticipated to be processed after the respective fiscal year has closed in order to determine the proportion of the hospital's GME payment attributable to ACA. Beginning with FY 2022-23, ACA adjustments for Q1 and Q2 will be processed following final settlements for the respective fiscal year. ACA adjustments for Q3 and Q4 will be processed once complete encounter data is available. The nonfederal share of the adjustment amount will be reimbursed to the DPHs.

8. Assume FY 2023-24 final settlements will be paid in FY 2024-25.

9. Assume all four quarters of FY 2024-25 will be paid in FY 2024-25.

10. Assume ACA adjustments for FY 2022-23 through FY 2023-24 Q2 will occur in FY 2024-25.

11. Assume FY 2024-25 final settlements will occur in FY 2025-26.

12. Assume all four quarters of FY 2025-26 will be paid in FY 2025-26.

13. Assume ACA adjustments for FY 2023-24 Q3 through FY 2024-25 Q2 will be paid in FY 2025-26.

(Dollars in Thousands)

FY 2024-25	**TF**	**IGT**	**FF**	**ACA FF**	**COVID-19 FF**	Return to DPHs*
FY 2022-23 Q1-Q2 ACA Adjustment	$43,553	$0	($64,427)	$115,969	($7,989)	$43,553
FY 2022-23 Q3-Q4 ACA Adjustment	$43,274	$0	($62,900)	$113,219	($7,045)	$43,274
FY 2023-24 Final Settlement	$115,684	$56,685	$57,842	$0	$1,157	$0
FY 2023-24 Q1-Q2 ACA Adjustment	$49,922	$0	($65,685)	$118,234	($2,627)	$49,922
FY 2024-25 Interim Payment Q1-Q4	$598,040	$299,020	$299,020	$0	$0	$0
Total	**$850,473**	**$355,705**	**$163,850**	**$347,422**	**($16,504)**	$136,749

GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS

REGULAR POLICY CHANGE NUMBER: 108

(Dollars in Thousands)

FY 2025-26	TF	IGT	FF	ACA FF	Return to DPHs*
FY 2023-24 Q3-Q4 ACA Adjustment	$52,549	$0	($65,685)	$118,234	$52,549
FY 2024-25 Final Settlement	$137,872	$68,936	$68,936	$0	$0
FY 2024-25 Q1-Q2 ACA Adjustment	$62,628	$0	($78,284)	$140,912	$62,628
FY 2025-26 Interim Payment Q1-Q4	$672,524	$336,262	$336,262	$0	$0
Total	**$925,573**	**$405,198**	**$261,229**	**$259,146**	$115,177

*The Return to DPHs column is for display purposes only.

Funding:
Title XIX FFP (4260-101-0890)
DPH Graduate Medical Education Special Fund (4260-601-8113)
Title XIX ACA (4260-101-0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)

PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER: 109
IMPLEMENTATION DATE: 7/2005
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 1071

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$746,417,000	$757,152,000
- STATE FUNDS	$373,039,500	$378,576,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$746,417,000	$757,152,000
STATE FUNDS	$373,039,500	$378,576,000
FEDERAL FUNDS	$373,377,500	$378,576,000

Purpose:
This policy change estimates the funds for the private Disproportionate Share Hospital (DSH) replacement payments.

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.11
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)
SB 90 (Chapter 19, Statutes of 2011)
SB 335 (Chapter 286, Statutes of 2011)
HR 2 (2015)
State Plan Amendment (SPA) 05-022
SPA 16-010
HR 1892 (2018)
HR 4378 (2019)
HR 3055 (2019)
HR 1865 (2019)
HR 748 (2020)
HR 133 (2020)
American Rescue Plan (ARP) Act (2021)
HR 5860 (2023)
HR 6363 (2023)
HR 2872 (2024)
HR 4366 (2024)

Interdependent Policy Changes:
ACA DSH Reduction

Background:
Beginning July 1, 2005, based on SB 1100, private hospitals receive Medi-Cal DSH replacement payments under the DSH Replacement Program. These payments are determined using the same formulas and methodology that were previously in effect under the prior DSH methodology for the 2004-05 fiscal year. These payments are distributed to private hospitals

PRIVATE HOSPITAL DSH REPLACEMENT
REGULAR POLICY CHANGE NUMBER: 109

along with $160, with the federal share of the $160 funded via the annual DSH allotment, and the non-federal share funded via the General Fund (GF). Combined, these payments satisfy the State's payment obligations to private hospitals under the Federal DSH statute.

The Centers for Medicare and Medicaid Services (CMS) approved SPA 16-010 in November 2017, which transferred the authority for DSH replacement payments from the BTR waiver to the California State Plan effective January 1, 2016.

The federal share of the DSH replacement payments is regular Title XIX funding and is not claimed from the federal DSH allotment. The non-federal share of these payments is GF.

The Affordable Care Act (ACA) requires a reduction to the DSH allotments and was previously scheduled to go into effect on October 1, 2013. Subsequent federal action has delayed the reduction; see the ACA DSH Reduction policy change for more information. Most recently, on March 9, 2024, HR 4366 was enacted which eliminated the Federal Fiscal Year (FFY) 2024 reduction and postponed implementation of the FFY 2025 reduction until January 1, 2025.

The private DSH replacement payments are affected by the ACA DSH reduction because, as required by SB 1100, the methodology to determine the DSH replacement payments is dependent on the DSH allotment and its associated payment methodologies.

As a result of the COVID-19 national public health emergency, increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable. Future reconciliation payments for the impacted fiscal years will apply the applicable FMAP.

The American Rescue Plan Act (ARP), HR 1319, enacted on March 11, 2021, requires that for the federal fiscal years in which the FFCRA increased FMAP is applicable, the states' annual DSH allotments be recalculated such that the total computable DSH expenditures for a state is equal to the total computable DSH expenditures that would have resulted in the absence of the FFCRA increased FMAP. The result is an increase in the DSH allotments for the impacted fiscal years. This policy change reflects the revised preliminary ARP-adjusted FFY 2023, and preliminary ARP-adjusted FFY 2024 allotment released by CMS on September 29, 2023, as well as the Department-estimated FFY 2025 and 2026 non-ARP-adjusted allotments.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to:

- The finalization of the DSH Third Party Payer Rule (Final Rule 2024-03542), published by CMS on February 23, 2024, which required additional payments and recoupments for FY 2021-22.
- An updated payment amount for the FY 2022-23 June Phase II B payment.
- Updated FY 2023-24 hospital type allocations due to updated major teaching hospital determinations. This resulted in an increased FY 2023-24 June payment amount and updated FY 2024-25 payment amounts.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to a larger DSH allotment estimate due to the FY 2025-26 DSH allotment being derived by trending forward the estimated FY 2024-25 allotment by 2%.

PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER: 109

Methodology:

1. CMS released a revised preliminary ARP-adjusted FFY 2023 DSH allotment and ARP-adjusted preliminary FFY 2024 DSH allotment on September 29, 2023.

2. The FFY 2025 DSH allotment will not be subject to ARP adjustments, and thus assumes a 2% annual increase from the preliminary non-ARP adjusted FFY 2024 allotment.

3. The FFY 2026 DSH allotment will not be subject to ARP adjustments, and thus assumes a 2% annual increase from the Department-estimated FFY 2025 DSH allotment.

4. FY 2021-22 CMS Final Rule Reconciliation payments will be subject to a 56.2% FMAP as outlined in the FFCRA.

5. FY 2022-23 June Phase II B and Audit Exemption payments will be subject to a 55% FMAP as outlined in the Consolidated Appropriations Act (CAA) 2023.

6. The remaining 1/12 of the FY 2023-24 DSH replacement payment will be completed in FY 2024-25.

7. Assume 11/12 of the FY 2024-25 DSH replacement payment will occur in FY 2024-25 and the remaining 1/12 will occur in FY 2025-26.

8. Assume 11/12 of the FY 2025-26 DSH replacement payment will occur in FY 2025-26.

9. DSH replacement payments will be made as follows on a cash basis:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF	COVID-19 FF
FY 2021-22	$1,448	$634	$724	$90
FY 2022-23	$1,585	$713	$793	$79
FY 2023-24	$63,096	$31,548	$31,548	$0
FY 2024-25	$680,288	$340,144	$340,144	$0
Total FY 2024-25	**$746,417**	**$373,039**	**$373,209**	**$169**

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
FY 2024-25	$61,844	$30,922	$30,922
FY 2025-26	$695,308	$347,654	$347,654
Total FY 2025-26	**$757,152**	**$378,576**	**$378,576**

Funding:

50% Title XIX/ 50% GF (4260-101-0001/0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)
COVID-19 Title XIX GF (4260-101-0001)

PROP 56 - MEDI-CAL FAMILY PLANNING

REGULAR POLICY CHANGE NUMBER: 110
IMPLEMENTATION DATE: 1/2020
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 2130

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$528,133,000	$554,314,000
- STATE FUNDS	$212,135,800	$222,931,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	2.95 %	2.80 %
APPLIED TO BASE		
TOTAL FUNDS	$512,553,100	$538,793,200
STATE FUNDS	$205,877,790	$216,689,220
FEDERAL FUNDS	$306,675,280	$322,103,980

Purpose:
This policy change estimates the cost for providing supplemental payments for family planning services in both Medi-Cal fee-for-service (FFS) and Managed Care (MC).

Authority:
SPA 19-0027
SPA 21-0034

Interdependent Policy Changes:
Proposition 56 Funding

Background:
The California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56, 2016), increased the excise tax rate on cigarettes and tobacco products and allocates a portion of the tobacco tax revenue to the Department for use as the non-federal share of health care expenditures, subject to appropriation by the Legislature.

The Budget Act of 2019 allocated Proposition 56 funds for supplemental payments for family planning services. The Legislature has continued this funding in subsequent budget acts.

On August 20, 2019, the Centers for Medicare and Medicaid Services (CMS) approved SPA 19-0027. SPA 19-0027 allows the Department to implement time-limited supplemental payments for specific family planning services delivered in the Medi-Cal FFS delivery system from July 1, 2019, through December 31, 2021. The FFS supplemental payment implemented in January 2020. In FY 2019-20, an Erroneous Payment Correction deployed to retroactively apply supplemental payments to July 1, 2019. SPA 21-0034 was submitted to CMS to extend the supplemental reimbursements under FFS indefinitely.

In the Medi-Cal managed care delivery system, the Department has implemented these payments as directed payments to eligible providers. Prior to implementation of a directed payment program, CMS requires states to seek pre-approval of any requested directed payment program through the standard CMS “pre-print” form. This “pre-print” is typically submitted on an

PROP 56 - MEDI-CAL FAMILY PLANNING
REGULAR POLICY CHANGE NUMBER: 110

annual basis. On May 5, 2020, the Department received pre-print approval from CMS for the July 1, 2019, through December 31, 2020, rating period. On October 8, 2021, the Department received pre-print approval from CMS for the CY 2021 rating period January 1, 2021, through December 31, 2021. On September 8, 2023, the Department received pre-print approval from CMS for the January 1, 2022, through December 31, 2022, rating period. On September 8, 2023, the Department received pre-print approval from CMS for the January 1, 2023, through December 31, 2023, rating period. On December 27, 2023, the Department received pre-print approval from CMS for the January 1, 2024, through December 31, 2024, rating period.

Beginning July 1, 2019, the directed payments are subject to a two-sided risk corridor which is calculated retrospectively by the Department. Recoupments/payments are captured in the Prop 56 Risk Mitigation policy change.

These supplemental payments for Medi-Cal family planning services are intended to help support the larger Medi-Cal population in accessing and using family planning services as well as the providers delivering such services in the Medi-Cal program. This policy change identifies the use of the General Fund (GF) for these Proposition 56 funded payments. See the Proposition 56 Funding policy change for the Proposition 56 offset to the GF.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is an increase due to updated higher MC expenditures. The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to a projected MC expenditures growth in FY 2025-26.

Methodology:
1. This policy became effective on July 1, 2019.

2. Assume the continuation of the Proposition 56 payments through FY 2025-26, on a cash basis.

3. The supplemental payments are paid in both FFS and MC for family planning office visits billed under specified procedure codes for service periods beginning July 1, 2019.

4. Expenditures are estimated to be:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
Fee-For-Service	$15,581	$6,701	$8,880
Managed Care	$512,552	$205,434	$307,118
Total	**$528,133**	**$212,135**	**$315,998**

PROP 56 - MEDI-CAL FAMILY PLANNING

REGULAR POLICY CHANGE NUMBER: 110

FY 2025-26	TF	GF	FF
Fee-For-Service	$15,503	$6,668	$8,835
Managed Care	$538,811	$216,263	$322,548
Total	**$554,314**	**$222,931**	**$331,383**

Funding:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
90% Title XIX / 10% GF (4260-101-0890/0001)	$351,108	$35,111	$315,997
100% GF (4260-101-0001)	$177,024	$177,024	$0
Total	**$528,133**	**$212,135**	**$315,998**

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
90% Title XIX / 10% GF (4260-101-0890/0001)	$368,203	$36,820	$331,383
100% GF (4260-101-0001)	$186,110	$186,110	$0
Total	**$554,314**	**$222,931**	**$331,383**

DSH PAYMENT

REGULAR POLICY CHANGE NUMBER: 111
IMPLEMENTATION DATE: 7/2005
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 1073

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$475,352,000	$487,442,000
- STATE FUNDS	$134,300,000	$135,713,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$475,352,000	$487,442,000
STATE FUNDS	$134,300,000	$135,713,000
FEDERAL FUNDS	$341,052,000	$351,729,000

Purpose:
This policy change estimates the payments to Disproportionate Share Hospitals (DSHs).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions (W&I) 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)
State Plan Amendment (SPA) 05-022
California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)
SB 815 (Chapter 111, Statutes of 2016)
American Rescue Plan (ARP) Act (2021)
HR 4366 (2024)

Interdependent Policy Changes:
ACA DSH Reduction

Background:
Effective July 1, 2005, based on SPA 05-022 and as part of the MH/UCD and BTR, the federal DSH allotment is available to provide funding for uncompensated Medi-Cal and uninsured costs incurred by DSHs. Eligible hospitals are to receive funding through the DSH program in the following manner:

- Designated Public Hospitals (DPH) receive their allocation of federal DSH payments from the DSH Fund based on the hospitals' certified public expenditures (CPE), up to 100% of uncompensated Medi-Cal and uninsured costs. DPHs may also receive allocations of federal and non-federal DSH funds through intergovernmental transfer-funded payments for expenditures above 100% of costs, up to 175% of the hospitals' uncompensated Medi-Cal and uninsured costs.

DSH PAYMENT
REGULAR POLICY CHANGE NUMBER: 111

Effective July 1, 2015, DPHs, except State Government-operated University of California (UC) Hospitals, receive their allocation of the federal DSH payments through the Global Payment Program (GPP). Beginning January 1, 2022, UC Hospitals became eligible to participate in GPP after obtaining Centers for Medicare and Medicaid Services (CMS) approval. See the GPP policy change for more information and for the portion of DSH budgeted for GPP. State Government-operated UC 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.

Beginning January 1, 2023, CMS approved University of California Los Angeles' (UCLA) request to participate in the GPP rather than the DSH program. Accordingly, beginning with Program Year (PY) 9 (Calendar Year [CY] 2023), the percentage of the DPH DSH Allotment federal financial participation (FFP) allocated to DSH DPH hospitals will be adjusted to 20.371% rather than 21.896%.

- Non-Designated Public Hospitals (NDPH) receive their allocation from the federal DSH allotment and State General Fund (GF) based on hospitals' uncompensated Medi-Cal and uninsured costs up to the Omnibus Budget Reconciliation Act of 1993 (OBRA) limits.

- Private DSH hospitals, under the waiver Special Terms and Conditions and SPA 05-022, are allocated a total of $160 from the federal DSH allotment and GF each demonstration year. All DSH-eligible Private hospitals receive a pro-rata share of the $160.

The MH/UCD was extended to October 31, 2010. CMS approved the BTR effective November 1, 2010, continuing the same DSH payment methodology from the MH/UCD. AB 1066 amended W&I Code 14166.1 and provides the authority for the Department to implement new payment methodologies under the successor demonstration project to determine the federal DSH allotment for DPHs.

The Affordable Care Act (ACA) requires a reduction to the DSH allotments and was previously scheduled to go into effect on October 1, 2013. Subsequent federal action has delayed the reduction; see the ACA DSH Reduction policy change for more information. Most recently, on March 9, 2024, HR 4366 was enacted which eliminated the Federal Fiscal Year (FFY) 2024 reduction and postponed implementation of the FFY 2025 reduction until January 1, 2025.

As a result of the COVID-19 national public health emergency, increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable. Future reconciliation payments for the impacted fiscal years will apply the applicable FMAP.

The American Rescue Plan Act (ARP), HR 1319, enacted on March 11, 2021, requires that for the federal fiscal years in which the FFCRA increased FMAP is applicable, the states' annual DSH allotments be recalculated such that the total computable DSH expenditures for a state are equal to the total computable DSH expenditures that would have resulted in the absence of the FFCRA increased FMAP. The result is an increase in the DSH allotments for the impacted fiscal years. This policy change reflects the revised preliminary ARP-adjusted FFY 2023, and preliminary ARP-adjusted FFY 2024 allotment released by CMS on September 29, 2023, as well as the Department-estimated FFY 2025 and 2026 non-ARP-adjusted allotments.

DSH PAYMENT
REGULAR POLICY CHANGE NUMBER: 111

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to:

- Updated FY 2024-25 hospital type allocations due to updated Major Teaching Hospital determinations. This resulted in NDPH FY 2023-24 June payment decreasing.
- The finalization of the DSH Third Party Payer Rule (Final Rule 2024-03542), published by CMS on February 23, 2024, which resulted in reconciliation payments for FY 2021-22 for NDPH hospitals and FY 2022-23 for UC hospitals.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due the estimated FFY 2025 DSH allotment being higher, which is derived by trending forward the estimated FY 2024-25 allotment by 2%.

Methodology:

1. CMS released a revised preliminary ARP-adjusted FFY 2023 DSH allotment and ARP-adjusted preliminary FFY 2024 DSH allotment on September 29, 2023.

2. The FY 2024-25 DSH allotment will not be subject to ARP adjustments and therefore assumes a 2% annual increase from the preliminary non-ARP-adjusted FY 2023-24 allotment.

3. The FY 2025-26 DSH allotment assumes a 2% annual increase from the FY 2024-25 DSH allotment estimate.

4. FY 2021-22 NDPH CMS Final Rule Reconciliation payments will be subject to a 56.2% FMAP as outlined in the FFCRA.

5. The impact of the Title XIX COVID-19 increased FMAP does not increase the claimable DSH allotment, as the DSH allotment is a capped amount. The DSH allocation for NDPHs claims the increased FMAP consistent with the FMAP phase-out included in the Consolidated Appropriations Act of 2023. The remaining DSH allotment FFP is then allocated to GPP and UC hospitals. For those remaining hospitals, the non-federal share is reduced according to the Consolidated Appropriations Act of 2023, reducing the overall total funds while keeping the FFP the same that would have been paid at 50% federal share / 50% non-federal share.

6. DSH payments will be made as follows on a cash basis:

FY 2024-25	TF	GF**	IGT*	FF	COVID-19 FF
DSH 2021-22	$38,000	$17,000	$0	$19,000	$2,000
DSH 2023-24	$101,739,000	$2,975,000	$24,300,000	$74,464,000	$0
DSH 2024-25	$373,575,000	$34,833,000	$72,175,000	$266,567,000	$0
Total FY 2024-25	**$475,352,000**	**$37,825,000**	**$96,475,000**	**$341,050,000**	**$2,000**

DSH PAYMENT

REGULAR POLICY CHANGE NUMBER: 111

FY 2025-26	TF	GF**	IGT*	FF
DSH 2024-25	$107,636,000	$3,167,000	$24,058,000	$80,411,000
DSH 2025-26	$379,806,000	$34,833,000	$73,655,000	$271,318,000
Total FY 2025-26	**$487,442,000**	**$38,000,000**	**$97,713,000**	**$351,729,000**

Funding:
100% Demonstration DSH Fund (4260-601-7502)
50% Title XIX / 50% GF (4260-101-0001/0890)**
100% GF (4260-101-0001)
100% Title XIX (4260-101-0890)
100% MIPA Fund (4260-606-0834)*
COVID-19 Title XIX Increased FFP (4260-101-0890)
COVID-19 Title XIX GF (4260-101-0001)

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 112
IMPLEMENTATION DATE: 7/2005
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 1085

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$446,253,000	$487,085,000
- STATE FUNDS	$189,123,000	$228,132,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$446,253,000	$487,085,000
STATE FUNDS	$189,123,000	$228,132,000
FEDERAL FUNDS	$257,130,000	$258,953,000

Purpose:
This policy change estimates the supplemental payments made to private hospitals from the Private Hospital Supplemental Fund (PHSF).

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
State Plan Amendment (SPA) 23-0013

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, and the Small and Rural Hospital Supplemental Payment Program (Fund 0688).

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
REGULAR POLICY CHANGE NUMBER: 112

SB 1100 requires the transfer of $118,400,000 annually from the 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 Contracting Program for private hospitals on July 1, 2013, 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 2023-24. The most recent SPA, 23-0013, was approved by CMS on November 21, 2023, and extended the Private Hospital Supplemental Fund Program through June 30, 2024. SPA 23-0013 also updated the program's total computable amount for FY 2023-24 for carryover funds to be matched with federal financial participation (FFP) and distributed to private hospitals. In the fourth quarter of FY 2023-24, a 1-year SPA was submitted to CMS to extend the Private Hospital Supplemental Fund program through FY 2024-25.

As a result of the COVID-19 national public health emergency, increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to:
- Addition of FY 2023-24 cash expenditures to providers due to delayed FY 2023-24 IGT payment,
- Updated FY 2023-24 Affordable Care Act (ACA) Adjustments based on more recent data,
- FY 2024-25 cash expenditures to providers updated based on actual anticipated FY 2024-25 distributions and IGT payment amounts.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to:
- Increased cash expenditures to providers in FY 2025-26 compared to FY 2024-25 due to increases in PHSF distributions and IGT payments,
- Decrease in ACA FF adjustment to special fund in FY 2025-26 compared to FY 2024-25 due to decrease in PHSF distributions from FY 2023-24 to FY 2024-25,
- An increase in ACA FF adjustments to counties in FY 2025-26 compared to FY 2024-25 due to increase IGT payments from FY 2023-24 to FY 2024-25.

Methodology:
1. The SF includes the annual GF appropriation, unspent funds from prior year, interest that has been accrued/estimated, and IGTs.

2. The FY 2024-25 and FY 2025-26 $118,400,000 GF appropriation will be adjusted by the enhanced federal funds provided by the ACA, resulting in carryover funds. The Department will match carryover funds with FFP and distribute to private hospitals in the subsequent SFY.

3. IGT payments will be $72.4 million TF in FY 2024-25 and $88.1 million TF in FY 2025-26.

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
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4. The ACA allows for 100% FMAP for calendar years 2014 through 2016. Beginning January 1, 2017, the ACA optional population FMAP is 95%, and reduces to 94% beginning January 1, 2018. Beginning January 1, 2019, the ACA optional population FMAP reduces to 93%, and further reduces to 90% beginning January 1, 2020. CMS approved the ACA claiming methodology in August 2017.

5. ACA payments will be processed nine months after the respective FY's supplemental payments have been issued in order to determine the proportion of the costs for newly eligible Medi-Cal members. FY 2023-24 ACA supplemental payments will be claimed in FY 2024-25, and FY 2024-25 ACA supplemental payments will be claimed in FY 2025-26.

   - The counties will be reimbursed for the IGTs (non-federal share) and an adjustment will be made for the federal share processed at the COVID-19 increased 52.5% FMAP for FY 2023-24 Q1, at the COVID-19 increased 51.5% FMAP for FY 2023-24 Q2, and at the 50% FMAP for FY 2023-24 Q3 and after.

   - The SF will be reimbursed for the SF portion (non-federal share) and an adjustment will be made for the federal share processed at the COVID-19 increased 52.5% FMAP for FY 2023-24 Q1, at the COVID-19 increased 51.5% FMAP for FY 2023-24 Q2, and at the 50% FMAP for FY 2023-24 Q3 and after.

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.

7. The estimated Private Hospital Supplemental payments and ending balance for FY 2024-25 are shown below:

(Dollars in Thousands)

FY 2024-25 Private Hospital Supplemental Fund Summary	SF
FY 2023-24 Ending Balance	$37,977
Appropriation (GF)	$118,400
Carryover Funds	$64,120
FY 2024-25 IGT	$36,253
FY 2023-24 Interest Earned	$6,181
Funds Available	$262,931
Less: FY 2024-25 Cash Expenditures to Hospitals	($189,123)
Est. FY 2024-25 Remaining Balance	$73,808

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
REGULAR POLICY CHANGE NUMBER: 112

(Dollars in Thousands)

FY 2024-25	TF	SF	FF	ACA FF	COVID-19 FF	Return to SF*	Return to Counties*
FY 2023-24 Cash Expenditures to Providers**	$133	$65	$67	$0	$1	$0	$0
FY 2024-25 Cash Expenditures to Providers**	$378,114	$189,058	$189,056	$0	$0	$0	$0
FY 2023-24 ACA FF Adjustment to Special Fund***	$64,120	$0	($82,206)	$147,970	($1,644)	$64,120	$0
FY 2023-24 ACA FF Adjustment to Counties***	$3,886	$0	($4,982)	$8,968	($100)	$0	$3,886
Total	**$446,253**	**$189,123**	**$101,935**	**$156,938**	**($1,743)**	$64,120	$3,886

8. The estimated Private Hospital Supplemental payments and ending balance for FY 2025-26 are shown below:

(Dollars in Thousands)

FY 2025-26 Private Hospital Supplemental Fund Summary	SF
FY 2024-25 Ending Balance	$73,808
Appropriation (GF)	$118,400
Carryover Funds	$25,322
FY 2025-26 IGT	$44,048
Est. FY 2024-25 Interest Earned	$6,181
Funds Available	$267,759
Less: FY 2025-26 Cash Expenditures to Hospitals	($228,132)
Est. FY 2025-26 Remaining Balance	$39,627

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 112

(Dollars in Thousands)

FY 2025-26	TF	SF	FF	ACA FF	Return to SF*	Return to Counties*
FY 2025-26 Cash Expenditures to Providers**	$456,261	$228,132	$228,129	$0	$0	$0
FY 2024-25 ACA FF Adjustment to Special Fund***	$25,322	$0	($31,652)	$56,974	$25,322	$0
FY 2024-25 ACA FF Adjustment to Counties***	$5,502	$0	($6,877)	$12,379	$0	$5,502
Total	**$487,085**	**$228,132**	**$189,600**	**$69,353**	$25,322	$5,502

*The Return to SF and Return to Counties columns are for display purposes only (see Methodology #5).

Funding:
100% Private Hospital Supplemental Fund (less funded by GF) (4260-698-3097)
100% Private Hospital Supplemental Fund (non-GF) (4260-601-3097)**
100% Title XIX ACA (4260-101-0890)***
100% Title XIX (4260-101-0890)**,***
100% GF (4260-105-0001)
100% GF (4260-101-0001)
COVID-19 Title XIX Increased FMAP (4260-101-0890)

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 113
IMPLEMENTATION DATE: 4/2004
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 78

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$233,064,000	$217,964,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$233,064,000	$217,964,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$233,064,000	$217,964,000

Purpose:
This policy change estimates the outpatient supplemental payments based on certified public expenditures (CPEs) for providing outpatient hospital care to Medi-Cal members.

Authority:
AB 915 (Chapter 747, Statutes of 2002)
State Plan Amendment (SPA) 02-018
SPA 16-019
SPA 22-0060

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 members. 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 members. The non-federal share used to draw down federal financial participation (FFP) is paid exclusively with funds from the participating facilities.

SPA 22-0060 was approved by the Centers for Medicare & Medicaid Services (CMS) on December 6, 2022, which updates the language to clarify Los Angeles County (LAC) hospitals' use of the relative value unit (RVU) system to apportion Medi-Cal hospital costs.

As a result of the COVID-19 national public health emergency, increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS
REGULAR POLICY CHANGE NUMBER: 113

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to:
- FY 2004-05 Non-LAC final reconciliations have shifted to FY 2025-26.
- FY 2018-19 LAC and Non-LAC final reconciliations have shifted to FY 2025-26.
- Revised FY 2022-23 Calendar Year Interim Payments based on updated actuals.
- Portion of FY 2022-23 payments originally scheduled to occur in FY 2023-24 were shifted to FY 2024-25.
- Revised FY 2023-24 Interim payments based on updated data.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to:
- Higher volume of final reconciliations are expected to occur in FY 2025-26 compared to FY 2024-25.
- Interim payments expected to increase in FY 2025-26 due to UC hospital acquisitions.

Methodology:
1. Payments of $233,064,000 and $217,964,000 are expected to be made in FY 2024-25 and FY 2025-26 respectively. These payments are based on CPE claims and are adjusted for the changes in the FMAP.

2. Final reconciliations are expected to begin in FY 2024-25.
   - Final reconciliations for LAC hospitals will be on a separate timeline from non-LAC hospitals.

3. The Affordable Care Act (ACA) allows for 100% FMAP for calendar years 2014 through 2016, for newly eligible Medi-Cal members. Beginning calendar year 2017, the ACA allows for the following FMAPs: 95% beginning on January 1, 2017, 94% beginning on January 1, 2018, 93% beginning on January 1, 2019, and 90% beginning on January 1, 2020.

4. Traditional and ACA claims are processed separately. Payments are based on CPE claims and ACA claims which are adjusted based on the FMAP methodology described above. FY 2023-24 and FY 2024-25 Traditional and ACA claims are estimated based on FY 2022-23 actuals that further adjusted the estimated percentage change in the Consumer Price Index for all Urban Consumers (CPI-U) for outpatient hospital services.

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 113

FY 2024-25	TF	FF	ACA	COVID-19 FF
FY 2011-12 (LAC Only Final Rec)	($2,991,000)	($2,991,000)	$0	$0
FY 2016-17 (Non-LAC Final Rec)	($3,329,000)	($1,822,000)	($1,507,000)	$0
FY 2017-18 (Non-LAC Final Rec)	($8,955,000)	($4,806,000)	($4,149,000)	$0
FY 2022-23 (Calendar Year) Interim Payments	$819,000	$456,000	$312,000	$51,000
FY 2022-23 Delayed Interim Payments	$1,346,000	$586,000	$689,000	$71,000
FY 2023-24 Interim Payments	$246,174,000	$132,700,000	$110,819,000	$2,655,000
Total	**$233,064,000**	**$124,123,000**	**$106,164,000**	**$2,777,000**

FY 2025-26	TF	FF	ACA	COVID-19 FF
FY 2004-05 (Non-LAC Final Rec)	($17,020,000)	($17,020,000)	$0	$0
FY 2005-06 (Non-LAC Final Rec)	($26,885,000)	($26,885,000)	$0	$0
FY 2013-14 (LAC Only Final Rec)	$1,880,000	$1,201,000	$679,000	$0
FY 2015-16 (LAC Only Final Rec)	($1,304,000)	($568,000)	($736,000)	$0
FY 2015-16 (Non-LAC Final Rec)	($6,387,000)	($3,731,000)	($2,656,000)	$0
FY 2018-19 (LAC Only Final Rec)	($696,000)	($254,000)	($442,000)	$0
FY 2018-19 (Non-LAC Final Rec)	($3,427,000)	($1,851,000)	($1,576,000)	$0
FY 2023-24 (Calendar Year) Interim Payments	$857,000	$491,000	$347,000	$19,000
FY 2024-25 Interim Payments	$270,946,000	$148,380,000	$122,566,000	$0
Total	**$217,964,000**	**$99,763,000**	**$118,182,000**	**$19,000**

Funding:
100% Title XIX FF (4260-101-0890)
100% Title XIX ACA FF (4260-101-0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)

FFP FOR LOCAL TRAUMA CENTERS

REGULAR POLICY CHANGE NUMBER: 114
IMPLEMENTATION DATE: 2/2006
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 104

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$144,174,000	$182,691,000
- STATE FUNDS	$65,239,500	$84,010,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$144,174,000	$182,691,000
STATE FUNDS	$65,239,500	$84,010,000
FEDERAL FUNDS	$78,934,500	$98,681,000

Purpose:
This policy change estimates the supplemental reimbursement to specific hospitals that provide trauma care to Medi-Cal members, through the use of Intergovernmental Transfers (IGTs).

Authority:
Welfare & Institutions Code, Sections 14164 and 14087.3
State Plan Amendment (SPA) 03-032
SPA 22-0026

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 members.

As a result of the COVID-19 national public health emergency, increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to:

- FY 2023-24 payments and Affordable Care Act (ACA) adjustments decreased due to updated estimates from the counties.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to:

- Higher estimated payments and ACA adjustments, due to higher county IGTs, to occur in FY 2025-26 as compared to FY 2024-25.

FFP FOR LOCAL TRAUMA CENTERS

REGULAR POLICY CHANGE NUMBER: 114

Methodology:

1. IGTs are deposited in the Special Deposit Fund (Local Trauma Centers).

2. ACA allows for 100% Federal Medical Assistance Percentage (FMAP) for calendar years 2014 through 2016, 95% FMAP for calendar year 2017, 94% FMAP for calendar year 2018 and 93% FMAP for calendar year 2019, and 90% for calendar year 2020 for newly eligible Medi-Cal members. The ACA methodology has been approved by the Centers for Medicare & Medicaid Services.

3. ACA payments will be processed nine months after the respective fiscal year's supplemental payments have been issued in order to determine the proportion of the hospital's trauma care costs for newly eligible Medi-Cal members. ACA payments for FY 2023-24 will be claimed in FY 2024-25 and ACA payments for FY 2024-25 will be claimed in FY 2025-26. The County will be reimbursed for the non-federal share, and an adjustment will be made for the federal share processed at the COVID-19 Increased FMAP 52.5% FMAP for FY 2023-24 Q1; 51.5% FMAP for FY 2023-24 Q2; and at the regular 50% FMAP for FY 2023-24 Q3 through FY 2024-25 Q4.

(Dollars in Thousands)

FY 2024-25	TF	Special Deposit Fund	FF	ACA FF	COVID-19 FF	*Return to Counties
FY 2023-24 ACA Adjustment to Counties	$11,033	$0	($14,145)	$25,461	($283)	$11,033
FY 2023-24	$133,141	$65,239	$66,571	$0	$1,331	$0
Total FY 2024-25	**$144,174**	**$65,239**	**$52,426**	**$25,461**	**$1,048**	$11,033

(Dollars in Thousands)

FY 2025-26	TF	Special Deposit Fund	FF	ACA FF	*Return to Counties
FY 2024-25 ACA Adjustment to Counties	$14,671	$0	($18,339)	$33,010	$14,671
FY 2024-25	$168,020	$84,010	$84,010	$0	$0
Total FY 2025-26	**$182,691**	**$84,010**	**$65,671**	**$33,010**	$14,671

*The Return to Counties column is for display purposes only (see Methodology #3).

Funding:

100% Local Trauma Centers Fund (4260-601-0942142)
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)
COVID-19 Title XIX Increased FFP (4260-101-0890)

DPH PHYSICIAN & NON-PHYS. COST

REGULAR POLICY CHANGE NUMBER: 115
IMPLEMENTATION DATE: 5/2008
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1078

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$120,572,000	$123,553,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$120,572,000	$123,553,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$120,572,000	$123,553,000

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
Welfare & Institutions Code 14166.4
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. Revisions to the “Physician and Non-Physician Practitioner Time Study Implementation Plan” were approved by CMS on September 1, 2020, which updated the language to reflect that in the event of a state of emergency, the alternate random moment time studies in the affected quarters will be statistically invalid.

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 members 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 using Medicaid

DPH PHYSICIAN & NON-PHYS. COST
REGULAR POLICY CHANGE NUMBER: 115

Management Information System data and 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.

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. SPA 24-0026, which is pending CMS approval, proposes to update the list of eligible hospital participants effective April 1, 2024.

As a result of the COVID-19 national public health emergency, increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to:

- The FY 2005-06 through FY 2007-08 final reconciliations and some final reconciliations for FY 2012-13 through FY 2019-20 for non-LA County DPHs have been shifted from FY 2023-24 to FY 2024-25,
- The FY 2019-20 final reconciliation for non-LA County DPHs has been added to the estimate for FY 2024-25,
- The FY 2011-12 final reconciliations for LA County have been shifted from FY 2023-24 to FY 2024-25, and
- FY 2022-23 interim reconciliations and FY 2024-25 interim payments for all DPHs have been updated based on revised payment calculations.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to fluctuations in the number of reconciliations and amounts each year.

Methodology:

1. One annual interim payment is expected to occur for all DPHs for in quarter 4 of each FY for the respective fiscal year.

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 was approved by CMS on August 17, 2021 and first time ACA payments were issue in FY 2021-22 Quarter 2. ACA payments will be retroactive to January 1, 2014. The ACA allows for 100% FMAP for calendar years (CYs) 2014 through 2016, 95% FMAP for CY 2017, 94% FMAP for CY 2018, 93% FMAP for CY 2019, and 90% FMAP for CY 2020 and after for newly eligible Medi-Cal members.

4. Reconciliation/final settlement of program years is anticipated to be completed upon conclusion of final audited settlements. Final reconciliations are subject to cost report audit schedules.

DPH PHYSICIAN & NON-PHYS. COST
REGULAR POLICY CHANGE NUMBER: 115

5. The Title XIX COVID-19 increased FMAP is assumed for final and interim reconciliations that fall within the increased FMAP time frame set forth in the Consolidated Appropriations Act of 2024.

FY 2024-25	TF	FF	ACA FF	COVID-19 FF
FY 2005-06 Final Reconciliation	($2,070,000)	($2,070,000)	$0	$0
FY 2006-07 Final Reconciliation	($2,032,000)	($2,032,000)	$0	$0
FY 2007-08 Final Reconciliation	($12,750,000)	($12,750,000)	$0	$0
FY 2008-09 Final Reconciliation	$7,569,000	$7,569,000	$0	$0
FY 2009-10 Final Reconciliation	($1,386,000)	($1,386,000)	$0	$0
FY 2010-11 Final Reconciliation	($6,507,000)	($6,507,000)	$0	$0
FY 2011-12 Final Reconciliation	($3,031,000)	($3,031,000)	$0	$0
FY 2012-13 Final Reconciliation	$6,900,000	$6,900,000	$0	$0
FY 2013-14 Final Reconciliation	($8,794,000)	($8,501,000)	($293,000)	$0
FY 2014-15 Final Reconciliation	($17,594,000)	($10,472,000)	($7,122,000)	$0
FY 2015-16 Final Reconciliation	($861,000)	($860,000)	($1,000)	$0
FY 2016-17 Final Reconciliation	$5,302,000	$5,302,000	$0	$0
FY 2017-18 Final Reconciliation	$2,320,000	$2,312,000	$8,000	$0
FY 2018-19 Final Reconciliation	($88,000)	($88,000)	$0	$0
FY 2019-20 Final Reconciliation	$4,380,000	$4,113,000	$12,000	$255,000
FY 2020-21 Final Reconciliation	$5,697,000	$6,265,000	($1,345,000)	$777,000
FY 2022-23 Interim Reconciliation	$74,360,000	($3,939,000)	$78,764,000	($465,000)
FY 2024-25 Interim Payment	$69,157,000	$69,157,000	$0	$0
Total	**$120,572,000**	**$49,982,000**	**$70,023,000**	**$567,000**

FY 2025-26	TF	FF	ACA FF	COVID-19 FF
FY 2015-16 Final Reconciliation	($9,514,000)	($7,755,000)	($1,759,000)	$0
FY 2016-17 Final Reconciliation	($11,064,000)	($10,018,000)	($1,046,000)	$0
FY 2017-18 Final Reconciliation	($3,639,000)	($3,200,000)	($439,000)	$0
FY 2018-19 Final Reconciliation	($3,177,000)	($1,355,000)	($1,822,000)	$0
FY 2021-22 Final Reconciliation	$5,697,000	$6,265,000	($1,345,000)	$777,000
FY 2023-24 Interim Reconciliation	$76,305,000	($5,780,000)	$82,188,000	($103,000)
FY 2025-26 Interim Payment	$68,945,000	$68,945,000	$0	$0
Total	**$123,553,000**	**$47,102,000**	**$75,777,000**	**$674,000**

Funding:
100% Title XIX FF (4260-101-0890)
100% Title XIX ACA FF (4260-101-0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)

MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 116
IMPLEMENTATION DATE: 11/2015
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 1899

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$116,334,000	$126,279,000
- STATE FUNDS	$50,093,000	$52,857,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$116,334,000	$126,279,000
STATE FUNDS	$50,093,000	$52,857,000
FEDERAL FUNDS	$66,241,000	$73,422,000

Purpose:
This policy change estimates the supplemental payments to Martin Luther King, Jr. – Los Angeles (MLK-LA) Healthcare Corporation, a private nonprofit hospital.

Authority:
SB 857 (Chapter 31, Statutes of 2014), Welfare & Institutions (W&I) Code 14165.50
State Plan Amendment (SPA) 18-0021
SPA 21-0012
SPA 23-0017

Interdependent Policy Changes:
Not Applicable

Background:
SB 857 requires specific funding requirements to facilitate the financial viability of MLK-LA, a private nonprofit hospital that serves the population of South Los Angeles. Pursuant to W&I Code 14165.50, the cost-based reimbursement methodology for Medi-Cal Fee-for-Service (FFS) and managed care payments to the 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 FY MLK-LA opens through FY 2016-17, the non-federal share of a guaranteed level (minimum payment level) of 77% of the total Medi-Cal FFS inpatient projected cost. If current Medi-Cal private hospital reimbursement methods result in funding that is less than 77% of the Medi-Cal FFS inpatient projected costs, GF appropriations are required to fund the non-federal share of the additional payments up to the 77% of costs.

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.

MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS
REGULAR POLICY CHANGE NUMBER: 116

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.

SPA 18-0021 capped payments at $115.2 million effective July 1, 2018. SPA 21-0012, which was approved by Center for Medicare and Medicaid Services (CMS) on July 16, 2021, increased the payment cap from $115.2 million to $123.1 million, effective July 1, 2021. SPA 23-0017, which was approved by CMS on August 29, 2023, decreased the payment cap from $123.1 million to $116.8 million, effective July 1, 2023. The $116.8 million total payment represents $100 million in supplemental payments and $16.8 million in Diagnosis Related Group (DRG) add-on payments. Effective July 1, 2024, the $116.8 million total payment represents $105.5 million in supplemental payments and $11.3 million in DRG add-on payments.

The reconciliation process may find an overpayment or underpayment to MLK-LA and will be handled as follows:

- For overpayments, MLK-LA will be subject to recovery of the payment for the amount exceeding the supplemental and DRG add-on payment cap and the amount of DRG add-on payments exceeding the minimum payment level based on actual costs.
- For underpayments, MLK-LA will receive an additional payment equal to the reconciled amount for DRG add-on payments needed to meet the minimum payment level, subject to the supplemental and DRG add-on payment cap.
- Reconciliations estimated in current year and budget year are subject to revisions based on updated data and audit reports, when applicable.

As a result of the COVID-19 national public health emergency, increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to:

- Updated FY 2024-25 supplemental payment due to updated methodology.
- Updated FY 2023-24 interim reconciliations based on updated data.
- Updated FY 2023-24 supplemental Affordable Care Act (ACA) adjustment based on updated data.
- Updated FY 2021-22 final reconciliations based on updated data.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to:

- Updated interim and final reconciliations, and
- Updated ACA payment data based on updated data.

Methodology:
1. Medi-Cal certification approval is retroactive to the effective date of June 30, 2015.

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2. DRG inpatient payments to MLK-LA were implemented beginning November 2015 for dates of service on or after July 1, 2015.

3. MLK-LA received the DRG statewide, wage adjusted, base rate.

4. Assume DRG payments and DRG add-on payments, if necessary, will be sufficient to reach the 72% minimum payment level for FY 2024-25 and FY 2025-26.

5. Expenditures for FY 2024-25 and FY 2025-26 costs up to 72% of total Medi-Cal FFS inpatient projected costs will be paid through DRG FFS payments which are incorporated in the FFS base.

6. Assume for FFS and supplemental payments, there are no Title XXI payments, based on updated MLK-LA payment data.

7. Supplemental payments are equal to the difference between MLK-LA's Medi-Cal FFS inpatient hospital charges and all amounts paid to MLK-LA by the Medi-Cal FFS inpatient hospital program per fiscal year. For FY 2024-25 and FY 2025-26, the supplemental payments and DRG add-on payments are limited by the payment cap of $116.8 million. FY 2024-25 and FY 2025-26 supplemental payments are estimated to be $105.5 million.

8. The ACA supplemental payments will be processed nine months after the respective FY's supplemental payments have been issued in order to determine the proportion of the costs for newly eligible Medi-Cal members. FY 2023-24 ACA supplemental payments will be claimed in FY 2024-25. For FY 2024-25, the ACA payment will be claimed in FY 2025-26. The County will be reimbursed for the IGT (non-federal share), and an adjustment will be made for the federal share processed at the regular 50% FMAP, including FFCRA increased FMAPs of 6.2%, 5%, 2.5%, and 1.5% when applicable. Beginning January 1, 2017, the ACA optional population FMAP is 95%, and reduces to 94% beginning January 1, 2018, and reduces again to 93% beginning January 1, 2019, and further reduces to 90% beginning January 1, 2020. CMS approved the ACA supplemental payment methodology in August 2017.

9. Managed care costs for MLK-LA are reflected in the Retro MC Rate Adjustment policy change.

10. On a cash basis, costs in FY 2024-25 and FY 2025-26 are expected to be:

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(Dollars in Thousands)

FY 2024-25	TF	GF	IGT*	FF	ACA FF	COVID-19 FF	Return to County**
Supplemental FY 2024-25	$105,500	$0	$52,750	$52,750	$0	$0	$0
Supplemental ACA FY 2023-24	$16,770	$0	$0	($21,500)	$38,700	($430)	$16,770
Interim Reconciliation FY 2023-24	($5,983)	($642)	($1,935)	($2,537)	($818)	($51)	$0
Final Reconciliation FY 2021-22	$47	$75	($155)	($125)	$268	($16)	$0
Total	**$116,334**	**($567)**	**$50,660**	**$28,588**	**$38,150**	**($497)**	$16,770

(Dollars in Thousands)

FY 2025-26	TF	GF	IGT*	FF	ACA FF	COVID-19 FF	Return to County**
Supplemental FY 2025-26	$105,500	$0	$52,750	$52,750	$0	$0	$0
Supplemental ACA FY 2024-25	$18,146	$0	$0	($22,683)	$40,829	$0	$18,146
Interim Reconciliation FY 2024-25	($4,352)	($499)	($1,400)	($1,829)	($624)	$0	$0
Final Reconciliation FY 2022-23	$6,985	($1,271)	$3,277	$1,917	$2,836	$226	$0
Total	**$126,279**	**($1,770)**	**$54,627**	**$30,155**	**$43,041**	**$226**	$18,146

**The Return to County column is for display purposes only (see methodology #8)

Funding:

50% Title XIX / 50% Reimbursement GF (4260-601-0995/4260-101-0890)*
100% Title XIX FF (4260-101-0890)
100% Title XIX ACA FF (4260-101-0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)
100% GF (4260-101-0001)

CAPITAL PROJECT DEBT REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 117
IMPLEMENTATION DATE: 7/1991
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 82

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$87,354,000	$91,283,000
- STATE FUNDS	$26,429,500	$26,353,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$87,354,000	$91,283,000
STATE FUNDS	$26,429,500	$26,353,000
FEDERAL FUNDS	$60,924,500	$64,930,000

Purpose:
This policy change estimates the Medi-Cal reimbursement for debt services incurred from the financing of capital construction projects.

Authority:
SB 1732 (Chapter 1635, Statutes of 1988)
SB 2665 (Chapter 1310, Statutes of 1990)
SB 1128 (Chapter 757, Statutes of 1999)
State Plan Amendment (SPA) 88-25
SPA 13-011

Interdependent Policy Changes:
Not Applicable

Background:
SB 1732 and SB 2665 authorized Medi-Cal reimbursement of revenue and general obligation bond debt for principal and interest costs incurred in the construction, renovation and replacement of qualifying disproportionate share contract hospitals. The Selective Provider Contracting Program (SPCP) ended June 30, 2013, due to the implementation of the Diagnosis Related Group payment methodology. The Centers for Medicare and Medicaid Services (CMS) approved 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.

As a result of the COVID-19 national public health emergency, increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the

CAPITAL PROJECT DEBT REIMBURSEMENT
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increased FMAP was only available through the end of Calendar Year 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to:
For hospitals (SB 1732):

- Updated interim payment amounts for FY 2023-24 and FY 2024-25 based on more recent data.
- Updated FY 2022-23 Affordable Care Act (ACA) adjustment amounts based on actuals.
- Updated FY 2021-22 interim reconciliation amounts based on more recent data.

For DP-NFs (SB 1128):

- Updated FY 2022-23 interim payment amounts based on actuals.
- Updated FY 2023-24 interim payment amounts based on more recent data.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to:
For hospitals (SB 1732):

- Increased interim payment expenditures in FY 2025-26 due to higher reimbursable debt service amounts; and
- Increased interim reconciliation expenditures occurring in FY 2025-26 because the difference between the final Medicaid Utilization Rate (MUR) and the interim MUR is expected to be higher for FY 2022-23 than FY 2021-22.

For DP-NFs (SB 1128):

- Increased interim payment expenditures are estimated in FY 2025-26 due to higher reimbursable debt service amounts.

Methodology:

1. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's FMAP increased from 50% to 61.59% for dates of service (DOS) 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 DOS January 1, 2011, through March 31, 2011, and 56.88% for DOS 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 FMAP for newly eligible Medi-Cal members.

3. For SB 1732, ACA payments will be processed one year after the respective fiscal year has closed in order to determine the proportion of the hospital's costs for newly eligible Medi-Cal members. FY 2022-23 and FY 2023-24 ACA supplemental payments will be claimed in FY 2024-25 and FY 2025-26, respectively. The General Fund (GF) will be reimbursed for the non-federal share, and an adjustment will be made for the federal share processed at the applicable FMAP percentages.

4. For SB 1732, capital projects funded by new debt for which final plans were submitted to the Office of the Statewide Architect and the Office of Statewide Health Planning and Development after September 1, 1988, and prior to June 30, 1994, are eligible for this program.

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Once the debt service for a project is paid in full, the hospital's interim supplemental payments and interim reconciliation will be reconciled using the final MUR data. If during the final reconciliation, it is determined that the eligible hospital has been overpaid, the hospital will repay the Medi-Cal program the overpayment amount. If it is determined that the eligible hospital has been underpaid, the hospital will receive an adjusted supplemental payment amount.

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5. The estimated payments on a cash basis are:

FY 2024-25	TF	GF	FF	COVID-19 FF	ARRA	ACA
Hospitals (SB 1732)						
Interim Payment						
FY 2023-24	$43,265,000	$21,592,000	$21,632,000	$41,000	$0	$0
FY 2024-25	$32,530,000	$16,265,000	$16,265,000	$0	$0	$0
ACA Adjustment						
FY 2022-23	$0	($10,822,000)	($15,793,000)	($1,812,000)	$0	$28,427,000
Interim Reconciliation						
FY 2021-22	($2,023,000)	($536,000)	($493,000)	($61,000)	$0	($933,000)
Final Reconciliation						
FY 2003-04 to FY 2021-22	($212,000)	($69,000)	($103,000)	$0	($40,000)	$0
DP-NF (SB 1128)						
Interim Payment						
FY 2022-23	$163,000	$0	$148,000	$15,000	$0	$0
FY 2023-24	$13,631,000	$0	$13,361,000	$270,000	$0	$0
Total FY 2024-25	**$87,354,000**	**$26,430,000**	**$35,017,000**	**($1,547,000)**	**($40,000)**	**$27,494,000**

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FY 2025-26	TF	GF	FF	COVID-19 FF	ARRA	ACA
Hospitals (SB 1732)						
Interim Payment						
FY 2024-25	$44,526,000	$22,263,000	$22,263,000	$0	$0	$0
FY 2025-26	$32,500,000	$16,250,000	$16,250,000	$0	$0	$0
ACA Adjustment						
FY 2023-24	$0	($12,167,000)	($15,541,000)	($265,000)	$0	$27,973,000
Interim Reconciliation						
FY 2022-23	$678,000	$165,000	$202,000	$65,000	$0	$246,000
Final Reconciliation						
FY 1997-98 to FY 2022-23	($261,000)	($158,000)	($101,000)	$0	($2,000)	$0
DP-NF (SB 1128)						
Interim Payment						
FY 2023-24	$210,000	$0	$210,000	$0	$0	$0
FY 2024-25	$13,630,000	$0	$13,630,000	$0	$0	$0
Total FY 2025-26	**$91,283,000**	**$26,353,000**	**$36,913,000**	**($200,000)**	**($2,000)**	**$28,219,000**

Funding:
100% Title XIX (4260-101-0890)
50% Title XIX Capital Debt FFP / 50% GF (4260-102-0001/0890)
100% GF Capital Debt (4260-102-0001)
100% Title XIX Capital Debt FFP (4260-102-0890)
100% Title XIX ACA (4260-101-0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)

CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS

REGULAR POLICY CHANGE NUMBER: 118
IMPLEMENTATION DATE: 6/2002
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 86

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$61,315,000	$26,513,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$61,315,000	$26,513,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$61,315,000	$26,513,000

Purpose:
This policy change estimates federal financial participation (FFP) payments based on Certified Public Expenditures (CPE) to nursing facilities (NF) that are distinct parts (DP) of acute care hospitals that are owned or operated by a public entity.

Authority:
AB 430 (Chapter 171, Statutes of 2001)
State Plan Amendment (SPA) 01-022
SPA 12-021

Interdependent Policy Changes:
Not Applicable

Background:
DP-NFs are allowed to claim FFP on the difference between their actual costs and the amount Medi-Cal currently pays. The acute care hospital must be owned and operated by a public entity, such as a city, city and county, or health care district. In addition, the acute care hospital must meet specified requirements and provide skilled nursing services to Medi-Cal members.

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 Centers for Medicare & Medicaid Services (CMS) approval on December 20, 2013, to prospectively exempt DP-NF Level B providers from the 10% payment reduction effective September 1, 2013, for providers located in designated rural and frontier areas. The remaining DP-NF Level B providers are exempt from the 10% payment reduction effective October 1, 2013, pursuant to the provisions of SB 239 (Chapter 657, Statutes of 2013).

ABX2 1 (Chapter 3, Statutes of 2016) prohibits the Department from seeking to retroactively implement certain Medi-Cal provider base payment reductions and limitations with regards to reimbursements for services provided by skilled nursing facilities that are distinct parts of

CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS
REGULAR POLICY CHANGE NUMBER: 118

general acute care hospitals for dates of service on or after June 1, 2011, and on or before September 30, 2013, and from seeking to recoup overpayments of the base rate. This prohibition does not apply to supplemental payments for skilled nursing services nor the recoupment of such supplemental funds.

As a result of the COVID-19 national public health emergency, increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year (CY) 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to:
- Rate Year (RY) 2022-23 interim payments revised based on actuals.
- RY 2022-23 interim reconciliations revised based on actuals.
- CY 2024 interim payments revised based on updated data.
- Addition of RY 2021-22 interim payments revised based on actuals.
- Addition of 2023 Bridge Period (August 2023 – December 2023) interim payments revised based on actuals.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to:
- Delayed interim payments for prior rate years occurring in FY 2024-25 compared to FY 2025-26.
- Decreased expenditures expected in FY 2025-26 compared to FY 2024-25 due to the transition from Fee-For-Service to Managed Care.

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 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. Affordable Care Act (ACA) allows for 100% FMAP for calendar years 2014 through 2016, for newly eligible Medi-Cal members. Beginning calendar year 2017, FMAP for ACA population allows for the following: 95% beginning on January 1, 2017, 94% beginning on January 1, 2018, and 93% beginning January 1, 2019, to draw the enhanced FMAP under this program was approved by CMS in 2017.

   Assume a portion of the interim ACA payments for the three most recent RYs will occur in FY 2024-25 and two most recent rate years will occur in FY 2025-26.

4. Assume a portion of the interim payments for the three most recent RYs will occur in FY 2024-25 and two most recent RYs will occur in FY 2025-26.

CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS

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FY 2024-25	TF	Regular FFP	ACA FF	COVID-19 FF
RY 2022/23 Interim Reconciliation	$38,377,000	$30,083,000	$4,458,000	$3,836,000
RY 2022/23 Interim Payments	$4,485,000	$3,115,000	$990,000	$380,000
RY 2021/22 Interim Payments	$865,000	$571,000	$223,000	$71,000
2023 Bridge Period Interim Payments	$3,086,000	$2,888,000	$87,000	$111,000
RY 2019/20 Final Reconciliation	($2,918,000)	($2,481,000)	($360,000)	($77,000)
CY 2024 Interim Payments	$17,420,000	$14,163,000	$3,257,000	$0
Total	**$61,315,000**	**$48,339,000**	**$8,655,000**	**$4,321,000**

FY 2025-26	TF	Regular FFP	ACA FF	COVID-19 FF
CY 2025 Interim Payments	$17,421,000	$14,164,000	$3,257,000	$0
CY 2024 Interim Payments Q1 & Q2	$1,141,000	$964,000	$177,000	$0
2023 Bridge Period Interim Reconciliation	$5,461,000	$4,597,000	$776,000	$88,000
RY 2020/21 Final Reconciliation	($2,883,000)	($2,465,000)	($341,000)	($77,000)
CY 2024 Interim Reconciliation Q1 & Q2	$5,373,000	$4,597,000	$776,000	$0
Total	**$26,513,000**	**$21,857,000**	**$4,645,000**	**$11,000**

Funding:
100% Title XIX FF (4260-101-0890)
100% Title XIX ACA FF (4260-101-0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)

NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 119
IMPLEMENTATION DATE: 2/2023
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 2185

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$52,500,000	$0
- STATE FUNDS	$26,250,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$52,500,000	$0
STATE FUNDS	$26,250,000	$0
FEDERAL FUNDS	$26,250,000	$0

Purpose:
This policy change (PC) estimates the cost of the Non-Hospital 340B Clinics Supplemental Payment Pool.

Authority:
Welfare & Institutions Code Section 14105.467
State Plan Amendment 21-0015

Interdependent Policy Change:
Not Applicable

Background:
On January 7, 2019, the Governor issued Executive Order N-01-19, which required the Department to transition Medi-Cal pharmacy from Managed Care (MC) to Fee-for-Service (FFS) through Medi-Cal Rx. The Medi-Cal Rx Assumption of Operations (AOO) began January 1, 2022.

Non-hospital 340B clinics that previously received reimbursement from MC plans for pharmacy services now bill Medi-Cal at their acquisition cost, which has resulted in cost savings to the State. To mitigate the revenue impact to these 340B clinics, the Department has created a supplemental payment pool.

Supplemental payments are provided to non-hospital 340B clinics. These payments support their overall safety net services that might otherwise be limited or eliminated due to the change in billing to a FFS delivery system.

Per Welfare and Institution Code Section 14105.467, the Department convened a stakeholder workgroup to develop the methodology for the distribution of supplemental pool payments to qualifying non-hospital 340B community clinics. The workgroup topics include the eligibility criteria for receipt of supplemental payments, the aggregate amount of pool funding available in a respective fiscal year, and the criteria for apportioning the pool funding among qualifying non-

NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS
REGULAR POLICY CHANGE NUMBER: 119

hospital 340B community clinics including the timing, frequency, and amount of the resultant supplemental payments.

Welfare and Institution Code section 14105.468 authorized the Department to establish and implement a directed payment program in the Managed Care delivery system for qualifying non-hospital 340B community clinics effective January 1, 2025. The managed care directed payments for non-hospital 340B clinics will replace the current FFS supplemental payments for service dates after December 31, 2024, and costs will be reflected in the Non-Hospital 340B Clinic Directed Payments policy change.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to assuming six months of payments rather than a full year of payments as a result of the 340B supplemental payment program transitioning to a directed payment program effective January 1, 2025.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to assuming no FFS payments in FY 2025-26 as a result of the 340B supplemental payment program transitioning to a directed payment program effective January 1, 2025.

Methodology:
1. The estimated Non-Hospital 340B Clinic Supplemental Payment Pool annual cost is $105,000,000 TF. The annual costs will end after December 2024.

(Dollars in Thousands)

Annual	TF	GF	FF
Non-hospital 340B Clinic Supplemental Payments	$105,000	$52,500	$52,500
Total	**$105,000**	**$52,500**	**$52,500**

2. The estimated cost in FY 2024-25 is $52,500,000 TF.

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
Non-hospital 340B Clinic Supplemental Payments	$52,500	$26,250	$26,250
Total	**$52,500**	**$26,250**	**$26,250**

Funding:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF	$52,500	$26,250	$26,250
Total	**$52,500**	**$26,250**	**$26,250**

NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 120
IMPLEMENTATION DATE: 10/2013
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 1600

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$52,164,000	$53,938,000
- STATE FUNDS	$26,391,000	$23,780,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$52,164,000	$53,938,000
STATE FUNDS	$26,391,000	$23,780,000
FEDERAL FUNDS	$25,773,000	$30,158,000

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)
State Plan Amendment (SPA) 10-026
SPA 16-015

Interdependent Policy Changes:
Not Applicable

Background:
AB 113 established a NDPH supplemental payment program funded by intergovernmental transfers (IGTs). AB 113 authorizes the State to retain 9% 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 9% 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 1st of each State fiscal year.

As a result of the COVID-19 national public health emergency, increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

NDPH IGT SUPPLEMENTAL PAYMENTS
REGULAR POLICY CHANGE NUMBER: 120

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to:

- The FY 2023-24 UPL was not approved when interim payments were issued; therefore, FY 2023-24 interim payments will be reconciled to the approved FY 2023-24 UPL. The FY 2023-24 Affordable Care Act (ACA) adjustment will now be a part of the payment finalization.
- FY 2023-24 General Funds Transfer for the benefit of Children's Services updated based on more recent data; and
- FY 2024-25 interim payments updated based on more recent data.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to:

- FY 2024-25 ACA adjustments expected to occur in FY 2025-26 which has higher expenditures than the FY 2023-24 payment finalizations occurring in FY 2024-25 because the payment finalizations will reconcile interim payments to an approved UPL, resulting in Traditional population recoupments, where ACA adjustments will not.

Methodology:

1. The NDPH IGT supplemental payments program is a formula-based program which depends on the UPL's available room. The available room is then applied to the formula to determine the supplemental payments, the administrative costs of operating the program, and the benefit of Medi-Cal's children's health programs.

2. The FY 2023-24 UPL was submitted to CMS in 2023-24 Q4 and the FY 2024-25 UPL will be subsequently submitted.

3. ACA allows for 100% FMAP for calendar years 2014 through 2016, for newly eligible Medi-Cal members. The ACA methodology has been approved. Beginning on January 1, 2017, FMAP for the ACA population decreases to 95%, 94% beginning on January 1, 2018, 93% beginning on January 1, 2019, and then 90% beginning on January 1, 2020, for all subsequent years.

4. FY 2023-24 interim supplemental payments were processed using 80% of the approved UPL room from FY 2022-23 which was the last approved UPL at the date of payment. Payment finalizations for FY 2023-24 will occur in FY 2024-25. FY 2024-25 and FY 2025-26 interim payment estimates assumes that the respective fiscal year's UPL will be approved prior to interim supplemental payments being processed. For the purpose of this estimate, FY 2023-24 payment finalizations and FY 2024-25 and FY 2025-26 interim payments utilized the tentative FY 2023-24 UPL room, which is subject to change and CMS approval.

5. ACA payments will be processed nine months after the respective fiscal year's supplemental payments have been issued in order to determine the proportion of the costs for newly eligible Medi-Cal members. FY 2023-24 ACA supplemental payments will be claimed in FY 2024-25, and FY 2024-25 ACA supplemental payments will be claimed in FY 2025-26. An adjustment will be made for the federal share processed at the COVID-19 Increased 52.5% FMAP for FY 2023-24 Q1, 51.5% FMAP for FY 2023-24 Q2, and 50% FMAP for FY 2023-24 Q3 through FY 2024-25 Q4.

6. FY 2023-24 Children's Services amounts that were collected based on the interim payments for the respective fiscal year will be reconciled to the respective fiscal year's approved UPL

NDPH IGT SUPPLEMENTAL PAYMENTS
REGULAR POLICY CHANGE NUMBER: 120

room and processed in FY 2024-25. FY 2024-25 Children's Services payments will be processed based on the FY 2024-25 UPL in FY 2025-26.

7. The estimated NDPH IGT supplemental payments are:

(Dollars in Thousands)

FY 2024-25	TF	GF	IGT	FF	ACA	COVID-19 FF	***Return to NDPHs
FY 2023-24 Payment Finalization	$3,588	$0	$1,595	($12,117)	$14,352	($242)	$0
FY 2023-24 Children's Services (Est.)	$1,016	($1,595)	$2,611	$0	$0	$0	$0
FY 2024-25 Interim Payments*	$47,560	$0	$23,780	$23,780	$0	$0	$0
Total FY 2024-25	**$52,164**	**($1,595)**	**$27,986**	**$11,663**	**$14,352**	**($242)**	$0

(Dollars in Thousands)

FY 2025-26	TF	GF	IGT	FF	ACA	***Return to NDPHs
FY 2024-25 ACA Adjustments	$6,378	$0	$0	($7,974)	$14,352	$6,378
FY 2024-25 Children's Services (Est.)	$0	($1,595)	$1,595	$0	$0	$0
FY 2025-26 Interim Payments*	$47,560	$0	$23,780	$23,780	$0	$0
Total FY 2025-26	**$53,938**	**($1,595)**	**$25,375**	**$15,806**	**$14,352**	$6,378

***The Return to NDPHs column is for display purposes only.

Funding:
50% Medi-Cal Inpatient Payment Adjustment Fund (MIPA) (4260-606-0834)*
50% Title XIX (4260-101-0890)*
100% GF (4260-101-0001)
100% Title XIX FF (4260-101-0890)
100% Title XIX ACA (4260-101-0890)
100% MIPA (4260-606-0834)
COVID-19 Title XIX Increased FFP (4260-101-0890)

PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 121
IMPLEMENTATION DATE: 1/2018
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2049

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$788,999,000	$880,840,000
- STATE FUNDS	$320,030,700	$357,084,150
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	94.19 %	94.79 %
APPLIED TO BASE		
TOTAL FUNDS	$45,840,800	$45,891,800
STATE FUNDS	$18,593,780	$18,604,080
FEDERAL FUNDS	$27,247,060	$27,287,680

Purpose:
This policy change estimates the expenditures related to providing supplemental payments for specific dental services.

Authority:
Budget Act of 2021
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Proposition 56 Funding

Background:
The California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56, 2016), increased the excise tax rate on cigarettes and tobacco products and allocates a portion of the tobacco tax revenue to the Department for use as the non-federal share of health care expenditures, subject to appropriation by the Legislature.

The Budget Act of 2017 allocated Proposition 56 funds for supplemental payments for dental services. The Legislature has continued this funding in subsequent budget acts.

These supplemental payments for specific dental categories include restorative, endodontic, prosthodontic, oral and maxillofacial, adjunctive, orthodontic, periodontal, preventative and visits and diagnostic services. For FY 2018-19 and FY 2019-20, the supplemental payment rates for the existing categories remain at a rate equal to 40 percent of the Schedule of Maximum Allowances (SMA). Effective July 1, 2018, SB 840 appropriated additional funds to allow for an increase in supplemental payments ranging from 20-60% and specified dollar amounts for specific procedures, and the addition of other dental procedures.

This policy change identifies the use of the General Fund for these Proposition 56 payments. See the Proposition 56 Funding policy change for the Proposition 56 offset to the GF.

PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 121

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a decrease due to updated check write projections. The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to updated managed care rates and check write projections.

Methodology:
1. Payments are made via supplemental payments.

2. This policy was effective on July 1, 2017. Beginning July 1, 2018, the Department made changes to add additional procedures and changed the supplemental amount for specific procedures.

3. Supplemental payments are either a percentage of the Dental SMA or a flat rate.

4. Funds allocated for the supplemental payments are as follows:

FY 2024-25	TF	SF	FF
Fee-for-Service			
50% Title XIX / 50% GF	$441,545,000	$220,773,000	$220,773,000
ACA 90% FFP/10% GF	$189,161,000	$18,916,000	$170,245,000
Title 21 65% FFP/35% GF	$80,671,000	$28,235,000	$52,436,000
UIS 100% State GF	$31,764,000	$31,764,000	$0
Total Fee-for-Service	**$743,141,000**	**$299,688,000**	**$443,454,000**
FY 2024-25	**TF**	**SF**	**FF**
Dental Managed Care			
50% Title XIX / 50% GF	$25,238,000	$12,619,000	$12,619,000
ACA 90% FFP/10% GF	$12,399,000	$1,240,000	$11,159,000
Title 21 65% FFP/35% GF	$2,672,000	$935,000	$1,737,000
UIS 100% State GF	$5,548,000	$5,548,000	$0
Total Dental Managed Care	**$45,857,000**	**$20,342,000**	**$25,515,000**
Combined FY 2024-25			
50% Title XIX / 50% GF	$466,784,000	$233,392,000	$233,392,000
ACA 90% FFP/10% GF	$201,560,000	$20,156,000	$181,404,000
Title 21 65% FFP/35% GF	$83,342,000	$29,170,000	$54,172,000
UIS 100% State GF	$37,313,000	$37,313,000	$0
Grand Total	**$788,999,000**	**$320,031,000**	**$468,968,000**

PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 121

FY 2025-26	TF	SF	FF
Fee-for-Service			
50% Title XIX / 50% GF	$496,101,000	$248,051,000	$248,051,000
ACA 90% FFP/10% GF	$212,533,000	$21,253,000	$191,280,000
Title 21 65% FFP/35% GF	$90,638,000	$31,723,000	$58,915,000
UIS 100% State GF	$35,689,000	$35,689,000	$0
Total Fee-for-Service	**$834,961,000**	**$336,716,000**	**$498,246,000**
FY 2025-26	**TF**	**SF**	**FF**
Dental Managed Care			
50% Title XIX / 50% GF	$25,234,000	$12,617,000	$12,617,000
ACA 90% FFP/10% GF	$12,397,000	$1,240,000	$11,157,000
Title 21 65% FFP/35% GF	$2,671,000	$935,000	$1,736,000
UIS 100% State GF	$5,576,000	$5,576,000	$0
Total Dental Managed Care	**$45,878,000**	**$20,368,000**	**$25,510,000**
Combined FY 2025-26			
50% Title XIX / 50% GF	$521,336,000	$260,668,000	$260,668,000
ACA 90% FFP/10% GF	$224,930,000	$22,493,000	$202,437,000
Title 21 65% FFP/35% GF	$93,309,000	$32,658,000	$60,651,000
UIS 100% State GF	$41,265,000	$41,265,000	$0
Grand Total	**$880,840,000**	**$357,084,000**	**$523,756,000**

Funding:
50% Title XIX / 50% GF (4260-101-0890/0001)
90% ACA Title XIX FF / 10% GF (4260-101-0890/0001)
65% Title XXI / 35% GF (4260-101-0890/0001)
100% State GF (4260-101-0001)

STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 122
IMPLEMENTATION DATE: 12/2010
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 1616

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$16,326,000	$16,016,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$16,326,000	$16,016,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$16,326,000	$16,016,000

Purpose:
This policy change estimates the supplemental payments to state veterans' homes.

Authority:
AB 959 (Chapter 162, Statutes of 2006)
State Plan Amendment 06-017

Interdependent Policy Changes:
Not Applicable

Background:
Under this program, state veterans' homes that are enrolled as Medi-Cal providers and are owned and operated by the State are eligible to receive supplemental payments. Eligible state veterans' homes may submit interim claims for federal financial participation (FFP) on the difference between their projected costs and the amount Medi-Cal pays under the program. Interim claims are subject to initial and final reconciliation. 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.

As a result of the COVID-19 national public health emergency, increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 122

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to:

- Updated estimated FY 2024-25 interim payments based on FY 2023-24 actuals with an 8% increase based on historical, annual per diem rate increases.
- Updated estimated FY 2023-24 initial reconciliation based on based on FY 2021-22 certified public expenditures (CPE) actuals and FY 2022-23 CPE actuals.
- Updated FY 2020-21 final reconciliations based on revised Affordable Care Act (ACA) calculations.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to:

- Increased interim payments occurring in FY 2025-26 based on updated data.
- Lower initial reconciliation payments estimated to occur in FY 2025-26 based on updated data.
- Larger final reconciliation overpayments estimated to occur in FY 2025-26 based on updated data.

Methodology:
Supplemental payments for state veterans' homes began in FY 2010-11 and payments are estimated based on actual historical reported certified expenditures.

The estimate is based on:

1. Interim payments,
2. Initial reconciliation payments,
    a. First time (interim) ACA payments occur during initial reconciliations using as filed cost report data to calculate payments, and;
3. A final reconciliation payment, if necessary.

STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 122

Program payment amounts are estimated to be:

FY 2024-25	TF	Regular FF	ACA FF	COVID-19 FF
Interim Payments				
FY 2024-25	$14,506,000	$14,506,000	$0	$0
Initial Reconciliation				
FY 2023-24	$2,816,000	$1,601,000	$1,165,000	$50,000
Final Reconciliation				
FY 2020-21	($996,000)	($853,000)	($37,000)	($106,000)
FY 2024-25 Total	**$16,326,000**	**$15,254,000**	**$1,128,000**	**($56,000)**

FY 2025-26	TF	Regular FF	ACA FF	COVID-19 FF
Interim Payments				
FY 2025-26	$15,697,000	$15,697,000	$0	$0
Initial Reconciliation				
FY 2024-25	$1,634,000	$537,000	$1,097,000	$0
Final Reconciliation				
FY 2021-22	($1,315,000)	($1,122,000)	($54,000)	($139,000)
FY 2025-26 Total	**$16,016,000**	**$15,112,000**	**$1,043,000**	**($139,000)**

Funding:
100% Title XIX FF (4260-101-0890)
100% Title XIX ACA FF (4260-101-0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH

REGULAR POLICY CHANGE NUMBER: 123
IMPLEMENTATION DATE: 1/2005
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 1038

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$10,000,000	$10,000,000
- STATE FUNDS	$5,000,000	$5,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$10,000,000	$10,000,000
STATE FUNDS	$5,000,000	$5,000,000
FEDERAL FUNDS	$5,000,000	$5,000,000

Purpose:
This policy change estimates the supplemental reimbursement to hospitals providing a disproportionate share of outpatient services.

Authority:
SB 2563 (Chapter 976, Statutes of 1988)

Interdependent Policy Changes:
Not Applicable

Background:
SB 2563 established a supplemental program for hospitals providing a disproportionate share of outpatient services. The Department calculates payments on a calendar year (CY) basis and reimburses eligible providers on a quarterly basis through a payment action notice. Each payment represents one quarter of the total annual amount due to each eligible hospital. Due to the payment being made at the end of a quarter, the last quarter of each calendar year will be paid the following calendar year.

Reason for Change:
There is no change in FY 2024-25, from the prior estimate.

There is no change from FY 2024-25 to FY 2025-26, in the current estimate.

Methodology:
1. Assume annual reimbursements for disproportionate share of outpatient services are $10,000,000 Total Fund (TF).

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH

REGULAR POLICY CHANGE NUMBER: 123

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
CY 2024	$7,500	$3,750	$3,750
CY 2025	$2,500	$1,250	$1,250
Total	**$10,000**	**$5,000**	**$5,000**

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
CY 2025	$7,500	$3,750	$3,750
CY 2026	$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: 124
IMPLEMENTATION DATE: 1/2005
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 1039

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$8,000,000	$8,000,000
- STATE FUNDS	$4,000,000	$4,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$8,000,000	$8,000,000
STATE FUNDS	$4,000,000	$4,000,000
FEDERAL FUNDS	$4,000,000	$4,000,000

Purpose:
This policy change estimates the supplemental reimbursement to Small and Rural Hospitals (SRHs) that provide outpatient services.

Authority:
AB 2617 (Chapter 158, Statutes of 2000)

Interdependent Policy Changes:
Not Applicable

Background:
This program provides eligible SRHs with supplemental reimbursement for outpatient services. The Department calculates payments on a calendar year (CY) basis and reimburses eligible providers on a quarterly basis through a payment action notice. Each payment represents one quarter of the total annual amount due to each eligible hospital. Due to the payment being made at the end of a quarter, the last quarter of each calendar year will be paid the following calendar year.

Reason for Change:
There is no change in FY 2024-25, from the prior estimate.

There is no change from FY 2024-25 to FY 2025-26, in the current estimate.

Methodology:
1. Assume annual reimbursements to SRHs providing outpatient services are $8,000,000 Total Fund (TF).

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH

REGULAR POLICY CHANGE NUMBER: 124

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
CY 2024	$6,000	$3,000	$3,000
CY 2025	$2,000	$1,000	$1,000
Total	**$8,000**	**$4,000**	**$4,000**

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
CY 2025	$6,000	$3,000	$3,000
CY 2026	$2,000	$1,000	$1,000
Total	**$8,000**	**$4,000**	**$4,000**

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

PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 125
IMPLEMENTATION DATE: 12/2017
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 2044

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$56,728,000	$56,881,000
- STATE FUNDS	$24,451,000	$24,670,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	89.51 %	89.01 %
APPLIED TO BASE		
TOTAL FUNDS	$5,950,800	$6,251,200
STATE FUNDS	$2,564,910	$2,711,230
FEDERAL FUNDS	$3,385,860	$3,539,990

Purpose:
This policy change estimates the expenditures related to supplemental reimbursements under the Family Planning, Access, Care, Treatment (Family PACT) program for the Evaluation and Management (E&M) portion of office visits and medical pregnancy termination services.

Authority:
Proposition 56 (2016)

Interdependent Policy Changes:
Proposition 56 Funding
SPA 17-029
SPA 18-0031
SPA 19-0040
SPA 21-0033

Background:
The California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56, 2016), increased the excise tax rate on cigarettes and tobacco products and allocates a portion of the tobacco tax revenue to the Department for use as the non-federal share of health care expenditures, subject to appropriation by the Legislature.

The Budget Act of 2017 allocated Proposition 56 funds for supplemental payments for supplemental reimbursements under the Family PACT program. The Legislature has continued this funding in subsequent budget acts.

The Centers for Medicare and Medicaid Services (CMS) approved State Plan Amendment (SPA) 17-029 on November 30, 2017. The SPA authorized time-limited supplemental reimbursements, at a rate equal to 150 percent of the current Family PACT rates, to Family PACT providers for E&M office visits rendered for comprehensive family planning services. The effective date for this SPA was July 1, 2017, with an end date of June 30, 2018. On September 5, 2018, CMS approved SPA 18-0031, which extended the supplemental reimbursements under Family PACT for the period of July 1, 2018, through June 30, 2019. On August 20, 2019, CMS

PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS
REGULAR POLICY CHANGE NUMBER: 125

approved SPA 19-0040, which extended the supplemental reimbursements under Family PACT for the period of July 1, 2019, through December 31, 2021. On October 13, 2021, SPA 21-0033 was submitted to CMS to extend the supplemental reimbursements under Family PACT indefinitely.

This policy change identifies the use of the General Fund (GF) for these Proposition 56 payments. See the Proposition 56 Funding policy change for the Proposition 56 offset to the GF.

Reason for Change:
The change for FY 2024-25, from the prior estimate, is a decrease due to Family PACT users transitioning to Medi-Cal because of the full-scope expansion occurring on January 1, 2024. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a slight increase due to projecting growth from FY 2024-25 to FY 2025-26 for Family PACT expenditures.

Methodology:
1. Payments will be made via fee-for-service supplemental payments and increased managed care capitation payments.

2. This policy became effective July 1, 2017; however, payments began for pregnancy termination supplemental payments in December 2017, and for E&M office visit supplemental payments in January 2018.

3. Estimated expenditures on a cash basis are as follows:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
Managed Care			
E&M Office Visits	$0	$0	$0
Medical Pregnancy Termination	$5,953	$5,953	$0
Fee-For-Service			
E&M Office Visits	$49,356	$17,078	$32,278
Medical Pregnancy Termination	$1,420	$1,420	$0
Total	**$56,728**	**$24,451**	**$32,278**

PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 125

FY 2025-26	TF	GF	FF
Managed Care			
E&M Office Visits	$0	$0	$0
Medical Pregnancy Termination	$6,254	$6,254	$0
Fee-For-Service			
E&M Office Visits	$49,253	$17,043	$32,211
Medical Pregnancy Termination	$1,374	$1,374	$0
Total	**$56,881**	**$24,671**	**$32,211**

*Totals may differ due to rounding.

Funding:
90% Title XIX / 10% GF (4260-101-0890/0001)
100% GF (4260-101-0001)

NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 126
IMPLEMENTATION DATE: 7/2005
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 1076

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$4,207,000	$16,479,000
- STATE FUNDS	$1,900,000	$8,031,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$4,207,000	$16,479,000
STATE FUNDS	$1,900,000	$8,031,000
FEDERAL FUNDS	$2,307,000	$8,448,000

Purpose:
This policy change estimates the supplemental payments made to Non-Designated Public Hospitals (NDPHs).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.17
State Plan Amendment (SPA) 14-009
SPA 15-004
SPA 16-031
SPA 18-017
SPA 19-0024
SPA 20-0013
SPA 21-0013
SPA 22-0025
SPA 23-0016
SPA 24-0014

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 for NDPHs on January 1, 2014, SPAs were required to continue the NDPH Supplemental Program and secure distributions from

NDPH SUPPLEMENTAL PAYMENT
REGULAR POLICY CHANGE NUMBER: 126

the NDPH Supplemental Fund. The Department received SPA approvals from the Centers for Medicare and Medicaid Services (CMS) to continue the NDPH Supplemental Program for FY 2016-17 through FY 2023-24. The most recent SPA 24-0014, was approved by CMS on July 16, 2024, to continue the NDPH Supplemental Program through June 30, 2025.

As a result of the COVID-19 national public health emergency, increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to:

- FY 2023-24 Affordable Care Act (ACA) adjustments updated based on more recent ACA data.
- FY 2024-25 cash expenditures to hospitals decreased due the distribution of retroactive carryover funds being shifted from FY 2024-25 to FY 2025-26.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to higher expenditures occurring in FY 2025-26 compared to FY 2024-25 due to the distribution of retroactive carryover funds.

Methodology:

1. The State Funds (SF) item includes the annual GF 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 GF to the NDPH Supplemental Fund to be used for the non-federal share of payments.

3. The ACA allows for 100% FMAP for calendar years 2014 through 2016 for newly eligible Medi-Cal beneficiaries. Beginning January 1, 2017, the ACA optional population FMAP is 95%, and reduces to 94% beginning January 1, 2018. Beginning January 1, 2019, the ACA optional population FMAP reduces to 93%, and further reduces to 90% beginning January 1, 2020. The ACA methodology to draw the enhanced FMAP has been approved by CMS.

4. ACA adjustments will be processed nine months after the respective fiscal year's supplemental payments have been issued in order to determine the proportion of the costs for newly eligible Medi-Cal beneficiaries. The FY 2023-24 ACA adjustment will be claimed in FY 2024-25, and the FY 2024-25 ACA adjustment will be claimed in FY 2025-26.

5. The ending balance shown is on a cash basis and does not necessarily mean that the remaining funds are available. Funds in the ending balance may be committed and scheduled to be expended in the following year.

NDPH SUPPLEMENTAL PAYMENT
REGULAR POLICY CHANGE NUMBER: 126

6. The estimated NDPH Supplemental payments and ending balance for FY 2024-25 are shown below:

FY 2024-25 NDPH Supplemental Fund Summary	SF
FY 2023-24 Ending Balance	$6,083,000
Appropriation (GF)	$1,900,000
Carryover Funds	$407,000
FY 2023-24 Interest Earned	$291,000
Funds Available	$8,681,000
Less: FY 2024-25 Cash Expenditures to Hospitals	($1,900,000)
Est. FY 2024-25 Remaining Balance	$6,781,000

FY 2024-25	TF	SF**	FF	ACA FF***	COVID-19 FF****	Return to SF*
FY 2024-25 Cash Expenditures to Hospitals**	$3,800,000	$1,900,000	$1,900,000	$0	$0	$0
FY 2023-24 ACA FF Adjustment to Special Fund	$407,000	$0	($521,000)	$938,000	($10,000)	$407,000
Total	**$4,207,000**	**$1,900,000**	**$1,379,000**	**$938,000**	**($10,000)**	$407,000

7. The estimated NDPH Supplemental payments and ending balance for FY 2025-26 are shown below:

FY 2025-26 NDPH Supplemental Fund Summary	SF
FY 2024-25 Ending Balance	$6,781,000
Appropriation (GF)	$1,900,000
Carryover Funds	$417,000
Est. FY 2024-25 Interest Earned	$291,000
Funds Available	$9,389,000
Less: FY 2025-26 Cash Expenditures to Hospitals	($8,031,000)
Est. FY 2025-26 Remaining Balance	$1,358,000

NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 126

FY 2025-26	TF	SF**	FF	ACA FF***	Return to SF*
FY 2025-26 Cash Expenditures to Hospitals**	$16,062,000	$8,031,000	$8,031,000	$0	$0
FY 2024-25 ACA FF Adjustment to Special Fund	$417,000	$0	($521,000)	$938,000	$417,000
Total	**$16,479,000**	**$8,031,000**	**$7,510,000**	**$938,000**	$417,000

*The Return to SF column is for display purposes only (see Methodology #4).

Funding:
100% GF (4260-104-0001)
100% NDPH Supplemental Fund (less funded by GF) (4260-698-3096)
100% NDPH Supplemental Fund (non-GF) (4260-601-3096)**
100% Title XIX ACA (4260-101-0890)***
100% Title XIX (4260-101-0890)**
COVID-19 Title XIX Increased FFP (4260-101-0890)****

FREE CLINICS AUGMENTATION

REGULAR POLICY CHANGE NUMBER: 127
IMPLEMENTATION DATE: 10/2021
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 2303

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$2,000,000	$2,000,000
- 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	$2,000,000	$2,000,000
STATE FUNDS	$2,000,000	$2,000,000
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the cost of providing funding to support to the California Association of Free and Charitable Clinics (CAFCC).

Authority:
Budget Act of 2021 [- AB 128 (Chapter 21, Statutes of 2021)]

Interdependent Policy Changes:
Not Applicable

Background:
AB 128 (Chapter 21, Statutes of 2021), the Budget Act of 2021, provides funding to support free and charitable clinics that are 501(c)(3) tax-exempt organizations, or operate as a program component or affiliate of a 501(c)(3) organization and do not qualify as Medi-Cal providers. The funds shall be distributed to the CAFCC and the amount allocated to each Free Clinic shall be determined through an allocation methodology developed by the CAFCC.

Reason for Change:
There is no change in FY 2024-25, from the prior estimate.

There is no change from FY 2024-25 to FY 2025-26 in the current estimate.

FREE CLINICS AUGMENTATION

REGULAR POLICY CHANGE NUMBER: 127

Methodology:

1. Assume an ongoing payment of $2 million General Fund (GF) annually to the CAFCC beginning in FY 2021-22.

(Dollars in Thousands)

Fiscal Year	TF	GF
FY 2024-25	$2,000	$2,000
FY 2025-26	$2,000	$2,000

Funding:

100% GF (4260-101-0001)

QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 128
IMPLEMENTATION DATE: 4/2014
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1563

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$1,002,000	$0
- STATE FUNDS	$501,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,002,000	$0
STATE FUNDS	$501,000	$0
FEDERAL FUNDS	$501,000	$0

Purpose:
This policy change estimates supplemental payments to Freestanding Skilled Nursing Facility Level-Bs (FS/NF-Bs) and Freestanding Subacute Nursing Facility Level-B (FSSA/NF-B) facilities through the Skilled Nursing Facility Quality and Accountability Special Fund (Special Fund).

Authority:
SB 853 (Chapter 717, Statutes of 2010)
AB 1489 (Chapter 631, Statutes of 2012)
AB 119 (Chapter 17, Statutes of 2015)
SB 97 (Chapter 52, Statutes of 2017)
State Plan Amendment (SPA) 17-024
SPA 18-0034
SPA 19-0043
AB 81 (Chapter 13, Statutes of 2020)
SPA 20-0021
SPA 22-0011
AB 186 (Chapter 46, Statutes of 2022)

Interdependent Policy Changes:
Not Applicable

Background:
SB 853 implemented a quality and accountability supplemental payments (QASP) program for FS/NF-Bs and FSSA/NF-B facilities. The supplemental payments are tied to demonstrated quality of care improvements. Supplemental payments began April 2014 and are paid through the Special Fund.

AB 186 (Chapter 46, Statutes of 2022) sunsets the QASP program as of December 31, 2022, and authorizes closeout activities after that date. Additionally, after December 31, 2022, funds collected as a result of staffing standard penalty violations will not be transferred to the Special Fund.

QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 128

Reason for Change:
There is no change in FY 2024-25 from the prior estimate.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to the conclusion of closeout activities in FY 2024-25.

Methodology:
1. Supplemental payments are eligible for Federal Financial Participation (FFP) match.

2. Supplemental payments are estimated to be:

(Dollars in Thousands)

FY 2024-25	TF	SF	FF
Supplemental Payments	$1,002	$501	$501
Total	**$1,002**	**$501**	**$501**

Funding:
SNF Quality & Accountability (4260-605-3167)
Title XIX FFP (4260-101-0890)

IGT ADMIN. & PROCESSING FEE

REGULAR POLICY CHANGE NUMBER: 129
IMPLEMENTATION DATE: 6/2020
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 1601

	FY 2024-25	FY 2025-26
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

Purpose:
This policy change estimates the savings to the General Fund (GF) due to the intergovernmental transfer (IGT) administrative and processing fees assessed to the counties or other approved public entities for the Graduate Medical Education Payments (GME) to Designated Public Hospitals (DPHs).

Authority:
SB 97 (Chapter 52, Statutes of 2017)
State Plan Amendment (SPA) 17-0009

Interdependent Policy Changes:
Not Applicable

Background:
In March 2020, the Centers for Medicare and Medicaid Services approved SPA 17-0009, with an effective date of January 1, 2017, for the Department to make new Medi-Cal GME supplemental payments to DPHs participating in the Medi-Cal managed care program. The Department will budget the GME payments to the DPHs and their affiliated governmental entities; IGTs will fund the nonfederal share of the cost. A 5% administrative fee will be assessed on the IGTs in order to reimburse the Department for support costs associated with administering the program. Fees assessed in excess of the support costs will result in a savings to the GF.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to revised FY 2023-24 final settlement amounts based on updated data.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to higher support costs in FY 2025-26 and higher interim payments and final settlement amounts subject to the fee in FY 2025-26 due to higher direct and indirect GME costs.

IGT ADMIN. & PROCESSING FEE

REGULAR POLICY CHANGE NUMBER: 129

Methodology:

1. Assume the fee for GME supplemental payments will be 5% of the aggregate nonfederal share, which is calculated at 50% FMAP of the Total Funds (TF) from the Graduate Medical Education Payments to DPHs policy change.

2. Beginning SFY 2018-19, GME support costs may be calculated and reimbursed through GME administrative fees.

3. The reimbursement to the GF will be the 5% administrative fee amount less any support costs.

4. Support costs will not be reduced from administrative fees collected as a result of final settlements because the support costs were reimbursed in full from administrative fees collected during interim payments.

5. Administrative costs will be collected each quarter during interim payments. Support costs are not available for reporting until at least one month after the close of the payment period; therefore, support costs for the entire state fiscal year will be calculated one quarter after the close of the respective state fiscal year. Funds transferred to the GF will not occur until support costs are calculated.

FY 2024-25	IGT Subject to the Fee	5% Admin Fee	Support Costs	Reimbursement to GF
FY 2023-24 Interim Payment	$250,899,000	$12,545,000	$77,000	$12,468,000
FY 2023-24 Final Settlement	$57,842,000	$2,892,000	$0	$2,892,000
Total	$308,741,000	$15,437,000	$77,000	$15,360,000

FY 2025-26	IGT Subject to the Fee	5% Admin Fee	Support Costs	Reimbursement to GF
FY 2024-25 Interim Payment	$299,022,000	$14,951,000	$85,000	$14,866,000
FY 2024-25 Final Settlement	$68,936,000	$3,447,000	$0	$3,447,000
Total	$367,958,000	$18,398,000	$85,000	$18,313,000

Fiscal Year	TF	GF	GME Special Fund Transfer
FY 2024-25	**$0**	**($15,360,000)**	**$15,360,000**
FY 2025-26	**$0**	**($18,313,000)**	**$18,313,000**

Funding:

100% State GF (4260-101-0001)
DPH Graduate Medical Education Special Fund (4260-601-8113)

PROPOSITION 56 FUNDING

REGULAR POLICY CHANGE NUMBER: 130
IMPLEMENTATION DATE: 7/2018
ANALYST: Erik Stacey
FISCAL REFERENCE NUMBER: 2102

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$0	-$134,262,000
- STATE FUNDS	$0	-$134,262,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$134,262,000
STATE FUNDS	$0	-$134,262,000
FEDERAL FUNDS	$0	$0

Purpose:
This policy change replaces General Fund expenditures for specified supplemental payments and rate increases with Proposition 56 funds, and budgets additional General Fund necessary to continue Proposition 56 payments as program expenditures exceed available Proposition 56 revenues.

Authority:
California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56)

Interdependent Policy Changes:
See Funding Chart Below

Background:
Effective April 2017, Proposition 56 (Prop 56) increased taxes imposed on distributors of cigarettes and tobacco products and allocates a specified percentage of those revenues to increase funding for existing health care programs under the Medi-Cal program relative to the level of general funds in effect on January 1, 2016.

The Budget Act of 2017 and subsequent Budget Acts allocated Prop 56 funds for supplemental payments for physician services. Pursuant to AB 118 (Chapter 42, Statutes of 2023), DHCS increased base rates for physician services to incorporate amounts equivalent to the Prop 56 physician services supplemental payments effective for dates on services beginning January 1, 2024. These increased base payment levels exceed those in effect as of January 1, 2016.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to updated expenditure projections for Prop 56 payments, updated Prop 56 revenue projections, and the transition of the physicians services supplemental payments to increased base rates.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is based on updated expenditure projections for Prop 56 payments and changes in the projected amount of Prop 56 funding available in FY 2025-26.

PROPOSITION 56 FUNDING
REGULAR POLICY CHANGE NUMBER: 130

Methodology:

1. The nonfederal share of Prop 56 payment items is initially budgeted as General Fund costs in the respective policy changes for these payments. Subsequently, this policy change replaces the General Fund with Healthcare Treatment Fund for those payments budgeted to be supported by Prop 56. Due to methodological changes, remaining Prop 56 revenues, beyond those required to cover the cost of remaining supplemental payments, will be directed to offset a portion of the cost of physician services base rate increases exceeding base payment levels in effect as of January 1, 2016.

2. In 2024-25, Prop 56 revenues are projected to be $628,655,000. Of this amount, $375,017,000 is budgeted to cover the non-federal share of costs for Prop 56 supplemental payments. The remaining $253,638,000 is budgeted to offset the non-federal share of cost for physicians services base rate increases (exceeding base payment levels in effect as of January 1, 2016) that are budgeted in base policy changes.

FY 2024-25	Total Funds	General Fund	Proposition 56
PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS	$320,031,000	$320,031,000	$0
PROP 56 - MEDI-CAL FAMILY PLANNING	$212,136,000	$212,136,000	$0
PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	$24,451,000	$24,451,000	$0
PROP 56 - DIRECTED PAYMENT RISK MITIGATION	($181,601,000)	($181,601,000)	$0
Total of GF Dollars in Prop 56 PCs	**$375,017,000**	**$375,017,000**	**$0**
Prop 56 Funding Available for Prop 56 Supplemental Payments	**$0**	**($375,017,000)**	**$375,017,000**
Prop 56 Funding Available for Physician Services Base Rate Increases	**$0**	**($253,638,000)**	**$253,638,000**
Totals	**$0**	**($628,655,000)**	**$628,655,000**

3. In 2025-26, Prop 56 revenues available to cover the non-federal share of Prop 56 supplemental payments are projected to be $472,460,000. On top of this amount, $132,225,000 from the General Fund is budgeted to cover the remaining non-federal share of supplemental payments. Due to an error in budget development, this policy change additionally includes a General Fund offset of $134,262,000 that is not supported by Prop 56 revenues. This will be updated in the May Revision.

PROPOSITION 56 FUNDING
REGULAR POLICY CHANGE NUMBER: 130

FY 2025-26	Total Funds	General Fund	Proposition 56
PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS	$357,084,000	$357,084,000	$0
PROP 56 - MEDI-CAL FAMILY PLANNING	$222,931,000	$222,931,000	$0
PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	$24,670,000	$24,670,000	$0
Total of GF Dollars in Prop 56 PCs	**$604,685,000**	**$604,685,000**	**$0**
Prop 56 Funding Available for Prop 56 Supplemental Payments	**$0**	**($472,460,000)**	**$472,460,000**
GF Offset Not Supported by Prop 56 Revenues	**($134,262,000)**	**($134,262,000)**	**$0**
Totals	**($134,262,000)**	**($606,722,000)**	**$472,460,000**

Funding:
Healthcare Treatment Fund (4260-101-3305)
100% Title XIX GF (4260-101-0001)
100% Title XXI GF (4260-101-0001)
Healthcare Treatment Fund (Less Funded by GF) (4260-695-3305)
GF Support for Prop 56 Payments (4260-112-0001)

GEMT SUPPLEMENTAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 131
IMPLEMENTATION DATE: 4/2014
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 1661

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	-$17,708,000	-$2,986,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$17,708,000	-$2,986,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$17,708,000	-$2,986,000

Purpose:
This policy change estimates the supplemental payments to publicly owned or operated ground emergency medical transportation (GEMT) service providers.

Authority:
AB 678 (Chapter 397, Statutes of 2011)
SB 523 (Chapter 773, Statutes of 2017)
State Plan Amendment (SPA) 09-024

Interdependent Policy Changes:
Not Applicable

Background:
A provider that delivers GEMT services to Medi-Cal members will be eligible for supplemental payment under the GEMT Supplemental Payment Program for services if the following requirements are met:

1. The provider must be enrolled as a Medi-Cal provider for the period being claimed, and
2. The provider must be owned or operated by the state, a city, county, city and county, federally recognized Indian tribe, health care district, special district, community services district, or fire protection district.

Supplemental payments combined with other reimbursements cannot exceed 100% of actual costs.

Specified governmental entities will pay the non-federal share of the supplemental reimbursement through certified public expenditures (CPEs). The supplemental reimbursement program is retroactive to January 30, 2010. The Centers for Medicare and Medicaid Services (CMS) approved 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: 131

SPA 18-0007, was submitted to CMS in FY 2018-19, proposes to update the definition of allowable costs to include shared direct costs and to revise the timeline for final settlements. However, as the Department continues to work on SPA 18-0007 approvals, supplemental reimbursements have resumed based on the payment methodologies set forth in the current approved SPA 09-024, which excludes shared direct costs.

Assembly Bill (AB) 1705, effective January 1, 2023, requires the Department to implement a public provider GEMT intergovernmental transfer (IGT) program. The public providers that participate in the GEMT Supplemental Payment Program transitioned into the new GEMT IGT program, so the GEMT Supplemental Payment Program sunset on December 31, 2022. However, closeout activities for the GEMT Supplemental Payment Program, such as interim and final reconciliations, will continue after the effective date of AB 1705.

As a result of the COVID-19 national public health emergency, increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to:
- FY 2018-19 through FY 2021-22 final reconciliations revised based on updated data.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to:
- Higher volume of retroactive final reconciliations expected to occur in FY 2024-25 compared to FY 2025-26.

Methodology:
1. The Affordable Care Act (ACA) allows for 100% FMAP for calendar years (CY) 2014 through 2016, 95% FMAP for CY 2017, 94% FMAP for CY 2018, 93% for CY 2019, and 90% for CY 2020 and after for newly eligible Medi-Cal members. The ACA methodology has been approved by CMS.

2. Effective July 1, 2018, SB 523 established the GEMT Provider Quality Assurance Fee (QAF) Program. GEMT QAF payments will reduce GEMT CPE reimbursements beginning in FY 2018-19.

3. The GEMT CPE reimbursements sunset on December 31, 2022.

4. Interim reconciliations are performed within two years of receipt of the as-filed cost report. Final reconciliations are based on audited cost reports, and the audit and settlement process is completed within three years of the postmark date of the approved cost report. Due to delays in receipt of cost reports, retroactive years are being reconciled in FY 2024-25.

5. SPA 18-0007, if approved, would be retroactive to dates of service beginning July 1, 2018. SPA 18-0007 proposes to expand claimable costs that can be allocated to two or more departmental functions on the basis of shared benefits, for increased GEMT supplemental reimbursement. However, as the Department continues discussions on SPA 18-0007, payments have resumed under the current approved SPA 09-024.

GEMT SUPPLEMENTAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 131

The estimated payments on a cash basis are:

FY 2024-25	Total FFP	Regular FFP	ACA	COVID-19 FF
FY 2018-19 Final Recon.	($4,504,000)	($1,512,000)	($2,992,000)	$0
FY 2019-20 Final Recon.	($5,336,000)	($1,892,000)	($3,332,000)	($112,000)
FY 2020-21 Final Recon.	($5,412,000)	($1,884,000)	($3,296,000)	($232,000)
FY 2021-22 Final Recon.	($2,456,000)	($836,000)	($1,516,000)	($104,000)
Total FY 2024-25	**($17,708,000)**	**($6,124,000)**	**($11,136,000)**	**($448,000)**

FY 2025-26	Total FFP	Regular FFP	ACA	COVID-19 FF
FY 2021-22 Final Recon.	($1,842,000)	($627,000)	($1,137,000)	($78,000)
FY 2022-23 Final Recon.	($1,144,000)	($340,000)	($764,000)	($40,000)
Total FY 2025-26	**($2,986,000)**	**($967,000)**	**($1,901,000)**	**($118,000)**

Funding:
100% Title XIX FFP (4260-101-0890)
100% Title XIX ACA (4260-101-0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)

COVID-19 REDETERMINATIONS IMPACT

REGULAR POLICY CHANGE NUMBER: 132
IMPLEMENTATION DATE: 7/2023
ANALYST: Ryan Woolsey
FISCAL REFERENCE NUMBER: 2218

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$798,398,000	$1,140,179,000
- STATE FUNDS	$279,471,050	$448,236,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$798,398,000	$1,140,179,000
STATE FUNDS	$279,471,050	$448,236,200
FEDERAL FUNDS	$518,926,950	$691,942,800

Purpose:
This policy change estimates the impact of changes in the number of monthly redeterminations related to the ending of the COVID-19 public health emergency (PHE) and subsequent unwinding activities.

Authority:
Families First Coronavirus Response Act (FFCRA)
Coronavirus Aid, Relief, and Economic Security (CARES) Act
Consolidated Appropriations Act, 2023

Interdependent Policy Changes:
Not Applicable

Background:

COVID-19 Pandemic
On March 4, 2020, Governor Newsom declared a state of emergency in response to the developing COVID-19 pandemic. A statewide stay at home order was introduced on March 19, 2020. The federal government declared a national public health emergency on January 31, 2020, and a national emergency on March 13, 2020. These actions triggered the availability of Medicaid and Children's Health Insurance Program flexibilities, including under Section 1135 of the Social Security Act. Additionally, the President signed major federal legislation—including the FFCRA and the CARES Act—that provided increased federal funding in Medicaid and created new options for states to address the COVID-19 pandemic.

Continuous Coverage Requirement
The FFCRA included a "continuous coverage requirement." Under the continuous coverage requirement, states were required to halt most disenrollment of Medicaid members enrolled at the beginning of the enrollment period or who would have enrolled during the emergency period until the end of the month the public health emergency ends in order to receive a temporary increase in the federal medical assistance percentage (FMAP). The Medi-Cal caseload increased due to reduced disenrollment under the continuous coverage requirement.

COVID-19 REDETERMINATIONS IMPACT
REGULAR POLICY CHANGE NUMBER: 132

PHE Unwinding
The Consolidated Appropriations Act, 2023, was approved on December 29, 2022. As part of the process of unwinding pandemic policies, the Consolidated Appropriations Act, 2023, ended the continuous coverage requirement on March 31, 2023, and required states to redetermine eligibility for all members. In Medi-Cal, the resumption of eligibility determinations began in April 2023 for beneficiaries due for renewal in June 2023. Those determined to still be eligible continue to be enrolled, while those determined to no longer be eligible began to be disenrolled in July 2023.

Individuals that are determined ineligible for Medi-Cal through this process have the opportunity to cure deficiencies in their renewal and regain coverage if found eligible. The vast majority of individuals found ineligible for Medi-Cal through the redetermination process are eligible for other forms of health coverage, including through an employer and through Covered California.

Unwinding Flexibilities
During the unwinding period, DHCS adopted flexibilities offered by the federal government to help increase administrative efficiencies in the Medi-Cal renewal process. The 17 federal flexibilities California elected to adopt helped DHCS streamline renewals and ease the burden on Medi-Cal members and counties as Medi-Cal members were redetermined within 12 months. Two of the 17 federal waivers, known as zero income waiver and 100 percent federal poverty level (FPL) waiver, have yielded significant retention in Medi-Cal caseload through the auto-renewal, or ex parte process. An additional waiver, known as the stable income waiver, also contributed to coverage retention for Medi-Cal members in the Seniors and Persons with Disabilities coverage groups. The Estimate assumes DHCS will maintain all 17 unwinding flexibilities through June 30, 2025, as authorized by federal guidance.

Base Projections
The Medi-Cal Estimate uses base projections to budget the significant majority of managed care and fee-for-service (FFS) costs. These base projections generally assume flat enrollment following the most recent actual month of data available for the Estimate. This policy change budgets the impact of projected deviations from this flat enrollment assumption for the various aid categories in Medi-Cal due to ongoing changes in how redeterminations are processed, the duration of unwinding flexibilities, and other factors.

Reason for Change:
The change for FY 2024-25, from the prior estimate, is an increase in costs due to:
- The impact of caseload reductions from February 2024 through July 2024 that were previously budgeted in this policy change have now moved into base projections.
- Unwinding flexibilities, which reduce disenrollments relative to standard unwinding procedures, are assumed to continue through FY 2024-25 and enrollment is projected to slightly increase during FY 2024-25.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase in costs. This reflects the net impact of:
- A net reduction in Medi-Cal enrollment in FY 2025-26 compared to FY 2024-25 as unwinding flexibilities are assumed to expire in July 2025, which results in reduced spending.
- Within the net reduction in projected enrollment relative to base projections, some aid categories are projected to decline while others are projected to grow, particularly the

COVID-19 REDETERMINATIONS IMPACT
REGULAR POLICY CHANGE NUMBER: 132

senior caseload. This policy change estimates growing managed care capitation costs compared to base projections associated with projected growth in the senior caseload. Because the senior caseload has a higher per member per month cost, increased costs budgeted in this policy change for the senior caseload more than offset the reduced spending from other aid categories that are projected to decline relative to base projections.

Methodology:

1. Based on recent trends in enrollment and disenrollment, this policy change estimates changes to the number of members assumed for the different categories of members compared to base projections.

2. The Estimate assumes that unwinding flexibilities end June 30, 2025. The Estimate assumes that upon the end of flexibilities disenrollments increase in August 2025 to a level similar to September 2023 through November 2023, and then gradually return to pre-pandemic levels over the following 12 months. Consistent with these assumptions, the estimated change in member months relative to base projections, with estimated per member per month costs, is:

	FY 2024-25		FY 2025-26	
Aid Category Group	**Member Months**	**Average Cost Per Member Per Month**	**Member Months**	**Average Cost Per Member Per Month**
Newly (ACA Expansion)	856,100	$554	616,300	$577
Families and Children	-943,200	$263	-4,137,200	$289
Seniors	961,000	$869	2,595,200	$883
Persons with Disabilities	-91,800	$1,556	-311,500	$1,666
Other	24,100	$1,115	85,700	$1,367
Total	**806,200**	**$1,173**	**-1,151,500**	**-$910**

3. After accounting for the impact of unwinding flexibilities ending June 30, 2025, the net impact of changes in redeterminations budgeted in this policy change on a cash basis is shown below. These estimates include both the impact of ending unwinding flexibilities June 30, 2025, as well as other redetermination impacts that result in caseload trends different from what is assumed in the base.

(Dollars in Thousands)

Fiscal Year	TF	GF	Title XIX FF	Title XXI FF	ACA FF
FY 2024-25	$798,398	$279,471	$150,253	$25,389	$343,285
FY 2025-26	$1,140,179	$448,236	$247,754	$99,025	$345,164

COVID-19 REDETERMINATIONS IMPACT
REGULAR POLICY CHANGE NUMBER: 132

4. Within the dollars budgeted in this policy change shown above, the estimated impact of unwinding flexibilities ending June 30, 2025, as distinct from other redetermination impacts captured in this policy change, is shown below. This impact is highly uncertain.

(Dollars in Thousands)

Fiscal Year	TF	GF	Title XIX FF	Title XXI FF	ACA FF
FY 2024-25	$0	$0	$0	$0	$0
FY 2025-26	-$1,500,096	-$532,542	-$306,796	$0	-$660,758

Funding:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	$300,505	$150,253	$150,253
90% Title XIX / 10% GF (4260-101-0001 / 0890)	$381,427	$38,143	$343,285
65% Title XXI / 35% GF (4260-101-0001 / 0890)	$39,061	$13,671	$25,389
100% State General Fund	$77,404	$77,404	$0
Total	**$798,398**	**$279,471**	**$518,927**

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	$495,507	$247,754	$247,754
90% Title XIX / 10% GF (4260-101-0001 / 0890)	$383,516	$38,352	$345,164
65% Title XXI / 35% GF (4260-101-0001 / 0890)	$152,346	$53,321	$99,025
100% State General Fund	$108,810	$108,810	$0
Total	**$1,140,179**	**$448,236**	**$691,943**

PHARMACY-BASED COVID-19 TESTS

REGULAR POLICY CHANGE NUMBER: 133
IMPLEMENTATION DATE: 1/2025
ANALYST: Whitney Li
FISCAL REFERENCE NUMBER: 2359

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$6,657,000	$14,858,000
- STATE FUNDS	$2,161,950	$4,824,650
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$6,657,000	$14,858,000
STATE FUNDS	$2,161,950	$4,824,650
FEDERAL FUNDS	$4,495,050	$10,033,350

Purpose:
This policy change estimates the costs for expanding COVID-19 specimen collections to pharmacies.

Authority:
American Rescue Plan Act (ARPA)
SPA 22-0004

Interdependent Policy Changes:
Not Applicable

Background:
According to the Centers for Medicare and Medicaid Services (CMS), the ARPA requires state Medicaid and Children Health Insurance Program (CHIP) to cover a broad array of COVID-19 testing, including all types of U.S. Food & Drug Administration (FDA) - authorized COVID-19 tests, without cost-sharing obligations that begins March 11, 2021, and ends on the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period described in section 1135(g)(1)(B) of the ARPA. The federal Coronavirus 2019 (COVID-19) Public Health Emergency (PHE) ended on May 11, 2023.

All types of FDA-authorized COVID-19 tests must be covered under CMS' interpretation of the ARPA COVID-19 testing coverage requirements, including laboratory tests where the specimen is collected via the pharmacy. Self-administered over-the-counter COVID-19 tests, pursuant to a covered List and quantity/frequency limits have been available as a Medi-Cal benefit since January 1, 2022.

PHARMACY-BASED COVID-19 TESTS

REGULAR POLICY CHANGE NUMBER: 133

Reason for Change:
The change in FY 2024-25, from the prior estimate, is a shift in the implementation date from April 2024 to January 2025.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to a full year of implementation in FY 2025-26.

Methodology:
Pharmacy Specimen Collection:

1. Assume the COVID-19 pharmacy specimen collection will be implemented January 1, 2025 and is retroactive to February 1, 2022. Minimal claims are expected during the retroactive period.

2. Assume this expansion of services will increase COVID-19 tests 50,000 per month and not offset any existing testing levels.

3. The 50,000 tests per month will incur a pharmacy collection fee and is also associated with laboratory costs. 98% of the laboratory costs will be incurred via the Medi-Cal Managed Care delivery system and 2% or 1,000 tests per month paid by Fee-For-Service.

4. The pharmacy specimen collection cost is $23.46 and assuming the specimen collection is sent to a laboratory for processing at an average cost of $63.16. The total cost is $86.62 per test.

5. Total costs are estimated to be:

FY 2024-25 (Lagged)	TF	GF	FF
Pharmacy Specimen Collection	$6,657,000	$2,162,000	$4,495,000
Total	**$6,657,000**	**$2,162,000**	**$4,495,000**

FY 2025-26 (Lagged)	TF	GF	FF
Pharmacy Specimen Collection	$14,858,000	$4,825,000	$10,033,000
Total	**$14,858,000**	**$4,825,000**	**$10,033,000**

PHARMACY-BASED COVID-19 TESTS

REGULAR POLICY CHANGE NUMBER: 133

Funding:

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$3,560,000	$1,780,000	$1,780,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	$2,808,000	$281,000	$2,527,000
65% Title XXI FF / 35% GF (4260-101-0001/0890)	$289,000	$101,000	$188,000
Total	**$6,657,000**	**$2,162,000**	**$4,495,000**

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$7,944,000	$3,972,000	$3,972,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	$6,269,000	$627,000	$5,642,000
65% Title XXI FF / 35% GF (4260-101-0001/0890)	$645,000	$226,000	$419,000
Total	**$14,858,000**	**$4,825,000**	**$10,033,000**

COVID-19 BEHAVIORAL HEALTH

REGULAR POLICY CHANGE NUMBER: 134
IMPLEMENTATION DATE: 7/2020
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2215

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$1,876,000	$0
- STATE FUNDS	$148,100	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,876,000	$0
STATE FUNDS	$148,100	$0
FEDERAL FUNDS	$1,727,900	$0

Purpose:
This policy change estimates the cost of establishing interim rates for certain Behavioral Health Medi-Cal programs due to impacts resulting from the Coronavirus Disease 2019 (COVID-19) pandemic.

Authority:
Coronavirus Aid, Relief, and Economic Security (CARES) Act

Interdependent Policy Changes:
Not Applicable

Background:
On March 4, 2020, Governor Newsom declared a state of emergency in response to the developing pandemic of COVID-19. A statewide stay at home order was introduced on March 19, 2020. The federal government declared a national public health emergency (PHE) on January 31, 2020, and a national emergency on March 13, 2020. These actions triggered the availability of Medicaid and Children's Health Insurance Program flexibilities, including under Section 1135 of the Social Security Act. Additionally, the President signed major federal legislation, including the Families First Coronavirus Response Act (FFCRA) and the CARES Act, which provided increased federal funding in Medicaid and created new options for states to address the COVID-19 pandemic.

Due to COVID-19, there was a significant decrease in the utilization of certain Specialty Mental Health Services (SMHS), while costs per unit of service increased. To account for the higher cost per unit of service and help counties continue to provide essential behavioral health services during the pandemic, while maintaining their provider networks, the Department implemented changes to the reimbursement rates. These changes were intended to ensure counties could provide behavioral health treatment to all Medi-Cal members in need of services after the PHE ended.

For specialty mental health outpatient services delivered by county-owned providers, the interim reimbursement methodology is the lower of the county's Certified Public Expenditure (CPE) or

COVID-19 BEHAVIORAL HEALTH
REGULAR POLICY CHANGE NUMBER: 134

the county's interim rate, which is developed using the most recently filed cost report and an appropriate cost of living adjustment. Effective March 1, 2020, until the end of the COVID-19 PHE, each county had the option to receive interim reimbursement equal to the lower of the county's CPE or the county's interim rate increased by 100%.

The COVID-19 PHE expired on May 11, 2023.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is a net increase due to the following:

- Lower estimate of the increased interim rates for SMHS-Children and SMHS-Adults, and
- A revision of the payment lag, with the percentage of claims assumed to be paid in the third year.

The change in the current estimate, from FY 2024-25 to FY 2025-26, is due to no COVID-19 interim rate costs assumed for FY 2025-26. FY 2024-25 includes only the third year payment lag costs for SMHS-Adults and SMHS-Children.

Methodology:
1. Interim rate increases for SMHS were implemented in July 2020.

2. For FY 2022-23 COVID-19 interim rate claims, which expired in May 2023, assume for SMHS-Adults, 25.4% of claims were paid in the first year, 73.9% in the second year, and the remaining 0.7% are expected to be paid in the third year (FY 2024-25). Assume for SMHS-Children that 28.7% of claims were paid in the first year, 70.9% paid in the second year, and 0.4% paid in the third year.

3. Total cost are as follows:

FY 2024-25	TF	GF	FF	CF
SMHS Interim Rate – Adult	$1,623,000	$102,000	$1,217,000	$304,000
SMHS Interim Rate – Children	$807,000	$46,000	$511,000	$250,000
Total	$2,430,000	**$148,000**	**$1,728,000**	$554,000

Funding:
100% GF (4260-101-0001)
100% Title XIX FF (4260-101-0890)
100% Title XXI FF (4260-101-0890)
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)

COVID-19 VACCINE FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 135
IMPLEMENTATION DATE: 7/2021
ANALYST: Whitney Li
FISCAL REFERENCE NUMBER: 2363

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$53,539,000	-$13,257,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$53,539,000	-$13,257,000
FEDERAL FUNDS	$53,539,000	$13,257,000

Purpose:
This policy change estimates the funding adjustment for the fee-for-service (FFS) COVID-19 vaccine payments to shift payments made at various Federal Medicaid Assistance Percentages (FMAPs) to 100% FMAP.

Authority:
American Rescue Plan Act (ARPA)

Interdependent Policy Changes:
COVID-19 Vaccines

Background:
On March 11, 2021, the President signed ARPA into law. The ARPA makes coverage of COVID-19 vaccines and their administration mandatory benefits under Medicaid for the period beginning on the date of the enactment through the last day of the first calendar quarter that begins at least one year after the last day of the emergency period declared by the Secretary of Health and Human Services (HHS). As of April 1, 2021, the FMAP for COVID-19 vaccines and administration of vaccines is increased to 100% for most Medi-Cal claims through September 30, 2024.

Prior to September 2023, the COVID-19 vaccine ingredient costs were paid directly by the federal government. Starting in September 2023 with the updated COVID-19 vaccine, the federal government will no longer be purchasing the vaccine and Medi-Cal will be responsible for the reimbursement of the COVID-19 vaccine ingredient cost, administration fee, and, as applicable, dispensing fee. Medi-Cal payments for all applicable COVID-19 vaccine costs are expected to start in October 2023.

Starting in October 2024, the 100% federal funding will end and the applicable FMAPs will apply.

COVID-19 VACCINE FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 135

Reason for Change:
The change in FY 2024-25, from the prior estimate, a shift of the July 2022 through September 2023 manual adjustments from FY 2023-24 to FY 2024-25 and a shift of the January 2024 through September 2024 manual adjustments from FY 2024-25 to FY 2025-26. With these updates, FY 2024-25 is now estimated to include six quarters of adjustments.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to FY 2025-26 having the final three quarters of this adjustment.

Methodology:
1. Quarters starting October 2023 to September 2024 adjusts for COVID-19 ingredient costs, vaccine administration costs, and dispensing fees to 100% FMAP.

2. Funding adjustments for the July 2022 to December 2023 quarters will be made in FY 2024-25.

3. Funding adjustments for the January 2024 to September 2024 quarters will be made in FY 2025-26.

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
Jul - Sept 2022	$0	($9,824)	$9,824
Oct - Dec 2022	$0	($9,824)	$9,824
Jan - Mar 2023	$0	($9,824)	$9,824
Apr - Jun 2023	$0	($9,824)	$9,824
Jul - Sept 2023	$0	($9,824)	$9,824
Oct - Dec 2023	$0	($4,419)	$4,419
Total	**$0**	**($53,539)**	**$53,539**

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
Jan - Mar 2024	$0	($4,419)	$4,419
Apr - Jun 2024	$0	($4,419)	$4,419
Jul - Sept 2024	$0	($4,419)	$4,419
Total	**$0**	**($13,257)**	**$13,257**

Funding:
100% GF (4260-101-0001)
100% Title XIX (4260-101-0890)

CONTINUOUS CHIP COVERAGE DURING THE COVID-19 PHE

REGULAR POLICY CHANGE NUMBER: 136
IMPLEMENTATION DATE: 7/2025
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2301

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$54,318,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$54,318,000
FEDERAL FUNDS	$0	-$54,318,000

Purpose:
The purpose of this policy change is to estimate the State General Fund impact to provide continuous coverage to individuals enrolled in the state's Title XXI children's health insurance programs during the full duration of the Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE).

Authority:
SPA 21-032
SB 129 (Chapter 69, Statutes of 2021)
SB 154 (Chapter 43, Statutes of 2022)
CalAIM Section 1115(a) Medicaid Demonstration

Interdependent Policy Changes:
Not Applicable

Background:
The Centers for Medicare & Medicaid Services (CMS) issued guidance which allowed individuals enrolled in Medicaid to remain in coverage for the duration of the COVID-19 PHE, excluding Children's Health Insurance Program (CHIP) populations. To prevent coverage disparities from federal policies as it relates to Medicaid and CHIP populations, the Department issued guidance to maintain continuous coverage for individuals enrolled in the Medi-Cal Access Program (MCAP), Medi-Cal Access for Infants Program (MCAIP), and the County Children Health Initiative Program (CCHIP) during the COVID-19 PHE.

On March 17, 2023, the Department received CMS approval to maintain continuous coverage for individuals enrolled in MCAP, MCAIP, and CCHIP during the COVID-19 PHE, provided such individuals have satisfactory immigration status. Expenditures are not allowed for individuals who do not have satisfactory immigration status. Data reconciliation and the final waiver evaluation cannot begin until after all continuous coverage redeterminations have been completed. The timing of these components will allow for the reconciliation to be completed no sooner than FY 2024-25.

CONTINUOUS CHIP COVERAGE DURING THE COVID-19 PHE

REGULAR POLICY CHANGE NUMBER: 136

Reason for Change:
The change from the prior cycle, for FY 2024-25, is a General Fund (GF) decrease and the change from FY 2024-25 to FY 2025-26, in the current estimate, is a GF increase due to shifting all payments into FY 2025-26.

Methodology:
1. Assume continuous coverage through the PHE and unwinding of the PHE for the MCAIP, CCHIP, and MCAP populations.

2. Assume a retroactive payment (covering March 2020 through May 2024) will occur in FY 2025-26, for individuals with unsatisfactory immigration status.

3. Assume the PHE Unwinding ended May 31, 2024.

4. The estimated costs for FY 2024-25 and FY 2025-26 are:

(Dollars in Thousands)

Fiscal Years	TF	GF	FF
FY 2024-25	$0	$0	$0
FY 2025-26	$0	$54,318	($54,318)

Funding:
100% Title XXI GF (4260-101-0001)
100% Title XXI FF (4260-101-0890)

COVID-19 VACCINES

REGULAR POLICY CHANGE NUMBER: 137
IMPLEMENTATION DATE: 7/2023
ANALYST: Whitney Li
FISCAL REFERENCE NUMBER: 2456

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$130,536,000	$120,849,000
- STATE FUNDS	$46,574,250	$43,118,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	100.00 %	100.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the costs for changes to the COVID-19 vaccines.

Authority:
American Rescue Plan Act (ARPA)
SPA CA-22-0004 (Approved February 24, 2023; effective January 1, 2022)
SPA 22-0067A

Interdependent Policy Changes:
Not Applicable

Background:
Under the ARPA, Medi-Cal's COVID-19 vaccine reimbursement was the CMS required $40 per dose COVID-19 vaccine administration cost.The COVID-19 vaccine ingredient costs were paid directly by the federal government. The ARPA also provides 100% federal funding for most Medi-Cal reimbursed COVID-19 vaccine claims through September 30, 2024. Starting in September 2023, with the updated COVID-19 vaccine, the federal government will no longer purchase the vaccine and Medi-Cal will be responsible for the reimbursement of the COVID-19 vaccine ingredient cost, administration fee, and, as applicable, dispensing fee. Starting in October 2024, the 100% federal funding will end and the applicable Federal Medicaid Assistance Percentages (FMAPs) will apply. A new vaccine administrative fee will also occur starting in October 2024 as the $40 per dose for COVID-19 vaccine will end.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is a reduction due to an assumed greater share of vaccines provided to children, which are largely covered by the Vaccines for Children (VFC) program.

COVID-19 VACCINES
REGULAR POLICY CHANGE NUMBER: 137

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to the $40 administration fee change to an estimated lower fee of $34 and annual implementation of the $34 vaccination administration fee for adults and children vaccinated by pharmacists. Both changes were effective October 1, 2024. FY 2024-25 accounted for three months of the $40 Medicare administrative fee and nine months of the current lower administrative fee. FY 2025-26 only includes the lower administrative fee.

Methodology:

1. Assume Medi-Cal will pay for approximately 1,500,000 COVID-19 vaccines.

2. Assume ingredient cost for COVID-19 vaccinations are as follows:
   - The Vaccine for Children (VFC) program is responsible for the ingredient fee for Medi-Cal children, ages 0-2 administered by all providers, starting with the FY 2023-24 COVID-19 vaccine.
   - VFC is responsible for the ingredient fee for Medi-Cal children ages 3-18 when administered for all providers except pharmacies. Medi-Cal is responsible for the administrative fee when administered by pharmacies through December 31, 2024 under the COVID-19 Public Readiness and Emergency Preparedness (PREP) Act. Beginning January 1, 2025, VFC is responsible for the ingredient fee for Medi-Cal children 3-18 for all providers.
   - Medi-Cal is responsible for the ingredient costs for adults ages 19 and over.

3. Assume the average COVID-19 vaccine ingredient reimbursement is $120.00 per dose.

4. Vaccine administration fee through September 2024:
   - Under the ARPA, the COVID-19 vaccine administration fee is $40 through September 30, 2024.
   - Per SPA 0067A, Federally Qualified Health Centers/ Rural Health Clinics (FQHCs/RHCs) receive the Medicare administrative fee for COVID-19 vaccine visits only. If the vaccine is given as part of a medical visit, no administrative fee is made.

5. Vaccine administration fees beginning October 1, 2024:
   - Statutory changes were approved to remove the Welfare and Institutions (W&I) code section 14124.12 requirement for Medi-Cal to reimburse providers at 100% of the Medicare rate. For the purpose of this policy change, the administration fee for pharmacies will be $34 for Medi-Cal and VFC.
   - For FQHCs/RHCs, the separate vaccine-only rate for clinics has been discontinued and reimbursements to FQHCs/RHCs have returned to the pre-pandemic policy of reimbursement as part of clinics' prospective payment system (PPS) rate.

Vaccine Administered by:	7/1/2023 – 9/30/2024	10/1/2024 onward
Pharmacies (Medi-Cal)	$40	$34
Pharmacies (VFC)	N/A	$34
FQHC/RHCs (vaccine-only)	$40	N/A
All Other Provider Types (Medi-Cal)	$40	$4.46
All Other Provider Types (VFC)	$40	$9

COVID-19 VACCINES
REGULAR POLICY CHANGE NUMBER: 137

6. Current Medicare reimbursement policy for COVID-19 vaccines and vaccine administration does not provide associated dispensing fees for pharmacies through September 30, 2024. Beginning October 1, 2024, a dispensing fee is assumed for pharmacies that dispense the COVID-19 vaccine.

7. Assume pharmacies receives an average dispensing fee of $11.63.

8. This policy change uses General Fund for the non-federal share of COVID-19 vaccine costs.

9. Total costs are estimated to be:

(Dollars in Thousands)

	FY 2024-25	FY 2025-26
Administrative Fee	$28,048	$22,237
Dispensing Fee	$4,205	$6,452
Ingredient Fee	$98,283	$92,160
Total Cost	**$130,536**	**$120,849**

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
COVID-19 Vaccines	**$130,536**	**$46,574**	**$83,962**

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
COVID-19 Vaccines	**$120,849**	**$43,118**	**$77,731**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX / 10% GF (4260-101-0001/0890)
65% Title XXI / 35% GF (4260-101-0001/0890)

STATE-ONLY CLAIMING ADJUSTMENTS - RETRO ADJ.

REGULAR POLICY CHANGE NUMBER: 138
IMPLEMENTATION DATE: 1/2021
ANALYST: Ryan Woolsey
FISCAL REFERENCE NUMBER: 2415

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$439,360,000	$944,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$439,360,000	$944,000
FEDERAL FUNDS	-$439,360,000	-$944,000

Purpose:
This policy change estimates (1) the return of Federal Financial Participation (FFP) to the federal government for claiming for non-emergency or non-pregnancy related services provided to individuals without satisfactory immigrant status in full scope Medi-Cal coverage and (2) the claiming of FFP for certain immigrant populations for which the state has previously underclaimed.

Changes in claiming processes as a result of the updates described in this policy change will also affect the amount of federal funding the state will claim compared to the amount that was claimed in the past, on an ongoing basis. These prospective, ongoing impacts are reflected in various policy changes that correspond to the various services these claiming processes support.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
California provides state-only full scope Medi-Cal services to certain immigrant populations who meet all Medi-Cal eligibility requirements except for their citizenship status. For these covered populations, FFP is only available for emergency and pregnancy-related services, and nonemergency and non-pregnancy related services are paid using state only funds. Affected populations include qualified non-citizens subject to the five-year bar, individuals who are Permanent Residents or Permanently Residing Under Color of Law, and individuals under 26 years of age who otherwise meet all Medi-Cal eligibility criteria (such as income and state residency) but for their citizenship status.

The Department identified claiming for ineligible covered benefits and is required to return the federal funding to the Centers for Medicare and Medicaid Services (CMS). The Department has

STATE-ONLY CLAIMING ADJUSTMENTS - RETRO ADJ.
REGULAR POLICY CHANGE NUMBER: 138

estimated the FFP amounts subject to repayment that must be retroactively returned and updates to associated claiming methodologies for prospective use.

CMS Deferrals
CMS has issued a number of deferrals for the state only claiming issue. The Department anticipates that these deferrals will ultimately be reconciled against the Department's total estimated repayments owed to the federal government once retroactive adjustments are complete and claiming process changes are in place. See the CMS Deferred Claims policy change for details on CMS deferral payments.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is an increase due to:
- Repayments related to dental and pharmacy services that were originally scheduled to be made in FY 2023-24 will now be made in FY 2024-25.
- Estimated repayments related to fee-for-service (FFS) expenditures for members with blank immigration status indicators and Title 21 newborn claiming have been newly added to the estimate.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to:
- Almost all retroactive repayments have been completed in FY 2024-25, leaving relatively much smaller repayments in FY 2025-26.

Methodology:

1. An estimated net amount of $65,531,000 will be repaid to CMS in FY 2024-25 related to FFS expenditures for members with a missing immigration status indicator for periods from April 2022 through June 2023. This amount reflects the net impact of repayments and offsetting new federal claiming.

2. Estimated FFP repayments for Pharmacy Rebates in FY 2024-25 cover claims from July 2020 through June 2024 and repayments in FY 2025-26 cover claims from July 2024 through June 2025.

3. The Pharmacy line also includes $131 million in repayments in FY 2024-25 related to pharmacy claims for members with a missing immigration status indicator.

4. Estimated FFP repayments for Dental FFS and Dental Managed Care in FY 2024-25 cover claims from January 2010 through June 2024.

5. This estimate newly includes the impact of repayments to CMS related to federal funds incorrectly claimed for citizen newborns born to a parent without satisfactory immigration status. The estimated net repayment is $1,070,000 in FY 2024-25.

6. The estimated net retroactive adjustments are:

STATE-ONLY CLAIMING ADJUSTMENTS - RETRO ADJ.

REGULAR POLICY CHANGE NUMBER: 138

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
FFS blanks impacts	$0	$65,531	($65,531)
Pharmacy	$0	$205,860	($205,860)
Dental FFS and managed care	$0	$166,899	($166,899)
Title 21 newborn claims	$0	$1,070	($1,070)
Total	**$0**	**$439,360**	**($439,360)**

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
Pharmacy	$0	$944	($944)
Total	**$0**	**$944**	**($944)**

Funding:
100% Title XIX GF (4260-101-0001)
100% Title XXI GF (4260-101-0001)
100% Title XIX FF (4260-101-0890)
100% Title XXI FF (4260-101-0890)
100% SCHIP FF (4260-101-0890)

ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS

REGULAR POLICY CHANGE NUMBER: 139
IMPLEMENTATION DATE: 5/2013
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1476

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$791,808,000	$900,026,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$791,808,000	$900,026,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$791,808,000	$900,026,000

Purpose:
This policy change estimates the federal match to the California Department of Developmental Services (CDDS) for participant-directed Home and Community Based Services (HCBS) for persons with developmental disabilities under a 1915(i) state plan option.

Authority:
Section 6086 of the Deficit Reduction Act (DRA) of 2005, Public Law 109-171
Interagency Agreement (IA) 09-86388

Interdependent Policy Changes:
Not Applicable

Background:
State Plan Amendment (SPA) 09-023A was approved on April 25, 2013, retroactive to October 1, 2009. It authorizes CDDS to claim federal financial participation (FFP) for the provision of certain services by the state's Regional Center (RC) network of nonprofit providers to persons with developmental disabilities. RC consumers who received or currently receive certain services will continue to be eligible for these services even though their institutional level of care requirements for the HCBS waiver for persons with developmental disabilities are not met. Services covered under this SPA include but are not limited to: habilitation, respite care, personal care services, homemaker services, and home health aide services.

On September 29, 2016, SPA 16-016 was approved by the Centers for Medicare and Medicaid Services (CMS) to renew SPA 09-023A with an effective date of October 1, 2016. The SPA expired on September 30, 2021. The Department submitted SPA 21-0002 to CMS on March 23, 2021, to renew the 1915(i) state plan option for a new five year term effective October 1, 2021, through September 30, 2026.

ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS
REGULAR POLICY CHANGE NUMBER: 139

ABX3 5 “AB 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.

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 IA to draw down FFP for infant development services.

As a result of the COVID-19 national public health emergency, increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to some slight increases in FY 2024-25 due to changes in caseload growth estimate and higher than expected prior year expenditures.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to continuing caseload growth and lower prior year expenditures expected for FY 2025-26.

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

2. The negative COVID-19 enhanced FMAP is due to refunding invoices under this program and billing the Department through the HCBS Spending Plan (HCBS SP) under the American Rescue Plan Act (ARPA). The federal fund minus the COVID-19 enhanced FMAP comes up to the General Fund amount. The funds that were identified as ARPA expenditures were refunded to the programs then billed under the HCBS Spending Plan. See the HCBS SP CDDS policy change for the estimated HCBS Spending Plan expenditures.

3. Negative COVID-19 FF and ARPA invoices went out for this program in September 2024.

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	FF	COVID-19 FF
FY 2024-25	$1,583,617	$791,809	**$792,403**	**($595)**
FY 2025-26	$1,800,052	$900,026	**$900,026**	**$0**

Funding:
100% Title XIX FFP (4260-101-0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)

BEHAVIORAL HEALTH BRIDGE HOUSING

REGULAR POLICY CHANGE NUMBER: 146
IMPLEMENTATION DATE: 5/2023
ANALYST: Tyler Shimizu
FISCAL REFERENCE NUMBER: 2354

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$272,087,000	$243,587,000
- STATE FUNDS	$272,087,000	$243,587,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$272,087,000	$243,587,000
STATE FUNDS	$272,087,000	$243,587,000
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the costs for behavioral health bridge housing.

Authority:
Budget Act of 2022 [AB 179 (Chapter 249, Statutes of 2022)]
Budget Act of 2024 [SB 108 (Chapter 166, Statutes of 2024)]

Interdependent Policy Changes:
Not Applicable.

Background:
Funding for behavioral health bridge housing is proposed to address the immediate housing and treatment needs of people experiencing unsheltered homelessness with serious behavioral health conditions by providing time-limited operational supports in various bridge housing settings, including existing assisted living settings.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is a decrease due to reevaluation of county funding needs and reduction of the General Fund funding to be spent in FY 2024-25.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due to a smaller share of previously approved authority anticipated to be expended in FY 2025-26.

Methodology:
1. Of the $957,936,000 GF appropriated for behavioral health bridge housing in FY 2022-23, assume $574,762,000 GF was estimated in FY 2023-24 and earlier, available for expenditure through June 30, 2027. Assume $132,500,000 GF is appropriated to the Department for behavioral health bridge housing in FY 2024-25.

2. The table below displays the estimated spending and remaining funds by Appropriation Years.

BEHAVIORAL HEALTH BRIDGE HOUSING
REGULAR POLICY CHANGE NUMBER: 146

The estimated costs in FY 2024-25 and FY 2025-26 are as follows:
(Dollars In Thousands)

	TF	GF
Appropriation Year 2022-23	$957,936	$957,936
Prior Years	$574,762	$574,762
Estimated in FY 2024-25	$191,587	$191,587
Estimated in FY 2025-26	$191,587	$191,587
Total Estimated Remaining	$0	$0
Appropriation Year 2024-25	$132,500	$132,500
Estimated in FY 2024-25	$80,500	$80,500
Estimated in FY 2025-26	$52,000	$52,000
Total Estimated Remaining	$0	$0

3. The estimated costs in FY 2024-25 and FY 2025-26 are as follows:
(Dollars In Thousands)

FY 2024-25	TF	GF
Appropriation Year 2022-23	$191,587	$191,587
Appropriation Year 2024-25	$80,500	$80,500
Total FY 2024-25	**$272,087**	**$272,087**

(Dollars In Thousands)

FY 2025-26	TF	GF
Appropriation Year 2022-23	$191,587	$191,587
Appropriation Year 2024-25	$52,000	$52,000
Total FY 2025-26	**$243,587**	**$243,587**

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

CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY

REGULAR POLICY CHANGE NUMBER: 148
IMPLEMENTATION DATE: 11/2022
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 2292

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$70,000,000	$0
- STATE FUNDS	$70,000,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$70,000,000	$0
STATE FUNDS	$70,000,000	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates funding for direct grants to county offices of education (COEs) and local educational agencies (LEAs) to build infrastructure, partnerships, and capacity statewide necessary to implement the Children and Youth Behavioral Health Initiative (CYBHI) fee schedule program (see Welfare & Institutions Code Section 5961.4).

Authority:
Budget Act of 2021 [SB 129 (Chapter 69, Statutes of 2021)]
Budget Act of 2022 [AB 179 (Chapter 249, Statutes of 2022)]
Budget Act of 2024 [SB 108 (Chapter 35, Statutes of 2024)]
Welfare & Institutions Code § 5961.2
Welfare & Institutions Code § 5961.4
DHCS Agreement #23-30276
AB 157 (Chapter 994, Statutes of 2024)

Interdependent Policy Changes:
Not applicable

Background:
Young people spend many hours in school settings and behavioral health (BH) services should be easily accessible and provided on or near school campuses, through partnerships between schools, commercial health insurance, Medi-Cal Managed Care Plans, counties, behavioral health providers and Community-Based Organizations (CBOs). This policy change estimates cost to provide direct grants available to COEs and LEAs to build infrastructure, partnerships, and capacity statewide to increase access to preventive and early intervention BH services for students.

As part of Children and Youth Behavioral Health Initiative (CYBHI), the Department is implementing the CYBHI Fee Schedule program. The School-Linked Partnership and Capacity grant program aims to support COE/LEA operational costs and infrastructure investments to support participation in school-based services reimbursement programs.

CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY

REGULAR POLICY CHANGE NUMBER: 148

This grant program will provide up to $400 million to LEAs and institutions of higher education to support individuals 25 years of age and younger from schools, in school providers, school affiliated CBOs, or school-based health centers.

The CYBHI is a multiyear package of investments. The CYBHI is intended to transform California's BH system for children and youth aged 0-25 into a world-class, innovative, up-stream focused, ecosystem where all children and young adults are routinely screened, supported, and served for emerging BH needs.

Reason for Change:
The change for FY 2024-25, from the prior estimate, is due to shift in timing of payments to grantees and updated amounts available for expenditure in FY 2024-25.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to no further funding available to be spent in FY 2025-26.

Methodology:
1. The Budget Act of 2021, SB 129 Provision 16(b) authorized $100,000,000 General Fund (GF) in FY 2021-22 with multi-year authority. This funding is available for expenditure through June 30, 2024. Assume $30,000,000 is reduced from the 2021-22 Appropriation in FY 2023-24. AB 157 (Chapter 994, Statutes of 2024) authorizes the reappropriation of up to $70,000,000 for encumbrance or expenditure until June 30, 2025.

2. The Budget Act of 2022, AB 179 Provision 16 authorized $450,000,000 GF in FY 2022-23, with multi-year authority. This funding is available for encumbrance or expenditure until June 30, 2025. Assume $120,000,000 is reduced from the 2022-23 Appropriation in FY 2024-25.

3. Of the $550,000,000 GF, $400,000,000 is targeted to pre-school through 12th grade and $150,000,000 is targeted to higher education. Grant dollars will be distributed to LEAs from county offices of education, school districts, school sites, charter schools, CA Schools for the Deaf, CA Schools for the Blind, and institutions of higher education. The Budget Act of 2024 reduces this funding for community colleges ($100,000,000 GF) and other higher education grants ($50,000,000 GF).

CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY

REGULAR POLICY CHANGE NUMBER: 148

5. The table below displays the estimated spending and remaining funds by Appropriation Years:

(Dollars in Thousands)

Appropriations	TF	GF
Appropriation Year 2021-22	$70,000	$70,000
Prior Years	$0	$0
Estimated in FY 2024-25	$70,000	$70,000
Total Estimated Remaining	$0	$0
Appropriation Year 2022-23	$330,000	$330,000
Prior Years	$330,000	$330,000
Total Estimated Remaining	$0	$0

6. The estimated costs in FY 2024-25 and FY 2025-26 are as follows:

(Dollars in Thousands)

FY 2024-25	TF	GF
Appropriation Year 2021-22	$70,000	$70,000
Total FY 2024-25	**$70,000**	**$70,000**

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

MEDICAL PROVIDER INTERIM PAYMENT LOAN REPAYMENT

REGULAR POLICY CHANGE NUMBER: 149
IMPLEMENTATION DATE: 9/2024
ANALYST: Celine Donaldson
FISCAL REFERENCE NUMBER: 2503

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$310,922,000	$0
- STATE FUNDS	$310,922,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$310,922,000	$0
STATE FUNDS	$310,922,000	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the cost or repaying a Medical Provider Interim Payment (MPIP) loan from the General Fund received in May 2024.

Authority:
Government Code Section 16531.1

Interdependent Policy Changes:
Not Applicable

Background:
Government Code Section 16531.1 allows DHCS to request a General Fund loan to support Medi-Cal operations if a budget is not passed by June 30 or if there is a deficiency. This loan comes in the form of a transfer from the General Fund of up to 10 percent of the amount appropriated from the General Fund for Medi-Cal benefit costs in the Budget Act of the most recent fiscal year, to the MPIP Fund. DHCS is required to repay the transfer either in the same fiscal year in which it was made or in the subsequent fiscal year, as determined by DHCS in consultation with Department of Finance.

In May 2024, DHCS determined it would not have sufficient General Fund authority to continue making necessary payments in the Medi-Cal program through the end of the 2023-24 fiscal year. DHCS received a loan from the MPIP fund which allowed DHCS to continue making payments while various other funding sources came in.

Reason for Change:
This is a new policy change.

MEDICAL PROVIDER INTERIM PAYMENT LOAN REPAYMENT

REGULAR POLICY CHANGE NUMBER: 149

Methodology:

After accounting for the other funding sources that came in before the end of the 2023-24 fiscal year, DHCS requires $310,922,000 in General Fund authority to repay the remainder of the MPIP loan. The MPIP loan repayment occurred in September 2024.

Funding:

100% General Fund (4260-101-0001)

QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES

REGULAR POLICY CHANGE NUMBER: 150
IMPLEMENTATION DATE: 2/2024
ANALYST: Tyler Shimizu
FISCAL REFERENCE NUMBER: 2329

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$245,666,000	$323,831,000
- STATE FUNDS	$36,850,000	$48,575,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$245,666,000	$323,831,000
STATE FUNDS	$36,850,000	$48,575,000
FEDERAL FUNDS	$208,816,000	$275,256,000

Purpose:
This proposal estimates the cost for counties to provide qualifying community-based mobile crisis intervention services to Medi-Cal members in need of Medi-Cal behavioral health services.

Authority:
Welfare & Institutions Code 14680-14685.1
California Constitution Article XIII Section 36
Specialty Mental Health Services (SMHS) Program 1915(b) Waiver
Drug Medi-Cal Organized Delivery System (DMC-ODS) 1115 Waiver
22 CCR § 51341.1
American Rescue Plan (ARP) Act of 2021

Interdependent Policy Changes:
Not Applicable

Background:
Under existing law, the Department is responsible for administering the Medi-Cal Specialty Mental Health Services (SMHS) Waiver Program that provides SMHS to Medi-Cal members through county Mental Health Plans (MHPs). The Department is also responsible for administering substance use disorder (SUD) treatment services through the Drug Medi-Cal Organized Delivery System (DMC-ODS), and the Drug Medi-Cal (DMC) program, for counties not participating in the DMC-ODS.

Crisis intervention services is a current benefit in SMHS, DMC-ODS, and DMC, and counties are required to provide or arrange the services anywhere in the community. However, these services are not currently required to be provided or arranged as “mobile” services, nor are they required to be available in the community 24 hours a day, 7 days a week, with on-call, multidisciplinary teams. Additionally, as currently defined, crisis intervention services does not meet the new federal definition for qualifying community-based mobile crisis intervention services.

QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES
REGULAR POLICY CHANGE NUMBER: 150

The Department added qualifying community-based mobile crisis intervention services, as of January 1, 2023, for a five-year period, as a mandatory Medi-Cal benefit in SMHS, DMC, and DMC-ODS, available to eligible Medi-Cal members, statewide, 24 hours a day, 7 days a week, implemented through the Medi-Cal behavioral health delivery systems by multidisciplinary mobile crisis teams in the community. The Department developed statewide standards for the new service, including requirements for the multidisciplinary team. The benefit would be provided outside a hospital or other facility setting and include rapid response, assessment, community-based stabilization and de-escalation, warm handoffs, and coordination with and referrals to health, social, and other services and supports, as appropriate.

Section 9813 of the ARP provides states with the option of providing qualifying community-based mobile crisis intervention services during a five-year period, starting April 1, 2022, with an opportunity for three years of 85 percent federal medical assistance percentage for qualifying services. The ARP requires the additional federal medical assistance percentage to supplement, not supplant, the level of state spending for these services in the fiscal year before the first quarter the state elects to implement this service. No current Medi-Cal behavioral health services meet the federal definition of a qualifying community-based mobile crisis intervention services.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is a decrease due to a reduction in the Cohort 2 (previously referred to as “Small County”) FY 2024-25 payments to account for supplemental payments that will occur in FY 2025-26.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to FY 2024-25 including lagged FY 2023-24 amounts which are still being rolled out meanwhile FY 2025-26 includes FY 2024-25 and FY 2025-26 amounts which are based on amounts assumed at full roll out.

Methodology:
1. To estimate the cost of qualifying community-based mobile crisis intervention services related to SMHS, use the total of FY 2018-19 approved claims for Crisis Stabilization (CS) as the basis. Assume the annual cost for qualifying community-based mobile crisis intervention services will be three times the total of FY 2018-19 CS approved claims.

2. For qualifying community-based mobile crisis intervention related to SUD, assume the annual cost is one-third of the total of FY 2018-19 CS approved claims, as we expect these calls to be less frequent. (Most SUD-related calls will be due to an overdose, where a paramedic is the appropriate response.) Assume the split between DMC-ODS and DMC State Plan counties is 80% and 20%, respectively.

3. Beginning January 1, 2024, under the ARP Act, initial funding splits for qualifying community-based mobile crisis intervention services will be covered with 85% federal funds and 15% State General fund through December 31, 2026.

4. Assume the delivery of services for all counties will increase by 16.6667% per month, for January 2024 through June 2024, due to roll-out. The accrual estimates for FY 2024-25 and FY 2025-26 are:

QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES
REGULAR POLICY CHANGE NUMBER: 150

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
Mobile Crisis Response – SMHS	$283,214	$42,482	$240,732
Mobile Crisis Response – DMC-ODS	$23,551	$3,533	$20,018
Mobile Crisis Response – DMC State Plan	$5,888	$883	$5,005
Cohort 2	$11,178	$1,677	$9,501
Total	$323,831	$48,575	$275,256

FY 2025-26	TF	GF	FF
Mobile Crisis Response – SMHS	$283,214	$42,482	$240,732
Mobile Crisis Response – DMC-ODS	$23,551	$3,533	$20,018
Mobile Crisis Response – DMC State Plan	$5,888	$883	$5,005
Cohort 2	$11,178	$1,677	$9,501
Total	$323,831	$48,575	$275,256

5. Assume 67% of claims for mobile crisis intervention will be paid in the year services are provided and 33% paid in the subsequent year. The cash estimates for FY 2024-25 and FY 2025-26 are:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
Mobile Crisis Response – SMHS	$217,016	$32,552	$184,464
Mobile Crisis Response – DMC-ODS	$18,046	$2,707	$15,339
Mobile Crisis Response – DMC State Plan	$4,512	$677	$3,835
Cohort 2	$6,092	$914	$5,178
Total	**$245,666**	**$36,850**	**$208,816**

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
Mobile Crisis Response – SMHS	$283,214	$42,482	$240,732
Mobile Crisis Response – DMC-ODS	$23,551	$3,533	$20,018
Mobile Crisis Response – DMC State Plan	$5,888	$883	$5,005
Cohort 2	$11,178	$1,677	$9,501
Total	**$323,831**	**$48,575**	**$275,256**

Funding:
85% Title XIX FF / 15% GF (4260-101-0001/0890)

CYBHI - EVIDENCE-BASED BH PRACTICES

REGULAR POLICY CHANGE NUMBER: 151
IMPLEMENTATION DATE: 4/2023
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 2323

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$219,285,000	$41,592,000
- STATE FUNDS	$219,285,000	$41,592,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$219,285,000	$41,592,000
STATE FUNDS	$219,285,000	$41,592,000
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the cost of grants to scale Evidence-Based Practices (EBP) and Community-Defined Evidence Practices (CDEP) statewide, to improve youth Behavioral Health (BH) based on robust evidence for effectiveness, impact on racial equity, and sustainability.

Authority:
Budget Act of 2022 [AB 179 (Chapter 249, Statutes of 2022)]
Welfare & Institutions Code 5961.5
Interagency Agreement (22-20616)
Agreement Number 23-30167

Interdependent Policy Changes:
Not Applicable

Background:
As part of the Children and Youth Behavioral Health Initiative (CYBHI), the Department, will distribute over $300 million in grants to organizations seeking to scale EBPs and/or CDEPs. By scaling EBPs and CDEPs throughout the state, the Department aims to improve access to critical BH interventions, including those focused on prevention, early intervention, and resiliency/recovery for children and youth, with a specific focus on children and youth who are from either or both of the following groups: Black, Indigenous, and People of Color (BIPOC) and the LGBTQIA+ community.

Through an extensive community engagement process, the Department selected a limited number of EBPs and CDEPs to consider for scaling throughout the state, subject to further refinement based on an assessment of sustainable financing mechanisms, including Medi-Cal and commercial coverage and/or other funding streams. Funding will be issued through competitive grants to counties, tribal entities, health plans (Medi-Cal and commercial), community-based organizations, and BH providers to support implementation of these EBPs and programs for children and youth. Grants would be administered through a third-party grant administrator. Grantees would be required to share standardized data in a statewide BH dashboard.

CYBHI - EVIDENCE-BASED BH PRACTICES

REGULAR POLICY CHANGE NUMBER: 151

The CYBHI is a multiyear package of investments. The CYBHI is intended to transform California's BH system for children and youth aged 0-25 into a world-class, innovative, up-stream focused, ecosystem where all children and young adults are routinely screened, supported, and served for emerging BH needs.

Reason for Change:
The change for FY 2024-25, from the prior estimate, is due to reduction in the 2024 Budget Act and timing of payments to the Third-Party Administrator (TPA) contractor and grantees.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to expected timing of the final payments to grantees and the TPA contractor.

Methodology:
1. The Department will convene a stakeholder workgroup to identify a small number of evidence-based practices that would then be deployed across the state, through grant-making. The $381.9 million Total Fund (TF) is available for encumbrance or expenditure until June 30, 2025.

2. The Department is partnering, via an Interagency Agreement (IA), with the Mental Health Oversight & Accountability Commission (MHSOAC) to co-lead two of the six workstreams. Through this IA, the Department will transfer a portion of the dollars. These funds will support the MHSOAC's grant management activities and provision of technical assistance to grantees in these rounds of funding. Of the $42.9 million carved out for MHSOAC, $15 million TF will support grant management and the provision of technical assistance and $27.9 million will support direct awards for grantees in these two rounds of funding.

3. The Department will utilize up to $42.9 million to fund a third-party administrator to assist with grant management, technical assistance and data collection.

4. $47,135,000 GF is assumed to be reduced from the 2022-23 Appropriation in FY 2024-25.

5. The table below displays the estimated spending and remaining funds by Appropriation Years:

(Dollars in Thousands)

	TF	GF
Appropriation Year 2022-23	$381,865	$381,865
Prior Year	$120,988	$120,988
Estimated in FY 2024-25	$219,285	$219,285
Estimated in FY 2025-26	$41,592	$41,592
Total Estimated Remaining	$0	$0

CYBHI - EVIDENCE-BASED BH PRACTICES
REGULAR POLICY CHANGE NUMBER: 151

6. The estimated costs in FY 2024-25 and FY 2025-26 are as follows:

(Dollars in Thousands)

FY 2024-25	TF	GF
Appropriation Year 2022-23	$219,285	$219,285
Total FY 2024-25	**$219,285**	**$219,285**

(Dollars in Thousands)

FY 2025-26	TF	GF
Appropriation Year 2022-23	$41,592	$41,592
Total FY 2025-26	**$41,592**	**$41,592**

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

SELF-DETERMINATION PROGRAM - CDDS

REGULAR POLICY CHANGE NUMBER: 152
IMPLEMENTATION DATE: 7/2020
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2208

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$202,734,000	$296,578,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$202,734,000	$296,578,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$202,734,000	$296,578,000

Purpose:
This policy change estimates the federal match for the Self Determination Program (SDP) Waiver of the California Department of Developmental Services (CDDS).

Authority:
Welfare & Institutions (W&I) Code Section 4685.8
Interagency Agreement (IA) 19-96260

Interdependent Policy Changes:
Not Applicable

Background:
CDDS, under a federal Home and Community Based Services (HCBS) 1915 (c) waiver, offers and arranges for non-State Plan Medicaid services via the Regional Center system. The SDP waiver allows the State to offer these services to individuals who would otherwise require the level of care provided in a hospital, nursing facility (NF), or in an intermediate care facility for the developmentally disabled (ICF/DD). Services covered under this waiver include but are not limited to: home health aide services, community living and integration supports, non-medical transportation, communication support, family and consumer training, homemaker, nutritional consultation, specialized medical equipment/supplies, respite services, personal emergency response system, crisis intervention and support, employment and prevocational supports, vehicle and environmental accessibility adaptations, skilled nursing, financial management services, independent facilitator services, and transition/set-up expenses.

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

SELF-DETERMINATION PROGRAM - CDDS

REGULAR POLICY CHANGE NUMBER: 152

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to higher paid expenditure and prior year expenditures in FY 2024-25.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to higher paid and prior year expenditures based on the projection of increased utilization of the program in FY 2025-26.

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

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	FF
FY 2024-25	$405,468	$202,734	**$202,734**
FY 2025-26	$593,156	$296,578	**$296,578**

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

HCBS SP CDDS

REGULAR POLICY CHANGE NUMBER: 153
IMPLEMENTATION DATE: 6/2022
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2348

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$431,814,000	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$431,814,000	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$431,814,000	$0

Purpose:
This policy change estimates the federal reimbursements for the California Department of Developmental Services (CDDS) home and community-based services (HCBS) spending plan items.

Authority:
American Rescue Plan (ARP) Act (2021)
Section 11.95, 2021 Budget Act

Interdependent Policy Changes:
Not Applicable

Background:
The American Rescue Plan Act of 2021 (ARP) provides additional Coronavirus Disease 2019 (COVID-19) relief to states. Section 9817 of the ARP provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS). Increased FMAP is available from April 1, 2021 through March 31, 2022. States must use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021, and states must use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. State funds equivalent to the amount of federal funds attributable to the increased FMAP are deposited in the Home and Community-Based Services American Rescue Plan Fund pursuant to Section 11.95 of the 2021 Budget Act. Section 11.95 appropriates this funding to eligible HCBS activities identified in the HCBS Spending Plan.

HCBS SP CDDS
REGULAR POLICY CHANGE NUMBER: 153

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to an updated spending plan estimate based on actual costs reported quarterly and projected expenditures.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to the sunset of ARP funds in FY 2024-25.

Methodology:
1. The cash basis estimate for the HCBS spending plan items for CDDS are:

(Dollars in Thousands)

FY 2024-25	TF	HCBS ARP Fund - CDDS	FF
Coordinated Family Support Services	$1,994	$1,004	**$990**
Developmental Services Rate Model Implementation	$544,501	$114,075	**$430,426**
Social Recreation and Camp Services for Individuals with Developmental Disabilities	$1,304	$906	**$398**
Total	$547,799	$115,985	**$431,814**

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

CALAIM - PATH WPC

REGULAR POLICY CHANGE NUMBER: 154
IMPLEMENTATION DATE: 7/2024
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2439

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$91,898,000	$0
- STATE FUNDS	$43,168,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$91,898,000	$0
STATE FUNDS	$43,168,000	$0
FEDERAL FUNDS	$48,730,000	$0

Purpose:
This policy change estimates the funding available for the California Advancing and Innovating Medi-Cal (CalAIM) Providing Access and Transforming Health (PATH) Initiative for the Whole Person Care (WPC) Services and Transition to Managed Care Mitigation Initiative.

Authority:
Penal Code Section 4011.11
Welfare & Institutions Code Sections 14011.10, 14132.275, 14184.800, and 14186
AB 133 (Chapter 133, Statutes of 2021)
AB 128 (Chapter 21, Statutes of 2021)
CalAIM Section 1115(a) Medicaid Demonstration
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
On December 29, 2021, the Centers for Medicare & Medicaid Services (CMS) approved the CalAIM Section 1115 Wavier Demonstration, which provided funding for the CalAIM PATH Initiative through December 31, 2026. The state is authorized up to $1.85 billion (total computable) in expenditure authority for PATH. The PATH Initiative is to build up the capacity and infrastructure of on-the-ground partners and providers to successfully participate in CalAIM Enhanced Care Management (ECM) and Community Supports, and Justice Involved (JI) Services. PATH is comprised of the following efforts.

Whole Person Care Services and Transition to Managed Care Mitigation Initiative
Costs for the WPC Services and Transition to Managed Care Mitigation Initiative, an initiative under PATH, are budgeted in this policy. Costs for the other PATH initiatives, Technical Assistance (TA) Initiative, Collaborative Planning and Implementation Initiative, Capacity and Infrastructure Transition, Expansion and Development (CITED) Initiative, and JI Capacity Building Program are budgeted in the CalAIM – PATH policy change.

CALAIM - PATH WPC
REGULAR POLICY CHANGE NUMBER: 154

Under the WPC Services and Transition to Managed Care Mitigation Initiative, services provided by former WPC Pilots were funded until the services transition to managed care coverage under CalAIM. This funding ended on April 1, 2024. All of PATH funding, except for WPC Mitigation Initiatives/Funding for Sustaining Services Through the Transition to Managed Care will be considered an administrative cost and will be paid at the 50% regular administrative expenditure matching rate. Funding for Sustaining Services Through the Transition to Managed Care will be matched at the federal medical assistance percentage (FMAP) matching rate as Medicaid services and benefits.

Support for Sustaining Reentry Demonstration Initiative Services Through Transition to Managed Care
PATH provides funding to former WPC Pilot Lead Entities to maintain reentry services currently provided through former WPC Pilots that do not transition to managed care until January 1, 2023, or later. Medi-Cal services for JI populations prior to release will launch in October 2024. Pre-release and reentry services that map to required ECM and MCP-offered Community Supports Services provided by former WPC Pilot will be funded until services transition to managed care. This funding will be matched at the regular administrative matching rate (50%) for these specific PATH expenditures.

As a result of the Coronavirus Disease 2019 (COVID-19) national public health emergency, increased FMAP was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase due to a delay in program invoicing and a shift in payment dates. As a result, some funding is shifting from FY 2023-24 into FY 2024-25. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease as final payments will be completed in FY 2024-25.

Methodology:
1. The Department has awarded eight former WPC Lead Entities to receive PATH WPC Services and Transition to Managed Care Mitigation Initiative funding. Invoices were processed in September 2023 for expenditures from January through June 2023 and in May 2024 for expenditures from July through December 2023. Invoices will be received for services through October 2024 to cover JI Services that are delayed to transition under a Managed Care Plan.
    a. Assume midyear invoices that captured expenditures from January through June 2023 were due in August 2023. The Department reviewed and provided approval for the payment process to begin in September 2023.
    b. Assume annual invoices that captured expenditures from July through December 2023 were due in April 2024. The Department reviewed and provided approval for the payment process to begin in May 2024.

2. The Department payment will be made through an Intergovernmental Transfer process. The Department will inform the WPC Lead Entity that their invoice has been approved. The former WPC Lead Entity has seven days to wire 50% of their approved invoice amount to the Department. The Department will provide the remaining 50% federal match amount. The total 100% approved invoice amount will be paid back to the former WPC Lead Entity.

CALAIM - PATH WPC
REGULAR POLICY CHANGE NUMBER: 154

3. Assume that due to the amendment of the 1115 waiver, Funding for Sustaining Services Through the Transition to Managed Care will be billed as direct member services and qualify for increased FMAP for services rendered through December 31, 2023, as a result of COVID-19.

4. On a cash basis, PATH WPC Program costs are estimated to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2024-25	**$91,898**	**$43,168**	**$48,730**

Funding:
(Dollars in Thousands)

FY 2024-25	TF	GF	FF
100% Title XIX FF (4260-101-0890)	$45,949	$0	$45,949
Reimbursement GF (4260-601-0995)	$43,168	$43,168	$0
COVID-19 Title XIX Increased FMAP (4260-101-0890)	$2,781	$0	$2,781
Total	**$91,898**	**$43,168**	**$48,730**

CYBHI - URGENT NEEDS AND EMERGENT ISSUES

REGULAR POLICY CHANGE NUMBER: 155
IMPLEMENTATION DATE: 7/2021
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2375

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$44,500,000	$12,130,000
- STATE FUNDS	$44,500,000	$12,130,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$44,500,000	$12,130,000
STATE FUNDS	$44,500,000	$12,130,000
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the program costs to address new programs categorized as Urgent Needs and Emergent Issues in Children and Youth Behavioral Health Initiative (CYBHI).

Authority:
AB 179 (Chapter 249, Statutes of 2022)
DHCS Agreement # 22-20444
DHCS Agreement # 22-20432
DHCS Agreement # 22-20435

Interdependent Policy Change:
Not Applicable

Background:
The CYBHI is a multiyear package of investments as part of the FY 2021-22 budget agreement. The CYBHI is intended to transform California's behavioral health system for children and youth aged 0-25 into a world-class, innovative, up-stream focused, ecosystem where all children and young adults are routinely screened, supported, and served for emerging behavioral health needs.

The COVID-19 pandemic has intensified already swelling children's behavioral health issues. Addressing these needs is vital to California's recovery and consistent with the state's priorities to improve behavioral health for all Californians.

The most glaring behavioral health challenges are borne inequitably by communities of color, low-income communities, LGBTQ+ communities, and in places where adverse childhood experiences are widespread and prominent. These investments align with the state's commitment and ongoing efforts to improve health equity.

The significant investment of one-time funds through the CYBHI will have a meaningful impact on outcomes for children and youth in the long-term. However, as the components of the CYBHI continue to be developed and implemented, there is an urgent and immediate need to continue

CYBHI - URGENT NEEDS AND EMERGENT ISSUES
REGULAR POLICY CHANGE NUMBER: 155

to invest in efforts that address children's behavioral health. Through this proposal, the Department will invest additional resources in targeted efforts to address urgent and emergent issues in children and youth behavioral health. These proposals are consistent with and complementary of the investments in the Children and Youth Behavioral Health Initiative.

The Budget Act of 2022 provided $120,500,000 in FY 2022-23, $25,500,000 in FY 2023-24, and $29,000,000 in FY 2024-25 from the General Fund as part of a multiyear plan to provide $175 million from the General Fund for the following:

- Wellness and Resilience Building Supports for Children, Youth, and Parents (Wellbeing and Mindfulness Program)
- A Video Series to Provide Parents with Resources and Skills to Support their Children's Mental Health
- Leveraging of Emerging Technologies to Develop Next Generation Digital Supports for Remote Mental Health Assessment and Intervention
- School-Based Peer Mental Health Demonstration Project (High School Peer-to-Peer Program)

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a decrease in FY 2024-25 due updated payments to the contractors. The change in the current estimate, from FY 2024-25 to FY 2025-26, is a decrease due to less payments to contractors.

Methodology:
1. The Budget Act for FY 2022-23 provided $120,500,000 in FY 2022-23, available through June 30, 2025. The Department requested an additional $25,500,000 in FY 2023-24 and an additional $29,000,000 for the FY 2024-25. The table below displays the estimated spending and remaining funds by Appropriation Year:

	TF	GF	FF
Appropriation Year 2022-23			
Prior Years	$92,870,000	$92,870,000	$0
Estimated in FY 2024-25	$27,630,000	$27,630,000	$0
Total Estimated Remaining	$0	$0	$0
Appropriation Year 2023-24			
Prior Years	$25,500,000	$25,500,000	$0
Estimated in FY 2024-25	$0	$0	$0
Total Estimated Remaining	$0	$0	$0
Appropriation Year 2024-25			
Prior Years	$0	$0	$0
Estimated in FY 2024-25	$16,870,000	$16,870,000	$0
Estimated in FY 2025-26	$12,130,000	$12,130,000	$0
Total Estimated Remaining	$0	$0	$0

CYBHI - URGENT NEEDS AND EMERGENT ISSUES

REGULAR POLICY CHANGE NUMBER: 155

Fiscal Year	TF	GF	FF
FY 2024-25	$44,500,000	$44,500,000	$0
FY 2025-26	$12,130,000	$12,130,000	$0

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

ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS

REGULAR POLICY CHANGE NUMBER: 156
IMPLEMENTATION DATE: 6/2011
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1232

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$98,775,000	$65,958,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$98,775,000	$65,958,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$98,775,000	$65,958,000

Purpose:
This policy change estimates the federal financial participation (FFP) for transportation and day care costs of Intermediate Care Facility - Developmentally Disabled (ICF-DD) members for the California Department of Developmental Services (CDDS).

Authority:
Interagency Agreement (IA) 07-65896

Interdependent Policy Changes:
Not Applicable

Background:
Members that reside in ICF-DDs receive active treatment services from providers located off-site from the ICF-DD. The active treatment and transportation are currently arranged for and paid by the local Regional Centers, which in turn bills the CDDS for reimbursement with 100% General Fund (GF) 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 members. CMS approved reimbursement for these costs retroactive to July 1, 2007.

The GF is in the CDDS budget on an accrual basis, the federal funds are on a cash basis in the Department’s budget.

ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS

REGULAR POLICY CHANGE NUMBER: 156

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to increases in utilization and prior year expenditures for FY 2024-25.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to lower prior year expenditures expected in FY 2025-26.

Methodology:
1. FY 2024-25 includes a portion of payments for FY 2021-22 and FY 2022-23 expenditures. FY 2025-26 includes a portion of payments for FY 2023-24 expenditures and FY 2024-25.

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

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	FFP Regular
FY 2024-25	$197,550	$98,775	**$98,775**
FY 2025-26	$131,916	$65,958	**$65,958**

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

MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG

REGULAR POLICY CHANGE NUMBER: 157
IMPLEMENTATION DATE: 7/2019
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 2097

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$62,240,000	$51,227,000
- STATE FUNDS	$62,240,000	$51,227,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$62,240,000	$51,227,000
STATE FUNDS	$62,240,000	$51,227,000
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the cost of the Medi-Cal Physicians and Dentists Loan Repayment Program.

Authority:
SB 170 (Chapter 240, Statutes of 2021)
AB-186 (Chapter 46, Statutes of 2022)
Welfare & Institutions Code Section 14114
Revenue & Taxation Code Section 31005
Contract 18-95474

Interdependent Policy Changes:
Not Applicable

Background:
The California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56, 2016), increased the excise tax rate on cigarettes and tobacco products and allocates a portion of the tobacco tax revenue to the Department for use as the non-federal share of health care expenditures, subject to appropriation by the Legislature.

SB 840 (Chapter 29, Statutes of 2018) appropriated $220 million in Proposition 56 funding to the Medi-Cal Physicians and Dentists Loan Repayment Program and enacted Welfare & Institutions Code 14114. The program provides loan assistance payments to qualifying, recent graduate physicians and dentists that serve members of Medi-Cal and other specified health care programs.

Each cohort will receive the payments over five years.

SB 89 (Chapter 2, Statutes of 2020) appropriated an additional $120 million in Proposition 56 funding and made the combined $340 million available until June 30, 2029. SB 170 (Chapter 240, Statutes of 2021) transferred the balance of these appropriations to the Loan Repayment Program Account, Healthcare Treatment Fund.

MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG

REGULAR POLICY CHANGE NUMBER: 157

SB 395 (Chapter 489, Statutes of 2021) increased the excise tax on electronic cigarettes. Revenue & Taxation Code Section 31005 allocates a portion of the increased revenue to the Physicians and Dentists Loan Repayment Program.

AB 186 (Chapter 46, Statutes of 2022) allocates a portion of remitted amounts of funds collected when Medi-Cal managed care plans do not comply with a minimum 85% medical loss ratio consistent with federal requirements to the program. AB 186 also:

- Requires the Department to expend all funds appropriated from the Loan Repayment Program Account of the Healthcare Treatment Fund before expending any funds from the Medi-Cal Loan Repayment Program Special Fund; and
- Deletes the provision making this program inoperative on January 1, 2026, thereby extending it indefinitely.

The Department has contracted with Physicians for a Healthy California to implement and administer the Proposition 56 funded Physicians and Dentists Loan Repayment Program pursuant to Welfare and Institutions Code section 14114(g).

Reason for Change:
There is a decrease for FY 2024-25, from the prior estimate, due to updated payment timings based on delayed invoicing and lower projected expenditures due to participants not meeting payment requirements. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due to Cohort 1 payments ending in FY 2024-25.

Methodology:

1. Cohort 1 is expected to receive $11.4 million each year for five years, with payments beginning in FY 2020-21. Cohort 2 is expected to receive $10.9 million each year for five years, with payments beginning in FY 2021-22. Cohort 3 is expected to receive $12.2 million each year for five years, with payments beginning in FY 2022-23. Cohort 4 is expected to receive $11.9 million each year for five years, with payments beginning in FY 2023-24. Cohort 5 is expected to receive $14.4 million each year for five years, with payments beginning in FY 2024-25. Cohort 6 payments are expected to begin in FY 2026-27 using unallocated Proposition 56 funding; the annual amount that Cohort 6 is expected to receive is yet to be determined.

2. The contract for the administrative costs is approximately $1.7 million in FY 2024-25 and $1.7 million FY 2025-26, with the payments being retrospective and invoices processed the month after services have been provided.

3. For each Cohort, awardee payments are issued retrospectively on an annual basis for five years after the program administrators complete an annual review and indicate the awardees comply with program requirements.

MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG

REGULAR POLICY CHANGE NUMBER: 157

4. The estimated program expenditures for FY 2024-25 and FY 2025-26 are:

Fiscal Years	TF	SF
FY 2024-25	$62,240,000	$62,240,000
FY 2025-26	$51,227,000	$51,227,000

Funding:
100% Prop 56 Loan Repayment Program (4260-601-3375)

QAF WITHHOLD TRANSFER

REGULAR POLICY CHANGE NUMBER: 158
IMPLEMENTATION DATE: 7/2017
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 2092

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$59,276,000	-$50,000
- STATE FUNDS	$29,638,000	-$25,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$59,276,000	-$50,000
STATE FUNDS	$29,638,000	-$25,000
FEDERAL FUNDS	$29,638,000	-$25,000

Purpose:
This policy change budgets for withheld Fee-for-Service payments (FFS) associated with the Hospital Quality Assurance Fee (HQAF), AB 1629 Skilled Nursing Facilities (SNF) QAF, Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs) QAF, and Ground Emergency Medical Transportation (GEMT) QAF.

Authority:
Welfare & Institutions (W&I) Code, Section 14169.52(h)
W&I Code, Section 14129.2(d)(2)
Health and Safety Code, Section 1324.22(e)(2)
Provider Bulletin LTC June 2009, #388, Code Section 103

Interdependent Policy Changes:
Long Term Care Quality Assurance Fund Expenditures

Background:
To recover past due QAF from delinquent providers, the Department currently withholds portions of the delinquent provider's FFS payments, applies those payments to the delinquent QAF debt, and transfers the withheld portion. As Medi-Cal is on a cash basis, these expenditures were originally budgeted in the fiscal year the claim was processed.

For the HQAF, the withheld portion is transferred to the Hospital Quality Assurance Revenue Fund.

For AB 1629 SNF and ICF/DD QAF, the withheld portions are transferred to the Long Term Care Quality Assurance Fund (LTC QAF), and subsequently to the General Fund (GF), providing savings once the transfer occurs. The fund adjustment from the LTC QAF to the GF is budgeted in the Long Term Care Quality Assurance Fund Expenditures policy change.

For GEMT QAF, the withheld portion is transferred to the Medi-Cal Emergency Medical Transport Fund.

QAF WITHHOLD TRANSFER
REGULAR POLICY CHANGE NUMBER: 158

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to:
- For HQAF, prior year withhold transfers increased as there was a decrease in providers making payments in FY 2023-24.
- For LTC QAF, the estimate decreased as there were delays in implementing the 2023 QAF rate.
- For GEMT, prior year withhold transfers decreased as there was an increase in providers making payments in FY 2023-24.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to:
- For HQAF, the net FY 2025-26 estimate decreased due to the prior year withhold transfers decreasing based on the updated FY 2024-25 HQAF FFS cycle schedule.
- For LTCQAF, the FY 2025-26 net estimate increased due to prior withhold transfers are expected to be higher than withhold transfers from FY 2023-24.
- For GEMT, the net FY 2025-26 estimate increased due to prior year withhold transfers are expected to be higher than withhold transfers from FY 2023-24.

Methodology:
HQAF
1. Prior year FY 2023-24 HQAF withheld payments totaling $65.48 million TF will be transferred in FY 2024-25.

2. An estimated $4.52 million TF in HQAF withholds will occur in FY 2024-25. These withholds are pending transfer in the next FY and offsets a portion of the $65.48 million HQAF withhold transfer.

3. An estimated $4.52 million TF of FY 2024-25 HQAF withheld payments will be paid in FY 2025-26. This prior year withhold transfer is offset by $4.52 million in withholds that are estimated to occur in FY 2025-26 but are pending transfer in FY 2026-27.

LTC QAF
4. Prior year FY 2023-24 LTC QAF withheld payments totaling $0.77 million TF will be transferred in FY 2024-25.

5. An estimated $2.43 million TF in LTC QAF withholds will occur in FY 2024-25. These withholds are pending transfer in the next FY and offsets a portion of the $0.77 million LTC QAF withhold transfer.

6. An estimated $2.43 million of FY 2024-25 LTC QAF withheld payments will be paid in FY 2025-26. This prior year withhold transfer is offset by $2.48 million in withholds that are estimated to occur in FY 2025-26 but are pending transfer in FY 2026-27.

GEMT QAF
7. Prior year FY 2023-24 GEMT withheld payments totaling $0.02 million TF will be transferred in FY 2024-25.

8. An estimated $0.05 million in GEMT QAF withholds will occur in FY 2024-25. These withholds are pending transfer in the next fiscal year and offsets a portion of the $0.02 million GEMT QAF withhold transfer.

QAF WITHHOLD TRANSFER
REGULAR POLICY CHANGE NUMBER: 158

9. An estimated $0.05 million of FY 2024-25 GEMT QAF withheld payments will be paid in FY 2025-26. This prior year withhold transfer is offset by $0.05 million in withholds that are estimated to occur in FY 2025-26 but are pending transfer in FY 2026-27.

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
HQAF			
HQAF Prior Year Withhold Transfers	$65,480	$32,740	$32,740
HQAF FY 2024-25 New Withholds Pending Transfer	($4,518)	($2,259)	($2,259)
Subtotal HQAF for FY 2024-25	$60,962	$30,481	$30,481
LTC QAF			
LTC QAF Prior Year Withhold Transfers	$774	$387	$387
LTC QAF FY 2024-25 New Withholds Pending Transfer	($2,426)	($1,213)	($1,213)
Subtotal LTC QAF for FY 2024-25	($1,652)	($826)	($826)
GEMT QAF			
GEMT QAF Prior Year Withhold Transfers	$20	$10	$10
GEMT QAF FY 2024-25 New Withholds Pending Transfer	($54)	($27)	($27)
Subtotal GEMT QAF for FY 2024-25	($34)	($17)	($17)
Total FY 2024-25	**$59,276**	**$29,638**	**$29,638**

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
HQAF			
HQAF Prior Year Withhold Transfers	$4,518	$2,259	$2,259
HQAF FY 2025-26 New Withholds Pending Transfer	($4,518)	($2,259)	($2,259)
Subtotal HQAF for FY 2025-26	$0	$0	$0
LTC QAF			
LTC QAF Prior Year Withhold Transfers	$2,426	$1,213	$1,213
LTC QAF FY 2025-26 New Withholds Pending Transfer	($2,476)	($1,238)	($1,238)
Subtotal LTC QAF for FY 2025-26	($50)	($25)	($25)
GEMT QAF			
GEMT QAF Prior Year Withhold Transfers	$54	$27	$27
GEMT QAF FY 2025-26 New Withholds Pending Transfer	($54)	($27)	($27)
Subtotal GEMT QAF for FY 2025-26	$0	$0	$0
Total FY 2025-26	**($50)**	**($25)**	**($25)**

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

CALAIM - PATH FOR CLINICS

REGULAR POLICY CHANGE NUMBER: 159
IMPLEMENTATION DATE: 7/2024
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2423

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$40,000,000	$0
- STATE FUNDS	$40,000,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$40,000,000	$0
STATE FUNDS	$40,000,000	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates cost for the California Advancing & Innovating Medi-Cal (CalAIM) Providing Access and Transforming Health (PATH) Initiative to support the implementation of Enhanced Care Management (ECM) and Community Supports at clinics, including Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs).

Authority:
AB 102 (Chapter 38, Statutes of 2023)
AB 107 (Chapter 22, Statutes of 2024)
CalAIM Section 1115(a) Medicaid Demonstration
AB 108 (Chapter 39, Statutes of 2024)

Interdependent Policy Changes:
Not Applicable

Background:
The PATH Initiative is to build up the capacity and infrastructure of on-the-ground partners and providers to successfully participate in CalAIM ECM and Community Supports, and Justice Involved Services. The Budget Act for FY 2023-24 included $40 million in additional State General Fund (GF) to support PATH activities to build and expand infrastructure and capacity and implement ECM and Community Supports at clinics, including FQHCs and RHCs. The Department made these awards in FY 2024-25.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase due to all payments shifting from FY 2023-24 into FY 2024-25. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease as all funding is expected to be expended in FY 2024-25.

Methodology:
1. Implementation began on July 1, 2024, for this effort.

CALAIM - PATH FOR CLINICS
REGULAR POLICY CHANGE NUMBER: 159

2. It is assumed that PATH funding to support the implementation of ECM and Community Supports at clinics is budgeted at 100% GF.

3. The Department will maximize the $40 million to eligible entities through one-time funding though a special round of the Capacity and Infrastructure Transition, Expansion, and Development (CITED) initiative in a special CITED-Clinics round. The CITED-Clinic application window opened on January 15, 2024, and closed on February 15, 2024. In May 2024, $40 million in awards was announced.

4. The Budget Act for FY 2023-24 provided $40 million GF. The table below displays the estimated spending and remaining funds by Appropriation Year:

(Dollars in Thousands)

Appropriation Year 2023-24	**TF**	**GF**	**FF**
Estimated in FY 2024-25	$40,000	$40,000	$0
Total Estimated Remaining	$0	$0	$0

5. Total estimated costs for FY 2024-25 are:

(Dollars in Thousands)

FY 2024-25	**TF**	**GF**	**FF**
Appropriation Year 2023-24	$40,000	$40,000	$0
Total FY 2024-25	**$40,000**	**$40,000**	**$0**

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

CARE ACT

REGULAR POLICY CHANGE NUMBER: 160
IMPLEMENTATION DATE: 8/2024
ANALYST: Tyler Shimizu
FISCAL REFERENCE NUMBER: 2396

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$36,621,000	$47,125,000
- STATE FUNDS	$36,621,000	$47,125,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$36,621,000	$47,125,000
STATE FUNDS	$36,621,000	$47,125,000
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates county behavioral health department costs to provide services for the Community Assistance, Recovery, and Empowerment Act (CARE).

Authority:
SB 1338 (Chapter 319, Statutes of 2022)
SB 35 (Chapter 283, Statues of 2023)

Interdependent Policy Changes:
Not Applicable

Background:
The CARE Act framework delivers mental health and substance use disorder services for individuals who lack decision-making capacity due to serious mental illness. The framework provides individuals with an individualized, appropriate range of services and supports consisting of behavioral health (BH) care, stabilization medications, housing, and enumerated services.

The CARE Act connects a person in crisis with a court-ordered CARE plan for up to 12 months, with the possibility to extend for an additional 12 months. If a participant cannot successfully complete a CARE plan, the individual may be referred by the court for a conservatorship, consistent with current law. For individuals whose prior conservatorship proceedings were diverted, those proceedings will resume under the presumption that no suitable alternatives to conservatorship are available. For individuals whose criminal cases were diverted, those proceedings will resume.

The counties of Glenn, Orange, Riverside, San Diego, Stanislaus, and Tuolumne and the City and County of San Francisco implemented the program as of October 1, 2023. Los Angeles County implemented as of December 1, 2023. The remaining counties will implement no later than December 1, 2024.

CARE ACT
REGULAR POLICY CHANGE NUMBER: 160

SB 35 includes new notification requirements for county behavioral health agencies effective with the implementation of the CARE Act.

FY 2024-25 includes $6 million GF funding to the California Health and Human Services Agency for outreach contracts.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is a decrease, due to a reduction in the FY 2023-24 accrual estimated based on actual number of respondents and a reduction to the ramp up rate for FY 2024-25 due to not all counties implementing CARE Act until December 1, 2024. Additionally, cashflow increased based on shifting 100% of the dollars from FY 2023-24 to FY 2024-25 to account for delays in actual county claiming.

The change from FY 2024-25 to FY 2025-26 in the current estimate, is an increase, is due to: an increase in the number of estimated CARE cases from FY 2024-25 to FY 2025-26 due to the first full year all counties are engaged in claiming. Additionally, there is a 3% increase in the rates for activities.

Methodology:
1. The estimated accrual costs associated with the CARE Act activities Court Time, Court Report, Outreach & Engagement, Notice, and Data Reporting, for FY 2023-24, FY 2024-25, and FY 2025-26 are reflected in the tables below.

(Dollars in Thousands)

FY 2023-24	TF	GF
Court Time	$1,066	$1,066
Court Report	$3,953	$3,953
Outreach & Engagement	$1,337	$1,337
Notice	$872	$872
Data Reporting	$377	$377
Total	$7,605	$7,605

(Dollars in Thousands)

FY 2024-25	TF	GF
Court Time	$5,421	$5,421
Court Report	$20,110	$20,110
Outreach & Engagement	$6,801	$6,801
Notice	$4,437	$4,437
Reporting	$1,920	$1,920
Total	$38,689	$38,689

CARE ACT
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(Dollars in Thousands)

FY 2025-26	TF	GF
Court Time	$6,997	$6,997
Court Report	$25,958	$25,958
Outreach & Engagement	$8,778	$8,778
Notice	$5,727	$5,727
Data Reporting	$2,478	$2,478
Total	$49,938	$49,938

2. Assume on a cash basis for FY 2024-25, the Department will pay 100% of FY 2023-24 claims and 75% of FY 2024-25 claims. On a cash basis for FY 2025-26, the Department will pay 25% of FY 2024-25 clams and 75% of FY 2025-26 claims. The estimated costs for FY 2024-25 and FY 2025-26 are:

(Dollars in Thousands)

FY 2024-25	TF	GF
Court Time	$5,131	$5,131
Court Report	$19,036	$19,036
Outreach & Engagement	$6,437	$6,437
Notice	$4,199	$4,199
Data Reporting	$1,818	$1,818
Total	**$36,621**	**$36,621**

(Dollars in Thousands)

FY 2025-26	TF	GF
Court Time	$6,603	$6,603
Court Report	$24,496	$24,496
Outreach & Engagement	$8,283	$8,283
Notice	$5,404	$5,404
Data Reporting	$2,339	$2,339
Total	**$47,125**	**$47,125**

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

MISC. ONE-TIME PAYMENTS

REGULAR POLICY CHANGE NUMBER: 161
IMPLEMENTATION DATE: 7/2024
ANALYST: Erik Stacey
FISCAL REFERENCE NUMBER: 2502

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$31,500,000	$0
- STATE FUNDS	$31,500,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$31,500,000	$0
STATE FUNDS	$31,500,000	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the costs of various miscellaneous one-time payments as directed by the Legislature.

Authority:
Budget Act of 2024

Interdependent Policy Changes:
Not Applicable

Background:
The Budget Act of 2024 appropriates various one-time payments from the state General Fund (GF) for a variety of purposes. The Department of Health Care services is the distributing entity for some of these funds.

Reason for Change:
This is a new policy change.

MISC. ONE-TIME PAYMENTS
REGULAR POLICY CHANGE NUMBER: 161

Methodology:

1. The following items from the Budget Act of 2024—totaling $31,500,000—are to be distributed by the Department of Health Care Services in FY 2024-25:
   - $25,000,000 for the nonprofit Martin Luther King Jr. Community Hospital in South Los Angeles.
   - $5,000,000 for Los Angeles County for an interim housing project at Metropolitan State Hospital.
   - $1,000,000 for the nonprofit Hope the Mission for mobile mental health equipment and vehicles.
   - $500,000 for Humboldt County to support the Mad River Behavioral Health Crisis Triage Center.

2. The estimated costs in FY 2024-25 are as follows:

(Dollars in Thousands)

FY 2024-25	TF	GF
Appropriation Year 2024-25	$31,500	$31,500
Total FY 2024-25	**$31,500**	**$31,500**

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

INFANT DEVELOPMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 162
IMPLEMENTATION DATE: 7/2016
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2009

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$23,567,000	$20,671,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$23,567,000	$20,671,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$23,567,000	$20,671,000

Purpose:
This policy change estimates the federal match provided to the California Department of Developmental Services (CDDS) for Infant Development Program (IDP) services for infants and toddlers ages 0 to 3 with or at risk of developmental disabilities.

Authority:
Interagency Agreement 11-88601

Interdependent Policy Changes:
Not Applicable

Background:
On October 9, 2015, State Plan Amendment (SPA) 11-040 was approved by the Centers for Medicare and Medicaid Services to extend Medi-Cal coverage for IDP services provided to Medi-Cal eligible infants and toddlers ages 0 to 3 with or at risk of developmental delay under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, retroactive to October 1, 2011. This SPA authorizes the Department to claim federal financial participation (FFP) for the provision of IDP services by the state's Regional Center network of nonprofit providers to persons with developmental disabilities.

As a result of the COVID-19 national public health emergency, increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to increased prior year expenditures in FY 2024-25.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to decreased prior year expenditures expected in FY 2025-26.

INFANT DEVELOPMENT PROGRAM
REGULAR POLICY CHANGE NUMBER: 162

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

2. The negative COVID-19 enhanced FMAP is due to refunding invoices under the Infant Development Program and billing the Department through the HCBS Spending Plan (HCBS SP) under the American Rescue Plan Act (ARPA). The federal fund minus the COVID-19 enhanced FMAP comes up to the CDDS General Fund amount. The funds that were identified as an ARPA expenditure were refunded to the programs and then billed under the HCBS Spending Plan. See the HCBS SP CDDS policy change for the estimated HCBS Spending Plan expenditures.

3. Negative COVID-19 FF and ARPA invoices went out for Infant Development Program in September 2024.

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	FF	COVID-19 FF	Total FFP
FY 2024-25	$47,134	$23,567	**$23,574**	**($7)**	**$23,567**
FY 2025-26	$41,342	$20,671	**$20,671**	**$0**	**$20,671**

Funding:
100% Title XIX FFP (4260-101-0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)

CYBHI - CALHOPE STUDENT SUPPORT

REGULAR POLICY CHANGE NUMBER: 164
IMPLEMENTATION DATE: 12/2021
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 2291

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$10,475,000	$0
- STATE FUNDS	$10,475,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$10,475,000	$0
STATE FUNDS	$10,475,000	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the funding available to provide training, technical assistance, technology and tools to build and enhance positive social-emotional learning environments in California schools through administration of the CalHOPE Student Support Program.

Authority:
Budget Act of 2021 [SB 129 (Chapter 69, Statutes of 2021)]
AB 177 (Chapter 999, Statutes of 2024)

Interdependent Policy Changes:
Not Applicable

Background:
The CalHOPE Student Support program launched as part of the Federal Emergency Management Agency (FEMA)/Substance Abuse and Mental Health Services Administration (SAMHSA) Crisis Counseling Program (CCP), in recognition of the challenges and stressors children, youth and families are experiencing: social isolation, lack of school structure, and need to adapt to distance learning. The Department previously partnered with the California Mental Health Services Authority to subcontract with the Sacramento County of Education (SCOE) and provided $12.6 million to SCOE to establish the CalHOPE Student Support program, available between November 2020 and February 9, 2022. There are $45 million included in the Children and Youth Behavioral Health Initiative (CYBHI) to extend this program and expand this effort over a three year period. In addition, a student engagement element will be added.

The CYBHI is a multiyear package of investments. The CYBHI is intended to transform California's behavioral health system for children and youth aged 0-25 into a world-class, innovative, up-stream focused ecosystem where all children and young adults are routinely screened, supported, and served for emerging behavioral health needs.

The CalHOPE Student Support Program was designed to give teachers and staff the skills to prepare a healthy learning environment for children, to be able to easily identify signs of stress and poor functioning, provide support for children and youth, and refer to more intensive

CYBHI - CALHOPE STUDENT SUPPORT
REGULAR POLICY CHANGE NUMBER: 164

services where needed. The training and technical assistance aims to create positive social-emotional learning environments in schools to support children, young people, parents, and school staff, addressing the behavioral health challenges created by social isolation and the stress of the public health emergency.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to a shift in timing of payments to the contractor with final contract invoices paid in FY 2024-25.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to remaining funds being paid out in FY 2024-25 and no more money will be spent in FY 2025-26.

Methodology:
1. Assume a total of $45,000,000 General Fund (GF) will be provided to a training and technical assistance provider and learning communities. The 2021 Budget Act, Item 4260-101-0001, Provision 16(c) authorizes the funds for encumbrance or expenditure until June 30, 2024. AB 177 (Chapter 999, Statutes of 2024) authorizes the reappropriation of the funds for encumbrance or expenditure until June 30, 2025.

2. The table below displays the estimated spending and remaining funds by Appropriation Year:

(Dollars in Thousands)

	TF	GF
Appropriation Year 2021-22	$45,000	$45,000
Prior Years	$34,525	$34,525
Estimated in FY 2024-25	$10,475	$10,475
Total Estimated Remaining	$0	$0

3. On a cash basis the Department will be paying $10,475,000 GF in FY 2024-25 for the CalHOPE Student Support program.

(Dollars in Thousands)

FY 2024-25	**TF**	**GF**
Appropriation Year 2021-22	$10,475	$10,475
Total FY 2024-25	**$10,475**	**$10,475**

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

EQUITY & PRACTICE TRANSFORMATION PAYMENTS

REGULAR POLICY CHANGE NUMBER: 166
IMPLEMENTATION DATE: 7/2023
ANALYST: Erik Stacey
FISCAL REFERENCE NUMBER: 2346

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$22,592,000	$40,600,000
- STATE FUNDS	$11,296,000	$20,300,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$22,592,000	$40,600,000
STATE FUNDS	$11,296,000	$20,300,000
FEDERAL FUNDS	$11,296,000	$20,300,000

Purpose:
This policy change estimates the costs of the Equity & Practice Transformation Payments.

Authority:
Budget Act of 2022 – AB 179 (Chapter 249, Statutes of 2022)

Interdependent Policy Changes:
COVID-19 Increased FMAP – DHCS

Background:
The Department will administer the Equity and Practice Transformation (EPT) Payments Program, which will support qualifying primary care providers (primary care pediatrics, family medicine, internal medicine, primary care obstetrician/gynecologists, or behavioral health providers of integrated behavioral health services in a primary care setting to Medi-Cal members). The program has a MCP incentive, payments to primary care practices, and a learning collaborative to do the following: advance equity; address gaps in preventive, childhood, birth-related, and behavioral health care measures; reduce COVID-19 driven care disparities; support upstream interventions to address social drivers of health; improve primary care infrastructure; and prepare practices to accept risk-based contracts and move towards value-based care payment methodologies. Such actions align with the goals of the Medi-Cal Comprehensive Quality and Equity Strategy and the Bold Goals 50x2025 initiative. Practices are paid based on improvement in relevant clinical quality measures.

The multiyear plan for these payments originally included $700 million TF over several years.

However, the 2024 May Revision reduced funding for EPT to $140 million. Therefore, funding from fiscal years past FY 2022-23 will not go ahead as originally planned. The size of EPT has thus been reduced. The newly designed program is still being finalized.

EQUITY & PRACTICE TRANSFORMATION PAYMENTS

REGULAR POLICY CHANGE NUMBER: 166

The new modified funding plan is as follows:

- $22.6 million TF ($11.3 million GF) in FY 2023-24
- $22.6 million TF ($11.3 million GF) in FY 2024-25
- $40.6 million TF ($20.3 million GF) in FY 2025-26
- $54.2 million TF ($27.1 million GF) in FY 2026-27

Reason for Change:

The change in FY 2024-25, from the prior estimate, is due to a portion of previously budgeted FY 2024-25 payments shifting to FY 2025-26 and FY 2026-27.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to a higher amount of EPT payments being issued in FY 2025-26.

Methodology:

1. The Budget Act for FY 2022-23 provides $140 million TF ($70 million GF), available for expenditure through June 30, 2027. The table below displays the estimated spending by Appropriation Year:

	TF	GF	FF
Appropriation Year 2022-23	**$140,000,000**	**$70,000,000**	**$70,000,000**
Prior Years	$22,608,000	$11,304,000	$11,304,000
Estimated in FY 2024-25	$22,592,000	$11,296,000	$11,296,000
Estimated in FY 2025-26	$40,600,000	$20,300,000	$20,300,000
Estimated Remaining	$54,200,000	$27,100,000	$27,100,000

2. The estimated costs in FY 2024-25 are as follows:

FY 2024-25	TF	GF	FF
Appropriation Year 2022-23	$22,592,000	$11,296,000	$11,296,000
Total FY 2024-25	**$22,592,000**	**$11,296,000**	**$11,296,000**

3. The estimated costs in FY 2025-26 are as follows:

FY 2025-26	TF	GF	FF
Appropriation Year 2022-23	$40,600,000	$20,300,000	$20,300,000
Total FY 2025-26	**$40,600,000**	**$20,300,000**	**$20,300,000**

Funding:

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

INDIAN HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER: 167
IMPLEMENTATION DATE: 4/1998
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 111

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$18,726,000	$17,493,000
- STATE FUNDS	$6,242,000	$5,831,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	9.30 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$16,984,500	$17,493,000
STATE FUNDS	$5,661,490	$5,831,000
FEDERAL FUNDS	$11,322,990	$11,662,000

Purpose:
This policy change estimates the annual rate change posted in the Federal Register for services in Indian Health facilities.

Authority:
Public Law 93-638
Public Law 102-573 (Title 25, U.S.C. 1665c)

Interdependent Policy Changes:
Not Applicable

Background:
The Department implemented the Indian Health Services/Memorandum of Agreement 638 Clinics (IHS/MOA) between the federal IHS and the Centers for Medicare & Medicaid Services (CMS) on April 21, 1998. The agreement permits the Department to be reimbursed at 100% FFP for payments made by the State for services rendered to American Indians (AIs) through IHS tribal facilities.

Federal policy permits retroactive claiming of 100% federal financial participation (FFP) to the date of the MOA, July 11, 1996, or at whatever later date a facility qualifies and elects to participate as an IHS facility under the MOA.

The Department implemented the enrollment and reimbursement of Youth Regional Treatment Centers (YRTCs) for services rendered to AI youths. Indian health clinics refer these youths to YRTCs for culturally appropriate in-patient substance use disorder treatment. The Department receives 100% FFP for YRTC services provided to eligible AI Medi-Cal members under the age of 21.

The per visit rate payable to the Indian health facilities 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.

INDIAN HEALTH SERVICES
REGULAR POLICY CHANGE NUMBER: 167

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a decrease due to the CY 2024 rate increase implementing in March 2024 and due to shifting the Calendar Year rate increases to align with the applicable State Fiscal Years. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due to the CY 2024 rate increase captured in FY 2024-25 being higher than the rate increases captured in FY 2025-26.

Methodology:
1. Effective CY 2024, the updated per visit rate payable to the Indian health clinics increased by $65, from $654 to $719. The annual rate increase for the additional $65 is estimated at $10,453,000 TF.

2. Effective CY 2025, the updated per visit rate payable to the Indian health clinics increased by $49, from $719 to $768. The retroactive rate increase from January through June 2025 is estimated at $8,274,000 TF, and the annual rate increase for the additional $49 is estimated at $8,274,000 TF.

3. It is estimated, effective CY 2026, the updated per visit rate payable to the Indian health clinics will increase by $52, from $768 to $821. The retroactive rate increase from January through June 2026 is estimated at $9,219,000 TF for the additional $52.

4. On a cash basis, the FY 2024-25 and FY 2025-26 estimates are:

Rate Increase	FY 2024-25	FY 2025-26
CY 2024 Rate Increase	$10,452,000	$0
Retro Jan-June 2025 Incr.	$8,274,000	$0
CY 2025 Rate Increase	$0	$8,274,000
Retro Jan-June 2026 Incr.	$0	$9,219,000
Total Rate Increase	**$18,726,000**	**$17,493,000**

*Totals may differ due to rounding.

Fiscal Year	TF	GF	FF
FY 2024-25	**$18,726,000**	**$6,242,000**	**$12,484,000**
FY 2025-26	**$17,493,000**	**$5,831,000**	**$11,662,000**

*Totals may differ due to rounding.

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

CALHOPE

REGULAR POLICY CHANGE NUMBER: 168
IMPLEMENTATION DATE: 5/2022
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 2355

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$23,602,000	$0
- STATE FUNDS	$23,602,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$23,602,000	$0
STATE FUNDS	$23,602,000	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the costs to temporarily extend support for the CalHOPE program.

Authority:
Budget Act of 2022 [AB 179 (Chapter 249, Statutes of 2022)]

Interdependent Policy Changes:
Not Applicable

Background:
The CalHOPE program, available to all populations including adults, is a component of the crisis continuum of support and care and its elements include:

- Media messaging to destigmatize stress and anxiety and promote help-seeking, including using trusted messengers to reach diverse populations,
- CalHOPE web services,
- CalHOPE Warm Line, and
- CalHOPE Connect partnership with up to 30 community-based organizations, with over 400 peer crisis counselors.

The CalHOPE program was initially funded through grants provided by the Federal Emergency Management Agency (FEMA), and the Substance Abuse and Mental Health Services Administration, with the federal grants expiring August 2022.

Because CalHOPE provides crisis services to a large California population, without additional funding to support the program after federal funding expires, services would abruptly stop, ending employment for 500 peer workers and ceasing the availability of crisis counseling by chat and phone for thousands of Californians currently using the services.

The Department, as part of the Children and Youth Behavioral Health Initiative (CYBHI) will procure a business services vendor to deliver and monitor BH wellness services and treatments through a direct service, virtual platform by January 2024. The behavioral health virtual services

CALHOPE
REGULAR POLICY CHANGE NUMBER: 168

platform will provide services, including peer support services, similar to those funded by the CalHOPE program.

In addition, the California Health and Human Services Agency is launching a stakeholder planning process to create a long term plan for the crisis continuum of care.

Until the CYBHI virtual platform launches in January 2024 and further work is done to enhance the behavioral health crisis continuum of care, temporary state funds would fund key services in CalHOPE through January 2024, at which point CalHOPE will continue by integrating into the CYBHI behavioral health virtual services platform.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to updated amounts available for expenditure in FY 2024-25.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to no further funding available to be spent in FY 2025-26.

Methodology:
1. A combined total of $120 million is available for expenditure over two years, FY 2022-23 and FY 2023-24. It is estimated that $65.38 million GF and $47.53 million in Behavioral Health Special Fund (BHSF) was spent in FY 2022-23 and FY 2023-24. In FY 2024-25, the remaining balance of $4.12 million GF and $2.96 million BHSF is estimated to be spent.

2. Additionally, the Budget Act of 2022 [AB 179 (Chapter 249, Statutes of 2022)] appropriated $16.423 million one-time GF and $13.577 million one-time BHSF, available for expenditure until June 30, 2025, to support the peer-run warm line, administered by the Mental Health Association of San Francisco.

   The table below displays the estimated spending and remaining funds by Appropriation Year:

(Dollars in Thousands)

	TF	GF	BHSF
CalHOPE	$120,000	$69,500	$50,500
Prior Year	$112,918	$65,380	$47,538
Estimated in FY 2024-25	$7,082	$4,120	$2,962
Total Estimated Remaining	$0	$0	$0
Appropriation Year 2022-23	$30,000	$16,423	$13,577
Prior Year	$13,480	$0	$13,480
Estimated in FY 2024-25	$16,520	$16,423	$97
Total Estimated Remaining	$0	$0	$0

3. This funding is for services that are separate and distinct from those covered in the CYBHI - CalHOPE Student Support Services policy change.

CALHOPE
REGULAR POLICY CHANGE NUMBER: 168

4. The estimated payments for FY 2024-25 are:

(Dollars in Thousands)

FY 2024-25	TF	GF	BHSF
CalHOPE	$7,082	$4,120	$2,962
Appropriation Year 2022-23	$16,520	$16,423	$97
Total FY 2024-25	**$23,602**	**$20,543**	**$3,059**

Funding:
100% State GF (4260-101-0001)
100% Behavioral Health Services Fund (4260-101-3085)

ABORTION SUPPLEMENTAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 169
IMPLEMENTATION DATE: 7/2023
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 2373

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$14,858,000	$0
- STATE FUNDS	$14,858,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$14,858,000	$0
STATE FUNDS	$14,858,000	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the abortion supplemental payment program for non-hospital community clinics that incur significant costs associated with providing abortion services to Medi-Cal members.

Authority:
AB 179 (Chapter 249, Statutes of 2022)

Interdependent Policy Changes:
Not Applicable

Background:
The Budget Acts of 2022 and 2023, appropriated funding for the Department to establish a limited-term supplemental payment program for non-hospital community clinics that incur significant costs associated with providing abortion services and that serve Medi-Cal members. On a quarterly basis the Department will provide qualifying non-hospital community clinics a supplemental payment for eligible abortion services billed in the Fee-for-Service delivery system.

Reason for Change:
There is an increase from the prior estimate for FY 2024-25 due to updated expenditures.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due to the final supplemental payments occurring in FY 2024-25.

Methodology:
1. This policy implemented on January 1, 2023, and all funding must be expended by June 30, 2025.

2. The Budget Act for FY 2022-23 includes $14,849,000 GF for this item, available for expenditure through June 30, 2024.

ABORTION SUPPLEMENTAL PAYMENT PROGRAM
REGULAR POLICY CHANGE NUMBER: 169

3. For FY 2023-24, additional funding is available in the amount of $14,858,000 GF for expenditure through June 30, 2025, for this item.

4. The table below displays the estimated spending and remaining funds by Appropriations Years:

(Dollars in Thousands)

Appropriation Year 2022-23	**TF**	**GF**	**FF***
Prior Years	$14,849	$14,849	$0
Estimated in FY 2024-25	$0	$0	$0
Total Estimated Remaining	$0	$0	$0
Appropriation Year 2023-24	**TF**	**GF**	**FF***
Prior Years	$0	$0	$0
Estimated in FY 2024-25	$14,858	$14,858	$0
Total Estimated Remaining	$0	$0	$0

* Federal funds authority is newly requested for the fiscal year in which funds are anticipated to be expended.

5. The estimated costs in FY 2024-25 and FY 2025-26 are as follows:

(Dollars in Thousands)

FY 2024-25	**TF**	**GF**	**FF***
Appropriation Year 2023-24	$14,858	$14,858	$0
Total FY 2024-25	**$14,858**	**$14,858**	**$0**

*Federal funds authority is newly requested for the fiscal year in which funds are anticipated to be expended.

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

ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS

REGULAR POLICY CHANGE NUMBER: 170
IMPLEMENTATION DATE: 7/2010
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1526

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$16,992,000	$11,536,000
- STATE FUNDS	$7,773,000	$5,272,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$16,992,000	$11,536,000
STATE FUNDS	$7,773,000	$5,272,000
FEDERAL FUNDS	$9,219,000	$6,264,000

Purpose:
This policy change estimates the costs for the increased administrative expenses related to the active treatment and transportation services provided to members residing in Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) and the costs of the increased rates due to the Quality Assurance Fee (QAF).

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 members residing in ICF-DDs.

ICF-DDs are subject to a QAF based upon their Medi-Cal revenues, with the revenue used to increase rates for the ICF-DDs.

ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS

REGULAR POLICY CHANGE NUMBER: 170

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to an increase in prior year expenditures in FY 2024-25.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due to an increase in utilization and less prior year expenditures in FY 2025-26.

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

(Dollars in Thousands)

Fiscal Year	RC Admin Fee	QAF & ICF Fee Reimbursements	Total Funds	CDDS GF	DHCS GF	FFP
FY 2024-25	$1,445	$7,773	$18,437	$1,445	**$7,773**	**$9,219**
FY 2025-26	$992	$5,272	$12,528	$992	**$5,272**	**$6,264**

Funding:
100% GF (4260-101-0001)
100% Title XIX FFP (4260-101-0890)

CYBHI - FEE SCHEDULE THIRD PARTY ADMINISTRATOR

REGULAR POLICY CHANGE NUMBER: 171
IMPLEMENTATION DATE: 7/2023
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2424

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$10,000,000	$0
- STATE FUNDS	$10,000,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$10,000,000	$0
STATE FUNDS	$10,000,000	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates costs related to the launch of a statewide infrastructure for provider management and to manage billing and claiming for the behavioral health (BH) services furnished to students by school-based/school-linked providers, under the Children and Youth Behavioral Health Initiative (CYBHI) fee schedule.

Authority:
W&I Code, Section 5961 and 5961.4
Contract 23-30348

Interdependent Policy Change:
Not Applicable

Background:
As part of CYBHI, the Department is mandated to establish a statewide all-payer fee schedule to reimburse school-linked BH providers who provide services to students at or near a school-site. Specifically, the Department is required to:

- Develop and maintain a school-linked statewide fee schedule for medically necessary outpatient mental health or substance use disorder services provided to a student 25 years of age or younger at or near a school site, who is an enrollee of the plan or delivery system.
- Develop and maintain a school-linked statewide provider network of school site BH counselors.

Commercial health plans, insurers, and the Medi-Cal delivery system must reimburse these school-linked providers at or above the fee schedule rate, regardless of network provider status. Local education agencies (LEAS) and institutions of higher education (California Community Colleges, California State University, and University of California) may adopt the fee schedule as well.

There are significant operational complexities around provider management and claims submission for the school-based/school-linked providers. Although many LEA districts

CYBHI - FEE SCHEDULE THIRD PARTY ADMINISTRATOR
REGULAR POLICY CHANGE NUMBER: 171

participate in the LEA Billing Option Program (BOP), LEAs, colleges, and universities do not currently have billing infrastructure necessary to submit claims to multiple Medi-Cal managed care plans, county behavioral health departments, commercial health plans, and self-insured plans in each county. Almost none of the school-based providers have any experience with billing commercial or self-insured plans for services provided to students.

In addition, although the statute states that the health plans are required to reimburse school-linked providers regardless of network status, there are also operational complexities around provider management, including critical functions such as credentialing and provider oversight.

The CYBHI is a multiyear package of investments. The CYBHI is intended to transform California's behavioral health system for children and youth aged 0-25 into a world-class, innovative, up-stream focused, ecosystem where all children and young adults are routinely screened, supported, and served for emerging behavioral health needs.

Funding is being utilized to begin the development and implementation of the infrastructure for provider, billing, and claiming management for behavioral health services provided to students by school-linked providers as part of the CYBHI.

Reason for Change:
The change from the previous estimate, for FY 2024-25, is an increase due a shift in payment timing with the contractor. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due to payments finishing in FY 2024-25.

Methodology:

Estimated dollars for FY 2024-25 are as follows:

Fiscal Year	TF	SF	FF
FY 2024-25	$10,000,000	$10,000,000	$0

Funding:
100% Behavioral Health Services Fund (4260-101-3085)

MINIMUM WAGE INCREASE FOR HCBS WAIVERS

REGULAR POLICY CHANGE NUMBER: 173
IMPLEMENTATION DATE: 1/2017
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 1975

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$7,522,000	$45,456,000
- STATE FUNDS	$4,137,000	$25,001,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$7,522,000	$45,456,000
STATE FUNDS	$4,137,000	$25,001,000
FEDERAL FUNDS	$3,385,000	$20,455,000

Purpose:
This policy change estimates the costs of increasing the minimum wage for the Home and Community-Based Services (HCBS) providers.

Authority:
SB 3 (Chapter 4, Statutes of 2016)

Interdependent Policy Changes:
Assisted Living Waiver Expansion
Waiver Personal Care Services (Misc. Svcs.)

Background:
The passage of AB 10 in 2013 set the minimum wage in California to $10 an hour after January 1, 2016. SB 3 requires a schedule for a phased increase in the minimum wage from $10.50 per hour to $15 per hour by January 1, 2022, or January 1, 2023, depending on the size of the employer and general economic conditions, and link the minimum wage to the U.S. Consumer Price Index once the minimum wage reaches $15 per hour.

Beginning January 1, 2023, an additional set of minimum wage increases will phase in over a 5-year period from $15 per hour to $17 per hour by January 1, 2027.

The minimum wage increase will result in increased costs for multiple long term care programs. HCBS are predominantly provided by individuals working for minimum wage, and this increase will raise the overall cost of HCBS for the Assisted Living Waiver (ALW), Waiver Personal Care Services (WPCS), and Personal Care Agencies (PCA).

The ALW offers Medi-Cal eligible members the choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility. The goal of the ALW is to facilitate nursing facility transition back into homelike and community settings or prevent skilled nursing admissions for members with an imminent need for nursing facility placement.

MINIMUM WAGE INCREASE FOR HCBS WAIVERS

REGULAR POLICY CHANGE NUMBER: 173

The Home and Community-Based Alternatives (HCBA) Waiver provides care management services to persons at risk for nursing home or institutional placement. WPCS is a benefit under the HCBA Waiver and was designed to assist waiver members with remaining safely in their residence and continuing to be part of the community. A PCA is a provider that employs individuals who provide services and is enrolled as an HCBA provider in the HCBA Waiver.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a decrease due to assuming all rate increases, prior January 1, 2025, are captured in the base estimates. Also, this policy change now budgets incremental rate increases. The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to capturing the January 1, 2025, and January 1, 2026, rate increases in FY 2025-26.

Methodology:
1. Beginning January 1, 2025, the minimum wage increased from $16.00 to $16.40 per hour. Beginning January 1, 2026, the minimum wage will increase from $16.40 to $16.70 per hour.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2024-25	$7,522	$4,137	$3,385
FY 2025-26	$45,456	$25,001	$20,455

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

ASSET LIMIT INCREASE & ELIM. - CNTY BH FUNDING

REGULAR POLICY CHANGE NUMBER: 174
IMPLEMENTATION DATE: 11/2024
ANALYST: Tyler Shimizu
FISCAL REFERENCE NUMBER: 2443

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$6,084,000	$4,413,000
- STATE FUNDS	$6,084,000	$4,413,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$6,084,000	$4,413,000
STATE FUNDS	$6,084,000	$4,413,000
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the cost of reimbursing Mental Health Plans (MHPs), Drug Medi-Cal (DMC) State Plan counties and DMC-Organized Delivery System (ODS) counties the non-federal share of services provided to members enrolled as a result of the asset limit test increase and elimination.

Authority:
AB 133 (Chapter 143, Statutes of 2021)
SPA 21-0053
SB 108 (Chapter 35, Statutes of 2024)

Interdependent Policy Changes:
Not Applicable

Background:
Pursuant to Chapter 143, Statutes of 2021, the Department increased, effective July 1, 2022, the asset limit test for Medi-Cal members not subject to the Modified Adjusted Gross Income (MAGI) eligibility requirements to $130,000 and eliminated the asset limit test effective January 1, 2024. This change has resulted in an increase in the number of people who qualify for full scope Medi-Cal benefits and receive services through the Medi-Cal behavioral health delivery systems. Payments will be provided to counties for the non-federal share of specialty mental health and substance use disorder services provided to the additional members enrolled in Medi-Cal, as a result of the asset limit test increase and elimination.

Reason for Change:
There is no change, from the prior estimate, for FY 2024-25.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due to FY 2024-25 including two years of payments and FY 2025-26 paying for only one.

ASSET LIMIT INCREASE & ELIM. - CNTY BH FUNDING

REGULAR POLICY CHANGE NUMBER: 174

Methodology:

1. Assume retroactive payments will be made for services provided since to July 1, 2022, and payments are estimated to start by November 2024.

2. On a cash basis, the FY 2022-23 totaling $2.6 million General Fund (GF) and FY 2023-24 payments totaling $3.5 million GF are estimated to be paid in FY 2024-25. Beginning FY 2025-26, retroactive payments are expected to be made annually at $4.4 million GF for the previous year.

Asset Limit Increase and Elimination	FY 2022-23	FY 2023-24	FY 2024-25
SMHS	$2,448,000	$3,314,000	$4,179,000
DMC	$8,000	$10,000	$13,000
DMC-ODS (Required Services)	$129,000	$175,000	$221,000
Total	$2,585,000	$3,499,000	$4,413,000

3. The estimated cost in FY 2024-25 and FY 2025-26 for the asset test increase and elimination is as follows:

FY 2024-25	TF	GF
FY 2022-23	$2,585,000	$2,585,000
FY 2023-24	$3,499,000	$3,499,000
Total FY 2024-25	**$6,084,000**	**$6,084,000**

FY 2025-26	TF	GF
FY 2024-25	$4,413,000	$4,413,000
Total FY 2025-26	**$4,413,000**	**$4,413,000**

Funding:

100% GF (4260-101-0001)

FOSTER YOUTH SUBSTANCE USE DISORDER GRANT PROGRAM

REGULAR POLICY CHANGE NUMBER: 175
IMPLEMENTATION DATE: 6/2024
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2371

	FY 2024-25	FY 2025-26
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

Purpose:
This policy change estimates the cost of the Foster Youth Substance Use Disorder (SUD) Evidence-Based and Promising Practices program.

Authority:
Budget Act of 2022 [AB 179 (Chapter 249, Statutes of 2022)]

Interdependent Policy Changes:
Not Applicable

Background:
AB 179 provides $5 million General Fund (GF) for the Department to implement the Foster Youth SUD Evidence-Based and Promising Practices Program to serve foster youth with substance use disorders, including those who are residing in family-based settings.

In establishing the grant program, the Department will:

- Develop an application process for eligible applicants, which includes county child welfare agencies, county probation agencies, county behavioral health agencies, foster family agencies, substance use disorder providers, tribal organizations within the state that serve as child welfare services agencies, short term residential therapeutic programs, and wraparound service providers.
- Develop criteria for awarding funding which includes establishing requirements for models and practices that have at the minimum:
    - Trauma-informed approaches to serving foster youth,
    - Harm-reduction approaches in service delivery,
    - Post treatment support planning, and
    - Training for clinical service providers to support foster youth with co-occurring substance use and mental health needs.
- Require grantees to collect data relating to the models and practices.
- Require grantees to submit reports, including reports that address the grantee's implementation activities, the number and characteristics of youth served, and completion rates, and an outcome report.

FOSTER YOUTH SUBSTANCE USE DISORDER GRANT PROGRAM

REGULAR POLICY CHANGE NUMBER: 175

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to all necessary funds being encumbered in prior years, with no additional costs budgeted in FY 2024-25.

The change in the current estimate, from FY 2024-25 to FY 2025-26, is due to no further funding available to be budgeted after FY 2023-24.

Methodology:
1. The Department entered into a contract to administer the grant program in September 2023.

2. AB 179 provides $5 million GF for this item, available for expenditure through June 30, 2025. The table below displays the estimated spending and remaining funds by Appropriation Year:

(Dollars in Thousands)

	TF	GF
Appropriation Year 2022-23		
Prior Years	$5,000	$5,000
Estimated in FY 2024-25	$0	$0
Total Estimated Remaining	$0	$0

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

SECTION 19.56 LEGISLATIVE PRIORITIES

REGULAR POLICY CHANGE NUMBER: 176
IMPLEMENTATION DATE: 11/2021
ANALYST: Erik Stacey
FISCAL REFERENCE NUMBER: 2316

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$2,357,000	$0
- STATE FUNDS	$2,357,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,357,000	$0
STATE FUNDS	$2,357,000	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change allocates funding approved through Sections 19.563 and 19.565 of the Budget Act of 2023 to the Department of Health Care Services as the designated state entity for the distribution of funds to the identified recipients.

Authority:
Budget Act of 2023 – SB 104 (Chapter 189, Statutes of 2023)

Interdependent Policy Changes:
Not Applicable

Background:
Sections 19.563 and 19.565 of the Budget Act of 2023 appropriate from the state General Fund (GF) for a variety of legislative priorities. The Department of Health Care services is the distributing entity for some of these funds.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to payments originally assumed to be distributed in the prior Fiscal Year being delayed.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to payments being assumed to be completed in FY 2024-25.

SECTION 19.56 LEGISLATIVE PRIORITIES
REGULAR POLICY CHANGE NUMBER: 176

Methodology:

1. The following items from the Budget Act of 2023—totaling $2,357,023—are to be distributed by the Department of Health Care Services and are available through June 30, 2025:
   - $357,023 for County of Stanislaus Mobile Mental Health Access Point for the Rural Californians Project.
   - $2,000,000 for Children's Hospital of Los Angeles (CHLA) or the County of Los Angeles to expand the Division of Adolescent and Young Adult Medicine.

2. The table below displays the estimated spending and remaining funds by Appropriation Year:

(Dollars in Thousands)

	TF	GF
Appropriation Year 2023-24	$42,224	$42,224
Prior Years	$39,867	$39,867
Estimated in FY 2024-25	$2,357	$2,357

3. The estimated costs in FY 2024-25 are as follows:

(Dollars in Thousands)

FY 2024-25	**TF**	**GF**
Appropriation Year 2023-24	$2,357	$2,357
Total FY 2024-25	**$2,357**	**$2,357**

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

ADVISORY COUNCIL ON PHYS. FIT. & MENTAL WELL-BEING

REGULAR POLICY CHANGE NUMBER: 177
IMPLEMENTATION DATE: 2/2024
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 2441

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$1,000,000	$0
- STATE FUNDS	$1,000,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,000,000	$0
STATE FUNDS	$1,000,000	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the costs of contracting to support the implementation of the Governor's Advisory Council on Physical Fitness & Mental Well-Being's (Council) goals media campaign.

Authority:
Interagency Agreement (IA) Amendment (22-10854)

Interdependent Policy Changes:
Not Applicable

Background:
In 2021, the Governor's Office established the Council. The Council is tasked with exploring healthy strategies to ensure Californians can thrive with special emphasis on child physical and mental health. The Council also works on providing guidance on California's physical activity and wellness, and work to promote equitable access to outdoor and physical activity for underserved California communities. The California Department of Public Health (CDPH) currently works with the Governor's Council on Physical Fitness and Mental Well-Being to help spread the word and work of the Council.

The Department will be contracting with the CDPH through an IA to support the implementation of the Council's goals through a wide variety of media tactics to promote physical fitness and mental well-being to all Californians.

Reason for Change:
There is no change in FY 2024-25, from the prior estimate.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to the last payment being made in FY 2024-25.

ADVISORY COUNCIL ON PHYS. FIT. & MENTAL WELL-BEING

REGULAR POLICY CHANGE NUMBER: 177

Methodology:

1. In FY 2024-25, the Department will make payments for the FY 2024-25 invoices received from CDPH.

(Dollars in Thousands)

Fiscal Year	TF	Reimbursement
FY 2024-25	$1,000	$1,000

Funding:

Reimbursement GF (4260-601-0995)

WPCS WORKERS' COMPENSATION

REGULAR POLICY CHANGE NUMBER: 178
IMPLEMENTATION DATE: 11/2016
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 1866

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$620,000	$620,000
- STATE FUNDS	$310,000	$310,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$620,000	$620,000
STATE FUNDS	$310,000	$310,000
FEDERAL FUNDS	$310,000	$310,000

Purpose:
This policy change estimates the cost of workers' compensation coverage for Waiver Personal Care Services (WPCS) providers.

Authority:
In-Home Supportive Services v. Workers' Comp. Appeals Bd. (1984) 152 Cal.App.3d 720, 727 [199 Cal.Rptr. 697]
Interagency Agreement (IA) 22-20032

Interdependent Policy Changes:
Not applicable

Background:
The WPCS benefit is designed to assist the Home and Community-Based Alternatives Waiver participant in gaining independence in his or her activities of daily living and preventing social isolation. These services assist the waiver participant in remaining in his or her residence and continuing to be part of the community. A waiver participant must be enrolled in and receiving personal care services through the federally funded State Plan Personal Care Services program in order to be eligible for WPCS benefits. WPCS providers receive payment via the Case Management Information Payrolling System. The California Department of Social Services (CDSS) pays for the insurance claims for the WPCS providers and the Department reimburses CDSS for the costs. The current Workers' Compensation contract, IA 22-20032, was implemented effective July 1, 2022. The contract is an evergreen contract and can only be terminated by CDSS or the Department.

Reason for Change:
There is no change from the prior estimate for FY 2024-25. There is no change from FY 2024-25 to FY 2025-26 in the current estimate.

Methodology:
1. The Department reimburses CDSS monthly for the costs of any WPCS program worker's compensation claims filed by eligible WPCS providers.

WPCS WORKERS' COMPENSATION
REGULAR POLICY CHANGE NUMBER: 178

2. The CDSS reimbursement covers costs associated with monthly administrative fees for Third Party Administrator / Sub-contractor services, monthly fees required by the State Controller's Office to perform Checkwrite functions and standard activities associated with issuing worker's compensation payments, and monthly administrative costs accrued by CDSS and the Office of Risk and Insurance Management.

3. WPCS recipients represent approximately 1% of the population receiving In-Home Supportive Services so the Department is only responsible for reimbursing CDSS for 1% of the sub-contractor administrative fees.

4. Based on data provided by the CDSS, the total cost to be paid for workers' compensation is $620,000 TF in FY 2024-25 and FY 2025-26.

Fiscal Year	TF	GF	FF
FY 2024-25	$620,000	$310,000	$310,000
FY 2025-26	$620,000	$310,000	$310,000

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

HCBS SP - CALBRIDGE BH NAVIGATOR PROGRAM

REGULAR POLICY CHANGE NUMBER: 180
IMPLEMENTATION DATE: 4/2022
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2318

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$75,000	$0
- STATE FUNDS	$75,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$75,000	$0
STATE FUNDS	$75,000	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the costs for the CalBridge Behavioral Health Navigator Program using enhanced federal funding from the American Rescue Plan Act of 2021 (ARP).

Authority:
American Recue Plan (ARP) Act (2021)
Budget Act of 2021 [SB 129 (Chapter 69, Statutes of 2021)]

Interdependent Policy Changes:
American Rescue Plan Increased FMAP for HCBS

Background:
The American Rescue Plan Act of 2021 (ARP) provides additional Coronavirus Disease 2019 (COVID-19) relief to states. Section 9817 of the ARP provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS). Increased FMAP is available from April 1, 2021, through March 31, 2022. States must use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021, and states must use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. State funds equivalent to the amount of federal funds attributable to the increased FMAP are deposited in the Home and Community-Based Services American Rescue Plan Fund pursuant to Section 11.95 of the 2021 Budget Act. Section 11.95 appropriates this funding to eligible HCBS activities identified in the HCBS Spending Plan.

The CalBridge Behavioral Health Navigator Program provides grants to acute care hospitals to support hiring trained behavioral health navigators in emergency departments to screen patients and, if appropriate, offer intervention and referral to mental health or substance use disorder programs. Applicants will include general acute care hospitals or health systems, hospital foundations, or physician groups. The one-time funding would also support technical assistance

HCBS SP - CALBRIDGE BH NAVIGATOR PROGRAM
REGULAR POLICY CHANGE NUMBER: 180

and training for participating emergency departments and support for the Department to administer the funding.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a decrease based on an updated estimate of the remaining funds to be spent in FY 2024-25.

The change in the current estimate, from FY 2024-25 to FY 2025-26, is due to no payments occurring in FY 2025-26 because of the $40 million allocation cap.

Methodology:
1. The Department entered into a contract with Public Health Institute (PHI), current administrator of the California Bridge Program, in FY 2021-22; PHI serves as an administrative and technical assistance (TA) entity for the CalBridge Behavioral Health Navigator Program.

2. The total contract amount is $40,000,000, with PHI receiving up to 10 percent ($4,000,000) to provide administrative and TA services to grantees, consistent with the current administrative percentage for the current contract with PHI. The remaining $36,000,000 was distributed to grantees for direct services beginning FY 2021-22.

3. Total estimated costs for the CalBridge Behavioral Health Navigator Program, on a cash basis, is as follows:

FY 2024-25	TF	HCBS ARP Fund
PHI Contractor	$75,000	$75,000
Total	**$75,000**	**$75,000**

Funding:
100% Home and Community-Based Services American Rescue Plan Fund (4260-101-8507)

HCBS SP - NON-IHSS CARE ECONOMY PMTS

REGULAR POLICY CHANGE NUMBER: 181
IMPLEMENTATION DATE: 11/2023
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2314

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$70,000	$0
- STATE FUNDS	$35,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$70,000	$0
STATE FUNDS	$35,000	$0
FEDERAL FUNDS	$35,000	$0

Purpose:
This policy change estimates the cost to provide a one-time incentive payment to each current direct care, non-In-Home Supportive Services (IHSS) provider of Medi-Cal home and community-based services (HCBS).

Authority:
American Rescue Plan (ARP) Act of 2021
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
The ARP provided additional Coronavirus Disease 2019 (COVID-19) relief to states. Section 9817 of the ARP provided qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for HCBS. Increased FMAP was available from April 1, 2021, through March 31, 2022. States were required to use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021, and states were required to use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. State funds equivalent to the amount of federal funds attributable to the increased FMAP were deposited in the Home and Community-Based Services American Rescue Plan Fund. States were required to expend the federal funds attributable to the increased FMAP by December 31, 2024.

On July 12, 2021, the Department submitted the Medicaid HCBS Spending Plan to the Centers for Medicare & Medicaid Services (CMS) for approval. The multi-departmental HCBS spending plan included HCBS initiatives and services that were led by the Department and/or various other State Departments. On September 3, 2021, CMS responded to the Department's plan, which included a request for more information. The Department submitted a further updated

HCBS SP - NON-IHSS CARE ECONOMY PMTS
REGULAR POLICY CHANGE NUMBER: 181

plan on September 17, 2021. On January 4, 2022, CMS approved California's HCBS Spending Plan, including the Non-IHSS Care Economy Payments initiative.

This policy change provided additional support for direct care non-IHSS HCBS providers servicing members during the COVID-19 emergency, to provide a one-time incentive payment of $500 to each current direct care, non-IHSS provider of Medi-Cal home and community-based services. This funding focused on payment for retention, recognition, and workforce development.

Reason for Change:
There is an increase for FY 2024-25 from the prior estimate, and a decrease from FY 2024-25 to FY 2025-26 in the current estimate, due to the final reconciliation payment being made in September 2024.

Methodology:
1. Assume a reconciliation occurred in September 2024.

Fiscal Year	TF	HCBS ARP Fund	FF
FY 2024-25	$70,000	$35,000	$35,000

Funding:
100% Title XIX FFP (4260-101-0890)
Home and Community-Based Services American Rescue Plan Fund (4260-101-8507)

HCBS SP - ETSB FOR LAGUNA HONDA HOSPITAL RESIDENTS

REGULAR POLICY CHANGE NUMBER: 182
IMPLEMENTATION DATE: 7/2023
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2393

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$49,000	$0
- STATE FUNDS	$49,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$49,000	$0
STATE FUNDS	$49,000	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the cost to provide Enhanced Transition Service Bundles (ETSB) to Laguna Honda Hospital (LHH) residents who need “bridge services” to support safe and sustainable transfers to alternate settings.

Authority:
American Rescue Plan (ARP) Act of 2021
Contract # 22-20595

Interdependent Policy Changes:
Not Applicable

Background:
The ARP provided additional COVID-19 relief to states. Section 9817 of the ARP provided qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS). Increased FMAP was available from April 1, 2021, through March 31, 2022. States were required to use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021, and states were required to use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. State funds equivalent to the amount of federal funds attributable to the increased FMAP were deposited in the HCBS American Rescue Plan Fund.

On July 12, 2021, the Department submitted the Medicaid HCBS Spending Plan to the Centers for Medicare & Medicaid Services (CMS) for approval. The multi-departmental HCBS spending plan includes HCBS initiatives and services that will be led by the Department and/or various other State Departments. On September 3, 2021, CMS responded to the Department’s plan, which included a request for more information. The Department submitted a further updated plan on September 17, 2021. On January 4, 2022, CMS approved California’s HCBS Spending Plan.

HCBS SP - ETSB FOR LAGUNA HONDA HOSPITAL RESIDENTS

REGULAR POLICY CHANGE NUMBER: 182

On July 22, 2022, the Department received approval from CMS to amend California's HCBS Spending Plan and utilize section 9817 funding to provide ETSBs to LHH residents who need "bridge services" to transition from LHH to community-based placements and enrollment into a Medi-Cal Managed Care Plan, HCBS Waiver, Program of All-Inclusive Care for the Elderly (PACE), In-Home Supportive Services (IHSS), etc. The intent of the service bundles is to combine intensive care management and housing navigation services to facilitate safe and sustainable transitions and continued access to care, for an extremely vulnerable population with complex care needs. If these services are not provided, some of the State's most vulnerable residents could experience limited access to essential services, homelessness, reduced quality of life, and other adverse events, including death.

On November 10, 2022, the City of San Francisco signed a settlement with CMS and the California Department of Public Health to extend the pause on involuntary discharges and transfers of residents until February 2, 2023. The San Francisco Department of Public Health (SFDPH) is working towards recertification and CMS will have the option to further extend the pause based on Laguna Honda's progress in complying with the settlement agreement. On June 27, 2023, the Department and SFDPH executed a contract that to provide ARPA Section 9817 funding as included in California's approved HCBS Spending Plan to support community transitions through the provision of ETSBs. The bundled services are to bridge the gap between LHH and enrollment into a Medi-Cal Managed Care Plan / HCBS Waiver / PACE / IHSS, etc., and to help facilitate the transition of residents that remain in Fee-For-Service. While the Settlement Agreement continues the pause on the involuntary discharge/transfer of nursing facility level of care residents, CMS clarified that LHH is still responsible for actively discharging residents that are determined to no longer meet nursing facility level of care.

On January 13, 2023, San Francisco's City Attorney's office sent CMS a request to extend the moratorium, until at least May 30, 2023, with the possibility of continuing the pause after that date, based on LHH's progress towards certification. On February 1, 2023, CMS approved the extended pause on involuntary discharges and transfers until at least May 19, 2023. On May 18, 2023, CMS agreed to continue the pause of involuntary transfers of LHH residents until September 19, 2023.

Reason for Change:
This policy change has been reactivated for the November 2024 Estimate. The change from FY 2024-25 to FY 2025-26 in the current estimate, is a decrease, due to funding ending on September 30, 2024.

Methodology:
1. Assume that LHHs are still responsible for actively discharging residents that are determined to no longer meet nursing facility level of care.

2. The estimated costs for FY 2024-25 are:

Fiscal Year	TF	HCBS ARP Fund	FF
FY 2024-25	$49,000	$49,000	$0

Funding:
Home and Community-Based Services American Rescue Plan Fund (4260-101-8507)

HCBS SP - ALW FUNDING SHIFT

REGULAR POLICY CHANGE NUMBER: 183
IMPLEMENTATION DATE: 7/2024
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2453

	FY 2024-25	FY 2025-26
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

Purpose:
This policy change estimates the technical adjustment in funding from Title XIX 50% General Fund (GF) to the Home & Community-Based Services American Rescue Plan (HCBS ARP) fund for Assisted Living Waiver (ALW) services.

Authority:
SB 840 (Chapter 29, Statutes of 2018)
American Rescue Plan Act (2021)

Interdependent Policy Changes:
Assisted Living Waiver Expansion

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 members.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase due to the inclusion of additional transfers that shifted from FY 2023-24 to FY 2024-25 for adjustment. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due to funding allocated to this initiative being completed in FY 2024-25.

Methodology:
1. Assume $105,788,000 will shift to the GF from the HCBS ARP fund in FY 2024-25.

HCBS SP - ALW FUNDING SHIFT

REGULAR POLICY CHANGE NUMBER: 183

(Dollars in Thousands)

FY 2024-25	TF	HCBS ARP Fund	GF	FF
100% HCBS ARP / 100% FF	$211,576	$105,788	$0	$105,788
Title XIX 50% GF / 50% FF	($211,576)	$0	($105,788)	($105,788)
Total	$0	**$105,788**	**($105,788)**	$0

Funding:
100% State GF (4260-101-0001)
Home and Community-Based Services American Rescue Plan Fund (4260-101-8507)

HEALTH CARE SVCS. FINES AND PENALTIES

REGULAR POLICY CHANGE NUMBER: 184
IMPLEMENTATION DATE: 10/2024
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2484

	FY 2024-25	FY 2025-26
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

Purpose:
This policy change budgets for the use of funds from the Healthcare Services Fines and Penalties Fund to support the Medi-Cal program in place of the General Fund.

Authority:
AB 107 (Chapter 22, Statutes of 2024)

Interdependent Policy Change:
Not Applicable

Background:
The Budget Act of 2024, AB 107 (Chapter 22, Statutes of 2024), proposes to eliminate the Major Risk Medical Insurance Program (MRMIP) and use the funds to support the Medi-Cal Program.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a decrease in General Fund (GF) due to the fines and penalties transfer occurring in FY 2024-25 instead of FY 2023-24. The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase in GF due to all fund transfers occurring in FY 2024-25.

Methodology:
1. For FY 2024-25, assume $69,930,000 will be transferred from the Healthcare Services Fines and Penalties Fund (3311) to the General Fund.

HEALTH CARE SVCS. FINES AND PENALTIES

REGULAR POLICY CHANGE NUMBER: 184

(Dollars in Thousands)

FY 2024-25	TF	GF	SF	FF
Fines & Penalties Transfer	$0	($69,930)	$69,930	$0
Total FY 2024-25	**$0**	**($69,930)**	**$69,930**	**$0**

Funding:
Health Care Services Fines and Penalties Fund (4260-101-3311)
Title XIX GF (4260-101-0001)

IMD ANCILLARY SERVICES

REGULAR POLICY CHANGE NUMBER: 185
IMPLEMENTATION DATE: 4/2017
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 35

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$68,429,000	$63,576,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$68,429,000	$63,576,000
FEDERAL FUNDS	-$68,429,000	-$63,576,000

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 members 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 members 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 member is residing in an IMD. Consequently, the Department's Fiscal Intermediary (FI) may not deny any claims that are ineligible for reimbursement. The Department uses data from the mental health Client and Services Information (CSI) system to retrospectively identify the dates individuals were residents of an IMD for repayment of the FF, as required by CMS. This information is not known at the time the claims were processed and paid by the FI. The Department matches the data from the CSI system to the claims data to determine which claims were inappropriately reimbursed while the individual was a resident of an IMD.

While the Department intends to develop eligibility and claiming processes to stop inappropriate claiming and reimbursement for ancillary services, the current inappropriately paid services must be repaid to CMS.

Due to the Court of Appeals' decision for the County of Colusa case on July 9, 2014, the counties will not reimburse the State for IMD ancillary costs. The State is now financially

IMD ANCILLARY SERVICES
REGULAR POLICY CHANGE NUMBER: 185

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 member was admitted and stayed in an IMD.

CMS has estimated IMD deferrals of $8 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 in FY 2024-25, from the prior estimate, is an increase in costs due to:
- Shifting the April to June 2023 FFS repayments and the October to December 2023 managed care repayments from FY 2023-24 to FY 2024-25,
- Updating the estimate for the April to June 2023 FFS repayments and the October 2023 to March 2024 managed care repayments with actuals, and
- Revising the projected FFS and managed care repayments.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease in costs due to:
- FY 2024-25 includes some actual repayments whereas FY 2025-26 repayments are based on estimates,
- FY 2024-25 estimate includes five quarters of FFS repayments and six quarters of managed care repayments, whereas FY 2025-26 estimate includes four quarters of FFS and managed care repayments, and
- Projected FFS quarterly repayments differ from FY 2024-25 to FY 2025-26.

Methodology:
1. The costs for ancillary services provided to Medi-Cal members in IMDs are in the Medi-Cal base estimate.

2. CMS defers the Department on a quarterly basis for the estimated unallowable expenditures for IMD ancillary services. The quarterly deferrals are immediately repaid while the Department continues to determine the actual repayments owed to CMS. The Department has repaid the deferral received for FFY 2024 Q1 and FFY 2024 Q2 and estimates to repay $8 million per quarter for the FFY 2024 Q3 and FFY 2024 Q4 deferrals in FY 2024-25. The Department estimates to repay $8 million per quarter for FFY 2025 Q1 through FFY 2025 Q4 in FY 2025-26.

3. The Department determines the actual FFS repayment owed for each quarter and submits the actual repayments to CMS. CMS may later release the amounts previously repaid based on the quarterly deferral letter. The FFS estimated repayment amounts for FY 2024-25 and FY 2025-26 are based on actual repayment amounts for the last nineteen quarters, using an average for estimated repayments to future quarters.

4. The Department determines the actual managed care repayment owed for each quarter and submits the actual repayments to CMS. CMS may later release the amounts previously repaid based on the quarterly deferral letter. The managed care estimated repayment amounts for FY 2024-25 and FY 2025-26 are based on estimates of the past quarters.

IMD ANCILLARY SERVICES
REGULAR POLICY CHANGE NUMBER: 185

5. For FY 2024-25, the Department estimates to repay ineligible FFS claims from April 2023 through June 2024 and ineligible managed care claims from October 2023 through March 2025.

6. For FY 2025-26, the Department estimates to repay ineligible FFS claims from July 2024 through June 2025 and ineligible managed care claims from April 2025 through March 2026.

7. The estimated IMD repayments are:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
Fee-For-Service (FFS)			
FY 2022-23 Q4 (Apr-Jun 2023)	$0	$5,565	($5,565)
Subtotal FY 2022-23	$0	$5,565	($5,565)
FY 2023-24 Q1 (Jul-Sep 2023)	$0	$5,805	($5,805)
FY 2023-24 Q2 (Oct-Dec 2023)	$0	$5,940	($5,940)
FY 2023-24 Q3 (Jan-Mar 2024)	$0	$6,074	($6,074)
FY 2023-24 Q4 (Apr-Jun 2024)	$0	$6,208	($6,208)
Subtotal FY 2023-24	$0	$24,027	($24,027)
Subtotal FFS	$0	$29,592	($29,592)
Managed Care			
FY 2023-24 Q2 (Oct-Dec 2023)	$0	$840	($840)
FY 2023-24 Q3 (Jan-Mar 2024)	$0	$747	($747)
FY 2023-24 Q4 (Apr-Jun 2024)	$0	$1,200	($1,200)
FY 2024-25 Q1 (Jul-Sep 2024)	$0	$1,350	($1,350)
FY 2024-25 Q2 (Oct-Dec 2024)	$0	$1,350	($1,350)
FY 2024-25 Q3 (Jan-Mar 2025)	$0	$1,350	($1,350)
Subtotal Managed Care	$0	$6,837	($6,837)
Deferral Repayments			

IMD ANCILLARY SERVICES
REGULAR POLICY CHANGE NUMBER: 185

FFY 2024 Quarter 1 (Oct-Dec 2023)	$0	$8,000	($8,000)
FFY 2024 Quarter 2 (Jan-Mar 2024)	$0	$8,000	($8,000)
FFY 2024 Quarter 3 (Apr-Jun 2024)	$0	$8,000	($8,000)
FFY 2024 Quarter 4 (Jul-Sep 2024)	$0	$8,000	($8,000)
Subtotal Deferrals	$0	$32,000	($32,000)
Total FY 2024-25	**$0**	**$68,429**	**($68,429)**

(Dollars in Thousands)

FY 2025-26	**TF**	**GF**	**FF**
Fee-For-Service (FFS)			
FY 2024-25 Q1 (Jul-Sep 2024)	$0	$6,343	($6,343)
FY 2024-25 Q2 (Oct-Dec 2024)	$0	$6,477	($6,477)
FY 2024-25 Q3 (Jan-Mar 2025)	$0	$6,611	($6,611)
FY 2024-25 Q4 (April-June 2025)	$0	$6,745	($6,745)
Subtotal FY 2024-25	$0	$26,176	($26,176)
Subtotal FFS	$0	$26,176	($26,176)
Managed Care			
FY 2024-25 Q4 (April-June 2025)	$0	$1,350	($1,350)
FY 2025-26 Q1 (Jul- Sep 2025)	$0	$1,350	($1,350)
FY 2025-26 Q2 (Oct- Dec 2025)	$0	$1,350	($1,350)
FY 2025-26 Q3 (Jan- Mar 2026)	$0	$1,350	($1,350)
Subtotal Managed Care	$0	$5,400	($5,400)
Deferral Repayments			
FFY 2025 Quarter 1 (Oct-Dec 2024)	$0	$8,000	($8,000)
FFY 2025 Quarter 2 (Jan-Mar 2025)	$0	$8,000	($8,000)

IMD ANCILLARY SERVICES
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FFY 2025 Quarter 3 (Apr-Jun 2025)	$0	$8,000	($8,000)
FFY 2025 Quarter 4 (Jul-Sep 2025)	$0	$8,000	($8,000)
Subtotal Deferrals	$0	$32,000	($32,000)
Total FY 2025-26	**$0**	**$63,576**	**($63,576)**

Funding:
100% General Fund (4260-101-0001)
Title XIX FFP (4260-101-0890)

HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 186
IMPLEMENTATION DATE: 4/2015
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 1760

	FY 2024-25	FY 2025-26
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

Purpose:
This policy change estimates the funding for health care coverage for children in the Medi-Cal program due to the permanent extension of a quality assurance fee (HQAF) for hospitals authorized under Proposition 52.

For more information about the HQAF, see the Hospital QAF - FFS Payments, Hospital QAF - Managed Care Payments, and Managed Care Private Hospital Directed Payments policy changes.

Authority:
SB 239 (Chapter 657, Statutes of 2013)
Proposition 52 (2016)

Interdependent Policy Changes:
Not Applicable

Background:
Proposition 52, approved by California voters on November 8, 2016, permanently extended the HQAF program.

The Department received federal approval for the HQAF VI program period (July 1, 2019, through December 31, 2021) in February 2020. This HQAF program period is referred to as HQAF VI.

The Department received federal approval for the HQAF VII program period (January 1, 2022, through December 31, 2022) in September 2022. This HQAF program period is referred to as HQAF VII.

The Department received federal approval for the HQAF VIII program period (January 1, 2023, through December 31, 2024) in December 2023. This HQAF program period is referred to as HQAF VIII.

HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 186

The Department will begin developing the subsequent program period (HQAF IX) in FY 2024-25 Q1 which will include payments for the period beginning January 1, 2025. The Department is proposing a one-year program period for dates of service January 1, 2025, through December 31, 2025, which will be submitted to the Centers for Medicare and Medicaid Services (CMS) before April 1, 2025, via SPAs 24-0048 and 24-0049.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to:

- Including the HQAF VI Children's Net Benefit reconciliation payment to be paid in FY 2024-25.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to:

- No reconciliation payments are estimated in FY 2025-26.

Methodology:

1. Payments for children's health care are estimated through the period ending December 31, 2025, in this policy change.

2. 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.

3. The HQAF VIII program period covers a 24-month period from January 1, 2023, through December 31, 2024.

4. HQAF VIII payments are based on the HQAF VIII model that was approved by CMS.

5. HQAF IX estimated payments are based on the HQAF VIII model for CY 2024 that was approved by CMS in December 2023. The amounts for HQAF IX will begin development in FY 2024-25 Q1 which will include payments for the period beginning January 1, 2025. Payment timing and amounts are subject to change.

6. On an accrual basis, annual funds for children's health care coverage are estimated to be:

(Dollars in Thousands)

Calendar Year (CY)	Authority	HQAF VIII Period (Last CY of the 24 months)	Amount
CY 2024	Proposition 52	01/01/24 to 12/31/24	$1,261,900

(Dollars in Thousands)

CY	Authority	HQAF IX Period (Pending)	Amount
CY 2025	Proposition 52	01/01/25 to 12/31/25	$1,981,900

HOSPITAL QAF - CHILDREN'S HEALTH CARE
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7. Four quarters of HQAF VIII Children's Health Care payments will be paid in FY 2024-25.

8. Four quarters of HQAF IX Children's Health Care coverage payments totaling an estimated $1,261,900,000 are expected to be paid in FY 2025-26. The remaining CY 2025 HQAF IX payments are expected to be collected and budgeted after FY 2025-26.

9. HQAF VI Children's Health Care coverage savings for the FY 2019-20 through FY 2021-22 reconciliation of $21,574,000 is estimated to be transferred from the Hospital Quality Assurance Revenue Fund (HQARF) to the General Fund in FY 2024-25. This amount is subject to change pending final approval.

10. On a cash basis, the payments to health care coverage for children and the funding adjustment are:

(Dollars in Thousands)

FY 2024-25	TF	GF	Hosp. QA Rev Fund
HQAF VI FY 2019-20 to FY 2021-22	$0	($21,574)	$21,574
Calendar Year 2024	$0	($1,261,900)	$1,261,900
Total FY 2024-25	**$0**	**($1,283,474)**	**$1,283,474**

(Dollars in Thousands)

FY 2025-26	TF	GF	Hosp. QA Rev Fund
Calendar Year 2025	$0	($1,261,900)	$1,261,900
Total FY 2025-26	**$0**	**($1,261,900)**	**$1,261,900**

Funding:
100% GF (4260-101-0001)
100% Hospital Quality Assurance Revenue Fund (4260-611-3158)

CIGARETTE AND TOBACCO SURTAX FUNDS

REGULAR POLICY CHANGE NUMBER: 187
IMPLEMENTATION DATE: 1/2006
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1087

	FY 2024-25	FY 2025-26
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

Purpose:
This policy change reduces the General Fund and replaces those funds with Cigarette and Tobacco Products Surtax (CTPS/Proposition 99) funds from the Hospital Services, Physicians' Services, and Unallocated Accounts. This funding shift is identified in the management summary funding pages.

Authority:
California Tobacco Health Protection Act of 1988 (Proposition 99)
AB 75 (Chapter 1331, Statutes of 1989)

Interdependent Policy Changes:
Not Applicable

Background:
The CTPS/Proposition 99 funds are allocated to aid in the funding of the *Orthopaedic Hospital* settlement and other outpatient payments. The *Orthopaedic Hospital* settlement increased hospital outpatient rates by a total of 43.44% between 2001 and 2004.

This policy change supports healthcare coverage for members 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: 187

Methodology:

FY 2024-25	
Hospital Services Account	$72,949,000
Physicians' Services Account	$20,826,000
Unallocated Account	$33,186,000
Total CTPS/Prop. 99	**$126,961,000**
GF	**($126,961,000)**
Net Impact	**$0**

FY 2025-26	
Hospital Services Account	$61,994,000
Physicians' Services Account	$17,700,000
Unallocated Account	$27,474,000
Total CTPS/Prop. 99	**$107,168,000**
GF	**($107,168,000)**
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)

FUNDING ADJUST.—ACA OPT. EXPANSION

REGULAR POLICY CHANGE NUMBER: 188
IMPLEMENTATION DATE: 7/2015
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1915

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$5,414,847,600	-$5,786,183,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$5,414,847,600	-$5,786,183,600
FEDERAL FUNDS	$5,414,847,600	$5,786,183,600

Purpose:
This policy change estimates the adjustment to accurately reflect the enhanced percentage of federal funding match for the Affordable Care Act (ACA) optional expansion population.

Authority:
ACA

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2014, the ACA expanded Medicaid coverage to previously ineligible persons, primarily childless adults at or below 138% of the federal poverty level. The expansion of Medicaid coverage to previously ineligible persons is referred to as the ACA optional expansion. Since January 2014, the Department has experienced significant growth in Medi-Cal enrollment as a result of the ACA optional expansions. The ACA provided an enhanced federal match for optional expansion adults of 100% through calendar year (CY) 2016, and then decreased the match in yearly phases to 90% by 2020.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a general fund savings increase due to updated estimates and data. The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase in general fund savings due to updated estimates and data.

Methodology:
1) The Department identified funds allocated to members in the Newly aid category that were Title XIX funding with 50% federal match.

2) The federal match for FY 2024-25 and FY 2025-26 is 90%.

FUNDING ADJUST.—ACA OPT. EXPANSION
REGULAR POLICY CHANGE NUMBER: 188

3) The total amount of unadjusted ACA optional expansion funding in FY 2024-25 is estimated as $13,537,119,003 and $14,465,459,079 in FY 2025-26. These amounts are credited to the Title XIX fund.

4) The amounts adjusted are as follows:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
50% Title XIX / 50%GF	($13,537,119)	($6,768,560)	($6,768,560)
90% Title XIX ACA FF / 10% GF	$13,537,119	$1,353,712	$12,183,407
Total	**$0**	**($5,414,848)**	**$5,414,848**

*Totals may differ due to rounding

FY 2025-26	TF	GF	FF
50% Title XIX / 50%GF	($14,465,459)	($7,232,730)	($7,232,730)
90% Title XIX ACA FF / 10% GF	$14,465,459	$1,446,546	$13,018,913
Total	**$0**	**($5,786,184)**	**$5,786,184**

*Totals may differ due to rounding.

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX ACA FF / 10% GF (4260-101-0001/0890)

FUNDING ADJUST.—OTLICP

REGULAR POLICY CHANGE NUMBER: 189
IMPLEMENTATION DATE: 7/2015
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1926

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$133,038,450	-$136,980,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$133,038,450	-$136,980,000
FEDERAL FUNDS	$133,038,450	$136,980,000

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:
Not Applicable

Background:
The Balanced Budget Act of 1997 added Title XXI to the Social Security Act creating CHIP to provide new coverage opportunities for children in families with incomes too high to qualify for Medicaid. States administer the CHIP program and they are jointly funded by federal and state governments.

The ACA provides enhanced federal funding to Title XXI. The California federal funding match was 65 percent through September 30, 2015. Effective October 1, 2015, the ACA extended and increased the enhanced federal matching rate for the CHIP program by 23 percent to 88 percent. Congress reauthorized the CHIP program in January, 2018, reducing the federal matching rate to 76.5 percent effective October 1, 2019, and further reducing the match rate to 65 percent effective October 1, 2020.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a general fund savings increase due to updated estimates and data. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a general fund savings increase due to updated estimates and data.

Methodology:
1) The Department identified funds allocated to CHIP members in the OTLICP aid category that were not adjusted for additional Title XXI funding.

FUNDING ADJUST.—OTLICP
REGULAR POLICY CHANGE NUMBER: 189

2) The total amount of unadjusted CHIP funding in FY 2024-25 is estimated as $886,923,371 and $913,199,590 in FY 2025-26. 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 2024-25, the Department estimates the additional CHIP funding will offset general fund spending by $133 million.
   b. In FY 2025-26, the Department estimates the additional CHIP funding will offset general fund spending by $137 million.

4) The amounts adjusted are as follows:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
50% Title XIX / 50%GF	($886,923)	($443,462)	($443,462)
65% Title XXI FF / 35% GF	$886,923	$310,423	$576,500
Total	**$0**	**($133,039)**	**$133,039**

*Totals may differ due to rounding

FY 2025-26	TF	GF	FF
50% Title XIX / 50%GF	($913,200)	($456,600)	($456,600)
65% Title XXI FF / 35% GF	$913,200	$319,620	$593,580
Total	**$0**	**($136,980)**	**$136,980**

*Totals may differ due to rounding.

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

CCI IHSS RECONCILIATION

REGULAR POLICY CHANGE NUMBER: 190
IMPLEMENTATION DATE: 7/2022
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 1942

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$115,000,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$115,000,000	$0
FEDERAL FUNDS	-$115,000,000	$0

Purpose:
This policy change estimates the reimbursement of In-Home Supportive Services (IHSS) overpayments and underpayments to the California Department of Social Services (CDSS) and the managed care plans.

Authority:
Welfare & Institutions Code (W&I) 14132.275

Interdependent Policy Changes:
Not Applicable

Background:
In coordination with Federal and State Government, the Coordinated Care Initiative (CCI) provided the benefits of coordinated care models to persons eligible for Medi-Cal. CCI aimed to improve service delivery for people with dual eligibility and Medi-Cal only members who relied on long-term services and supports (LTSS) to maintain residence in their home or community. LTSS includes both home and community-based services, such as IHSS and institutional long-term care services. Services were provided through the managed care delivery system for all Medi-Cal members who relied on such services. CDSS and the county social service offices were responsible for the administration and payment of IHSS expenditures. The cost of IHSS was built into the CCI capitated rates and paid to CDSS to reimburse IHSS providers for personal care services. The Department is responsible for the reconciliation of the IHSS category of service, which was a component of the capitated rate, to actual IHSS expenditures paid out to providers by CDSS for a specified period of time. The Department determined the overpayments or underpayments to CDSS or the managed care plans (MCPs) during the reconciliation process.

The 2017 Budget extended the Cal MediConnect program and the mandatory enrollment of dual eligibles and integration of LTSS, except IHSS, into managed care. IHSS was removed from capitation rate payments as of January 1, 2018.

CCI IHSS RECONCILIATION
REGULAR POLICY CHANGE NUMBER: 190

As part of the CalAIM Initiative's standardized mandatory enrollment of dual eligibles and statewide integration of long-term care into managed care, the CCI pilot program sunset December 31, 2022.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a General Fund (GF) increase due to the repayment to the Centers for Medicare and Medicaid Services (CMS) shifting from FY 2023-24 to FY 2024-25. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a GF decrease due to the repayment to CMS being completed in FY 2024-25.

Methodology:
1. The 2015, 2016, and 2017 reconciliation for CY 2015, CY 2016, and CY 2017 service months and reimbursement for overpayments and underpayments were completed in FY 2022-23.

2. Based on CY 2015, CY 2016, and CY 2017 data, the MCPs were owed a net of approximately $162,000,000 GF for IHSS managed care in the seven CCI counties.

3. Additionally, due to the difference between total claims paid by CDSS and claims for members who were not flagged as receiving IHSS services for MCP capitation, the Department recorded an additional $86,000,000 million as a GF cost.

4. Total estimated net amount paid to MCPs in FY 2022-23 was $248,000,000 GF.

5. In FY 2023-24, $30,986,000 GF was recouped from plans that no longer have active contracts with the state.

6. $115,000,000 GF will be used in FY 2024-25 to repay CMS for reduced capitation payments to the MCPs.

Funding:
100% State GF (4260-101-0001)
100% FFP (4260-001-0001)

CMS DEFERRED CLAIMS

REGULAR POLICY CHANGE NUMBER: 191
IMPLEMENTATION DATE: 4/2017
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 2034

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$4,000,000	-$109,127,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$4,000,000	-$109,127,000
FEDERAL FUNDS	-$4,000,000	$109,127,000

Purpose:
This policy change estimates the repayment of deferred claims to the Centers for Medicare and Medicaid Services (CMS).

Authority:
California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)
Title 42, Code of Federal Regulations (CFR), 430.40

Interdependent Policy Changes:
Not Applicable

Background:
CMS reviews claims submitted by state Medicaid agencies to ensure federal financial participation (FFP) eligibility. Claims for which CMS questions the FFP eligibility are deferred and the state Medicaid agency is issued a deferral notice. Upon receipt of the deferral notice, the state Medicaid agency has 120 days to resolve the deferred claim.

When CMS issues a deferral to the state Medicaid agency, in accordance with the timelines set forth in 42 CFR 430.40, the state Medicaid agency must immediately return the deferred FFP to the applicable Payment Management System (PMS) subaccount while the deferral is being resolved. As part of the resolution process, the state Medicaid agency submits documentation in support of the deferred claim to CMS for review. If CMS determines the deferred claim is allowed, then the deferral is released, the funds are returned to the appropriate PMS subaccount, and the state Medicaid agency is notified that the funds are available to be redrawn.

CMS DEFERRED CLAIMS
REGULAR POLICY CHANGE NUMBER: 191

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to:
- Updating FFY 2024 Q1 and FFY 2024 Q2 repayments based on the actual deferrals for these quarters,
- Removing the placeholder projections of $25 million per quarter for future deferrals for FFY 2024 Q3 and FFY 2024 Q4 based on recent actual deferrals, and
- Shifting the state only cost deferrals related to pharmacy claims through FFY 2024 Q1 that were previously estimated to be returned to the GF in FY 2024-25 to FY 2025-26.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to estimating state only cost deferrals related to pharmacy claims through FFY 2025 Q1 will be returned to the GF in FY 2025-26.

Methodology:
1. The Department received CMS deferrals for FFY 2015 Quarter 1 through FFY 2024 Quarter 2.

2. In FY 2024-25, the Department estimates to repay a total of $4 million FF, which includes $2 million of actual CMS deferrals issued for FFY 2024 Quarter 1 and FFY 2024 Quarter 2.

3. The repayments for state only costs deferrals related to pharmacy claims were $2 million in FFY 2024 Quarter 1 and FFY 2024 Quarter 2 and estimated to be $2 million for FFY 2024 Quarter 3 and FFY 2024 Quarter 4.

4. Repayments for state only cost deferrals for pharmacy claims are estimated to be $3 million in FY 2025-26 for FFY 2025 Quarter 1 through FFY 2025 Quarter 3. Deferrals for the pharmacy claims are not assumed for FFY 2025 Quarter 4 and later quarters, consistent with the expected implementation of correct claiming for these items.

5. An additional $1 million is included for potential future deferrals estimated for FFY 2025 Quarter 4.

6. The Department estimates recovering $113.13 million in resolved deferrals during FY 2025-26 related to pharmacy claims.

7. The Department will repay the following estimated deferred claims:

(Dollars in Thousands)

FY 2024-25	**Total Estimated Repayment**
FFY 2024 Quarter 1 (Oct-Dec 2023)	$1,000
FFY 2024 Quarter 2 (Jan-Mar 2024)	$1,000
FFY 2024 Quarter 3 (Apr-Jun 2024)	$1,000
FFY 2024 Quarter 4 (Jul-Sep 2024)	$1,000
Subtotal Estimated Repayments	$4,000
Estimated Resolved Deferrals	$0
Total FY 2024-25	**$4,000**

CMS DEFERRED CLAIMS
REGULAR POLICY CHANGE NUMBER: 191

(Dollars in Thousands)

FY 2025-26	Total Estimated Repayment
FFY 2025 Quarter 1 (Oct-Dec 2024)	$1,000
FFY 2025 Quarter 2 (Jan-Mar 2025)	$1,000
FFY 2025 Quarter 3 (Apr-Jun 2025)	$1,000
FFY 2025 Quarter 4 (Jul-Sep 2025)	$1,000
Subtotal Estimated Repayments	$4,000
Estimated Resolved Deferrals	($113,127)
Total FY 2025-26	**($109,127)**

Funding:
100% Title XIX FFP (4260-101-0890)
100% Title XIX GF (4260-101-0001)

INDIAN HEALTH SERVICES FUNDING SHIFT

REGULAR POLICY CHANGE NUMBER: 192
IMPLEMENTATION DATE: 7/2019
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2156

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$25,549,500	-$27,294,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$25,549,500	-$27,294,500
FEDERAL FUNDS	$25,549,500	$27,294,500

Purpose:
This policy change estimates the technical adjustment in funding from Title XIX 50% federal financial participation (FFP) to Title XIX 100% FFP for services provided by Indian health facilities to American Indians (AIs) eligible for Fee-For-Service (FFS) Medi-Cal.

Authority:
Public Law 93-638
Public Law 102-573

Interdependent Policy Changes:
Not Applicable

Background:
The Department implemented the Indian Health Services/Memorandum of Agreement 638 Clinics (IHS/MOA) between the federal IHS and the Centers for Medicare & 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.

The Department implemented the enrollment and reimbursement of Youth Regional Treatment Centers (YRTCs) for services rendered to AI youths. Indian health clinics refer these youths to YRTCs for culturally appropriate in-patient substance use disorder treatment. The Department receives 100% FFP for YRTC services provided to eligible AI Medi-Cal members under the age of 21.

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.

INDIAN HEALTH SERVICES FUNDING SHIFT
REGULAR POLICY CHANGE NUMBER: 192

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a decrease in General Fund (GF) savings based on two additional quarters of actual expenditures that were lower than previously estimated. The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase in GF savings due to revised quarterly adjustments based on actuals.

Methodology:
1. Assume a one quarter lag when the claims are adjusted from 50% GF / 50% FF to 100% FFP.

2. In FY 2024-25, it is estimated the Department will spend $51,099,000 TF ($25,550,000 GF). In FY 2025-26, it is estimated the Department will spend $54,589,000 TF ($27,295,000 GF).

3. Estimated expenditures for FY 2024-25 and FY 2025-26 are in the table below.

(Dollars in Thousands)

FY 2024-25	**TF**	**GF**	**FF**
IHS FY 2024-25 Base exp. (50% GF / 50% FF)	($51,099)	($25,550)	($25,549)
IHS total expenditures (100% FF)	$51,099	$0	$51,099
FY 2024-25 Total	**$0**	**($25,550)**	**$25,550**
FY 2025-26	**TF**	**GF**	**FF**
IHS FY 2025-26 Base exp. (50% GF / 50% FF)	($54,589)	($27,295)	($27,294)
IHS total expenditures (100% FF)	$54,589	$0	$54,589
FY 2025-26 Total	**$0**	**($27,295)**	**$27,295**

*Totals may differ due to rounding.

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

DENTAL MANAGED CARE MLR RISK CORRIDOR

REGULAR POLICY CHANGE NUMBER: 193
IMPLEMENTATION DATE: 12/2021
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2356

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	-$3,000,000	$0
- STATE FUNDS	-$1,198,250	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$3,000,000	$0
STATE FUNDS	-$1,198,250	$0
FEDERAL FUNDS	-$1,801,750	$0

Purpose:
This policy change budgets recoveries from managed care plans related to the Medical Loss Ratio (MLR) risk corridor calculations applicable to the Medi-Cal Dental Managed Care (DMC) plans.

Authority:
Title 42, Code of Federal Regulations, Part 438.8
Access Dental Plan Contract #12-89341
Access Dental Plan Contract #13-90115
Access Dental Plan Contract #22-20508
Access Dental Plan Contract #22-20509
Health Net of California Contract #12-89342
Health Net of California Contract #13-90116
Health Net of California Contract #22-20510
Health Net of California Contract #22-20511
Liberty Dental Plan of California, Inc. Contract #12-89343
Liberty Dental Plan of California, Inc. Contract #13-90117
Liberty Dental Plan of California Contract #22-20512
Liberty Dental Plan of California Contract #22-20513
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

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 members in Sacramento and Los Angeles counties.

DENTAL MANAGED CARE MLR RISK CORRIDOR

REGULAR POLICY CHANGE NUMBER: 193

Each dental plan receives a 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.

The Medi-Cal DMC plan contracts establish a single-sided risk corridor in the form of a minimum MLR of 85% beginning with the FY 2019-20 rating period. The Department will require DMC plans to remit necessary funds that do not meet the 85% threshold.

As a result of the COVID-19 national public health emergency, increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase in expected recoupments due to CY 2023 calculations having been completed. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease in recoupments due to known recoupments being completed in FY 2024-25.

Methodology:

1. The Department estimates total collections of $3 million total funds in FY 2024-25. This amount is associated with the CY 2023 rating period.

2. The Title XIX and Title XXI COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

3. The Department estimates any remittances for the CY 2024 rating period will be collected in FY 2025-26. At this time, an estimated remittance amount is not available as the data needed to perform the calculations can be collected only after the end of the rating period.

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF	($1,638,000)	($819,000)	($819,000)
90% ACA Title XIX FF / 10% GF	($754,000)	($75,000)	($679,000)
65% Title XXI / 35% GF	($371,000)	($130,000)	($241,000)
COVID-19 Title XIX Increased FMAP	$0	$54,000	($54,000)
COVID-19 Title XXI Increased FMAP	$0	$9,000	($9,000)
100% GF	($237,000)	($237,000)	$0
Total	**($3,000,000)**	**($1,198,000)**	**($1,802,000)**

*Totals may differ due to rounding.

DENTAL MANAGED CARE MLR RISK CORRIDOR

REGULAR POLICY CHANGE NUMBER: 193

Funding:
50% Title XIX / 50% GF (4260-101-0890/0001)
90% ACA Title XIX FF / 10% GF (4260-101-0890/0001)
65% Title XXI / 35% GF (4260-101-0890/0001)
COVID-19 Title XIX Increased FFP (4260-101-0890)
COVID-19 Title XIX GF (4260-101-0001)
COVID-19 Title XXI Increased FFP (4260-101-0890)
COVID-19 Title XXI GF (4260-101-0001)
100% State GF (4260-101-0001)

QUALITY SANCTIONS

REGULAR POLICY CHANGE NUMBER: 194
IMPLEMENTATION DATE: 6/2024
ANALYST: Whitney Li
FISCAL REFERENCE NUMBER: 2497

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	-$5,549,000	-$3,500,000
- STATE FUNDS	-$2,514,500	-$1,750,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$5,549,000	-$3,500,000
STATE FUNDS	-$2,514,500	-$1,750,000
FEDERAL FUNDS	-$3,034,500	-$1,750,000

Purpose:
This policy change estimates the savings from sanctions collected from the health plans.

Authority:
Welfare & Institutions Code (WIC) 14197.7

Interdependent Policy Changes:
Not Applicable

Background:
Starting FY 2022-23, the Department issued health plan quality sanctions and these sanctions will continue annually. These amounts will be recouped and deposited into the General Fund.

As a result of the COVID-19 national public health emergency, increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to:

- Displaying the collections according to calendar year (CY) periods,
- Updated funding splits applied to CY 2022,
- Adding an estimate for the CY 2023 collections, and
- This policy change was budgeted as an administrative policy change in the May 2024 Estimate and has now changed to a benefits policy change.

The changes from FY 2024-25 to FY 2025-26, in the current estimate, are due to:

- Two CYs are estimated in FY 2024-25 while only one CY is estimated in FY 2025-26, and
- COVID-19 increased FMAP is no longer applicable for CY 2024 sanctions.

QUALITY SANCTIONS
REGULAR POLICY CHANGE NUMBER: 194

Methodology:
1. Assume CY 2022 sanctions will be collected August 2024.

2. Assume two collection periods, one for Calendar Year 2023 and a second for Calendar Year 2024, are collected in FY 2024-25. Assume CY 2024 is collected in FY 2025-26.

FY 2024-25	TF	GF	FF
CY 2022 Collected Sanctions	($2,049,000)	($897,000)	($1,152,000)
CY 2023 Collected Sanctions	($3,500,000)	($1,617,000)	($1,883,000)
Total	**($5,549,000)**	**($2,514,000)**	**($3,035,000)**

FY 2025-26	TF	GF	FF
CY 2024 Collected Sanctions	($3,500,000)	($1,750,000)	($1,750,000)
Total	**($3,500,000)**	**($1,750,000)**	**($1,750,000)**

Funding:
COVID-19 Title XIX GF (4260-101-0001)
COVID-19 Title XIX Increased FFP (4260-101-0890)
50% Title XIX / 50% GF (4260-101-0001/0890)

ASSISTED LIVING WAIVER EXPANSION

REGULAR POLICY CHANGE NUMBER: 195
IMPLEMENTATION DATE: 10/2021
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2054

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	-$8,576,000	-$24,880,000
- STATE FUNDS	-$5,146,000	-$14,928,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	4.12 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$8,222,700	-$24,880,000
STATE FUNDS	-$4,933,980	-$14,928,000
FEDERAL FUNDS	-$3,288,680	-$9,952,000

Purpose:
This policy change estimates the cost to increase the capacity of the Assisted Living Waiver (ALW).

Authority:
SB 840 (Chapter 29, Statutes of 2018)
American Rescue Plan (ARP) Act (2021)

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 members.

The ARP provided additional Coronavirus Disease 2019 (COVID-19) relief to states. Section 9817 of the ARP provided qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS). States were required to use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021, and states were required to use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. State funds equivalent to the amount of federal funds attributable to the increased FMAP were deposited in the Home and Community-Based Services American Rescue Plan Fund. States were required to expend the federal funds attributable to the increased FMAP by December 31, 2024.

On October 27, 2021, the Department submitted an ALW technical amendment to increase the maximum number of waiver slots by 7,500 to the Centers for Medicare and Medicaid Services

ASSISTED LIVING WAIVER EXPANSION
REGULAR POLICY CHANGE NUMBER: 195

(CMS) for approval. On January 7, 2022, CMS approved the amendment with a retroactive implementation date of July 1, 2021. CMS informed the Department that agencies could immediately start enrolling members on the waitlist. As of June 2024, all 7,500 slots have been released for transitioning members for placement into the ALW.

The ALW reached the 7,500-slot capacity in FY 2023-24 and the current waiver expired on February 29, 2024. Due to the growth of the program and continued high demand, the Department submitted a slot increase amendment to CMS for approval. On May 20, 2024, CMS approved the amendment to increase the allocated slots by about 1,800 each Waiver Year over the next five years.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is a decrease in costs due to this policy change only capturing the incremental costs/savings for the ALW. It is assumed that the enrollment costs/savings for all prior fiscal years are captured in the base estimates.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase in savings due additional savings being realized from members transitioning from a skilled nursing facility (SNF) to the waiver.

Methodology:
1. Assume 7,500 new members transitioned in FY 2023-24.

2. Of the new 7,500 members, assume 5,000 will be from the community only and 2,500 will be from the community and SNF.

3. Of the 2,500 members, assume 60% will be from long-term SNFs and 40% will be from the community; 1,500 members are from SNFs, and 1,000 members are from the community.

4. With all 7,500 slots filled, assume members who leave the waiver will be backfilled with 60% of members coming from long-term SNFs and 40% of members coming from the community.

5. Assume 1,332 members will transition in FY 2024-25 and 1,446 members in FY 2025-26.

6. Beginning January 1, 2024, assume ALW costs increased due to the minimum wage increase from $15.50 to $16.00 per hour. Beginning January 1, 2025, assume ALW costs increased due to the minimum wage increase from $16.00 to $16.40 an hour. Beginning January 1, 2026, assume an increase in ALW costs due to the minimum wage increase from $16.40 to $16.70 an hour. Prospective minimum wage increases are budgeted in the Minimum Wage Increase for HCBS Waivers policy change.

7. Assume an average of 114 members will enroll per month in FY 2024-25 and 112 members in FY 2025-26.

8. Assume the average annual cost for waiver services is $57,989.

9. Assume the average annual cost in an SNF is $115,263 in FY 2024-25 and $116,645 in FY 2025-26.

ASSISTED LIVING WAIVER EXPANSION

REGULAR POLICY CHANGE NUMBER: 195

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
Total Cost from Waiver Services	$42,975	$25,785	$17,190
Total Savings from SNF Transitions	($51,551)	($30,931)	($20,620)
Net Impact	**($8,576)**	**($5,146)**	**($3,430)**

FY 2025-26	TF	GF	FF
Total Cost from Waiver Services	$119,274	$71,564	$47,710
Total Savings from SNF Transitions	($144,154)	($86,492)	($57,662)
Net Impact	**($24,880)**	**($14,928)**	**($9,952)**

*Totals may differ due to rounding.

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

COUNTY SHARE OF OTLICP-CCS COSTS

REGULAR POLICY CHANGE NUMBER: 196
IMPLEMENTATION DATE: 7/2014
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 1906

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	-$12,456,000	-$12,456,000
- STATE FUNDS	-$12,456,000	-$12,456,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$12,456,000	-$12,456,000
STATE FUNDS	-$12,456,000	-$12,456,000
FEDERAL FUNDS	$0	$0

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 members shifted to CCS-OTLICP in FY 2013-14. CCS-HFP was funded with 65% FFP, 17.5% GF, and 17.5% county funds through September 30, 2015. From October 1, 2015, to September 30, 2019, CCS-HFP was funded with 88% FFP, 6% GF, and 6% county funds. From October 1, 2019, to September 30, 2020, CCS-HFP was funded with 76.5% FFP, 11.75% GF, and 11.75% county funds. Effective October 1, 2020, CCS-HFP is funded with 65% FFP, 17.5% GF, and 17.5% county funds. It is assumed that the county share will continue under OTLICP.

Reason for Change:
There is a decrease in county share reimbursement for FY 2024-25, from the prior estimate, due to updated actual expenditures. There is no change in the current estimate from FY 2024-25 to FY 2025-26.

Methodology:
1. The county share reimbursement for OTLICP-CCS in FY 2024-25, at 17.5% for quarter 1 through 4, is estimated to be $12,456,000.

COUNTY SHARE OF OTLICP-CCS COSTS
REGULAR POLICY CHANGE NUMBER: 196

2. The county share reimbursement for OTLICP-CCS in FY 2025-26, at 17.5% for quarter 1 through 4, is estimated to be $12,456,000.

3. The county share of OTLICP-CCS costs is estimated in the table below:

Fiscal Year	TF	GF	CF*
FY 2024-25	**$12,456,000**	**$12,456,000**	($12,456,000)
FY 2025-26	**$12,456,000**	**$12,456,000**	($12,456,000)

* County Funds are not included in the Total Fund.

Funding:
100% Title XXI State GF (4260-101-0001)

HCBA WAIVER EXPANSION

REGULAR POLICY CHANGE NUMBER: 197
IMPLEMENTATION DATE: 10/2017
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2010

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	-$29,901,000	-$86,738,000
- STATE FUNDS	-$15,011,000	-$43,545,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	7.83 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$27,559,800	-$86,738,000
STATE FUNDS	-$13,835,640	-$43,545,000
FEDERAL FUNDS	-$13,724,110	-$43,193,000

Purpose:
This policy change estimates the cost of the Home and Community-Based Alternatives (HCBA) Waiver.

Authority:
Welfare & Institutions Code, Section 14132.991

Interdependent Policy Changes:
HCBA Waiver Renewal Administrative Cost

Background:
The HCBA waiver offers services in the home or community to Medi-Cal members 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 member'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.

On February 2, 2023, the Centers for Medicare & Medicaid Services (CMS) approved a HCBA Waiver for a new five-year term, from January 1, 2023, through December 31, 2027. The new waiver term includes phases in additional slots each Calendar Year, beginning on January 1, 2025. However, based on historical enrollment and attrition trends, it was determined that the waiver would reach capacity before the end of 2023. The Department submitted a waiver amendment to begin phasing in new slots on January 1, 2024; CMS approved the waiver amendment on December 11, 2023.

HCBA WAIVER EXPANSION
REGULAR POLICY CHANGE NUMBER: 197

Under the new waiver term, the waiver:

- Adds new waiver services,
- Increases waiver slots beginning January 1, 2024, based on projected enrollment and attrition trends, and
- Increases the rates for Intermediate Care Facilities/Developmentally Disabled – Continuous Nursing Care.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a decrease due to the following methodology updates:
- Capturing the Waiver Personal Care Services costs in a separate policy change; and
- Budgeting only the incremental costs and savings for the HCBA waiver in this policy change.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase in savings due to the additional savings being realized from members transitioning from a skilled nursing facility (SNF) to the HCBA waiver.

Methodology:
1. Assume there are 9,046 members in the HCBA Waiver in FY 2023-24.

2. Assume the annual cost per member is $25,951.

3. Assume 1,284 new members will transition in FY 2024-25 and in FY 2025-26.

4. Assume 60% will be from long-term SNFs and 40% members will be from the community.

5. Assume the average monthly cost in a SNF is $9,605 in FY 2024-25 and $9,720 in FY 2025-26.

(Dollars in Thousands)

FY 2024-25	**TF**	**GF**	**FF**
Waiver Costs	$18,049	$9,061	$8,988
Savings from SNF	($47,949)	($24,072)	($23,877)
Net Cost	**($29,901)**	**($15,011)**	**($14,890)**
FY 2025-26	**TF**	**GF**	**FF**
Waiver Costs	$51,370	$25,789	$25,581
Savings from SNF	($138,107)	($69,334)	($68,774)
Net Cost	**($86,738)**	**($43,545)**	**($43,193)**

*Totals may differ due to rounding.

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

MEDICARE PART A BUY-IN PROGRAM

REGULAR POLICY CHANGE NUMBER: 198
IMPLEMENTATION DATE: 1/2025
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 2442

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	-$41,778,000	-$103,168,000
- STATE FUNDS	-$1,384,000	-$5,712,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$41,778,000	-$103,168,000
STATE FUNDS	-$1,384,000	-$5,712,000
FEDERAL FUNDS	-$40,394,000	-$97,456,000

Purpose:
This policy change estimates the fiscal impact from automatically enrolling Medi-Cal enrollees into the Medicare Part A Buy-In program.

Authority:
SB 311 (Chapter 707, Statutes of 2023)

Interdependent Policy Changes:
Not Applicable

Background:
SB 311 requires the Department to enter into a Medicare Part A Buy-In Agreement with the Centers for Medicare and Medicaid Services (CMS), effective no sooner than January 1, 2025, or upon system readiness for implementation, whichever is later. The Medicare Part A Buy-In Agreement would enable Qualified Medicare Beneficiary (QMB)-eligible individuals to be automatically enrolled in Medicare Part A at any time of the year and shift the costs for their hospital and initial skilled nursing facility services from Medi-Cal to Medicare as the primary payer. Medi-Cal would also start paying Medicare Part A premiums for QMB individuals but will no longer have to pay late enrollment penalties for individuals who do not enroll in Medicare Part A timely.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to:

- The removal of the California Statewide Automated Welfare System (SAWS) contract cost, which will now be budgeted in the SAWS policy change.
- Updated payment lags applied to the fee-for-service (FFS) and penalty savings.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase in net savings based on projecting savings for 12 months in FY 2025-26.

MEDICARE PART A BUY-IN PROGRAM

REGULAR POLICY CHANGE NUMBER: 198

Methodology:

1. Assume this policy will implement no sooner than January 1, 2025, or upon system readiness for implementation, whichever is later.

2. Hospital inpatient and initial skilled nursing facility costs for individuals newly enrolled in Medicare Part A would shift from Medi-Cal to Medicare.

3. The State would no longer have to pay late enrollment penalties for individuals who do not enroll in Medicare during open enrollment.

4. The State would begin paying Part A premiums for QMB-eligible individuals that are currently not enrolled in Part A Buy-In without a requirement for a separate application.

5. Supplemental Security Income/State Supplementary Payment (SSI/SSP) eligible individuals who are dually eligible for Medicare Part A and B will be automatically enrolled in QMB in the month following their SSI enrollment, starting January 1, 2025. SSI/SSP eligible individuals would be enrolled in Part A Buy-In automatically.

FY 2024-25	TF	GF	FF
FFS (Lagged)	($861,000)	($300,000)	($561,000)
Managed Care	($38,583,000)	$1,250,000	($39,833,000)
Penalty Savings (Lagged)	($2,334,000)	($2,334,000)	$0
Total	**($41,778,000)**	**($1,384,000)**	**($40,394,000)**

FY 2025-26	TF	GF	FF
FFS (Lagged)	($2,847,000)	($991,000)	($1,856,000)
Managed Care	($92,600,000)	$3,000,000	($95,600,000)
Penalty Savings (Lagged)	($7,721,000)	($7,721,000)	$0
Total	**($103,168,000)**	**($5,712,000)**	**($97,456,000)**

Funding:

FY 2024-25	TF	GF	FF
100% GF (4260-101-0001)	($1,384,000)	($1,384,000)	$0
100% Title XIX (4260-101-0890)	($40,394,000)	$0	($40,394,000)
Total	**($41,778,000)**	**($1,384,000)**	**($40,394,000)**

FY 2025-26	TF	GF	FF
100% GF (4260-101-0001)	($5,712,000)	($5,712,000)	$0
100% Title XIX (4260-101-0890)	($97,456,000)	$0	($97,456,000)
Total	**($103,168,000)**	**($5,712,000)**	**($97,456,000)**

COUNTY BH RECOUPMENTS

REGULAR POLICY CHANGE NUMBER: 199
IMPLEMENTATION DATE: 1/2025
ANALYST: Tyler Shimizu
FISCAL REFERENCE NUMBER: 2343

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	-$128,319,000	-$64,160,000
- STATE FUNDS	-$128,319,000	-$64,160,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$128,319,000	-$64,160,000
STATE FUNDS	-$128,319,000	-$64,160,000
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the recoupments due to the Department from psychiatric inpatient hospital claims approved and paid through the Fiscal Intermediary, and overpayments of Federal Financial Participation (FFP) related to members with unsatisfactory immigration status (UIS).

Authority:
AB 757 (Chapter 633, Statutes of 1994)

Interdependent Policy Changes:
Not Applicable

Background:
Psychiatric Inpatient Hospital Claims
The Department consolidated the responsibility to provide inpatient and outpatient specialty mental health services under county mental health plans (MHP) of outpatient Specialty Mental Health Services (SMHS) in 1994 and inpatient services in 1997. The majority of hospitals providing inpatient SMHS receive payment via Medi-Cal's Fee-for-Service claims adjudication system. Medi-Cal pays the federal and non-federal share for psychiatric inpatient hospital services. The non-federal share is initially funded by General Fund (GF) and later reimbursed by subtracting the expenditure amount from each county's Mental Health Subaccount in the Sales Tax Account of the Local Revenue Fund.

The Department routinely adds aid codes to the Medi-Cal program. The Department and the former Department of Mental Health did not add new aid codes to the reporting structure used to identify the expenditure amounts for the Mental Health Subaccount. As a result, the Department did not identify and was not fully reimbursed for all of the psychiatric inpatient hospital service expenditures between CY 2011 and 2020.

COUNTY BH RECOUPMENTS
REGULAR POLICY CHANGE NUMBER: 199

Medi-Cal Members with UIS
California provides state only full scope Medi-Cal services to certain immigrant populations who meet all Medi-Cal eligibility requirements except for their citizenship status. For these covered populations, FFP is only available for emergency and pregnancy-related services, and nonemergency and non-pregnancy related services are paid using state only funds. Affected populations include qualified non-citizens subject to the five-year bar, individuals who are Permanent Residents or Permanently Residing Under Color of Law, and individuals under 26 years of age who otherwise meet all Medi-Cal eligibility criteria (such as income and state residency) but for their citizenship status.

The Department has identified claiming for ineligible covered benefits and is required to return the federal funding to the Centers for Medicare and Medicaid Services (CMS). The Department is recouping the amounts that were the responsibility of the county; specifically amounts associated with qualified non-citizens subject to the five-year bar and individuals who are Permanent Residents or Permanently Residing Under Color of Law. In FY 2021-22, the Department identified incorrect claiming for Medicaid Children's Health Insurance Program (MCHIP) members in which claims for emergency services were paid at an enhanced rate instead of 50% Federal Medical Assistance Percentage (FMAP).

Reason for Change:
The change, from the prior estimate, for FY 2024-25 is a net increase is due to recoupments that were planned for FY 2023-24 will be rolled into FY 2024-25.

The change, in the current estimate, from FY 2024-25 to FY 2025-26 is due to recoupments from FY 2023-24 are being rolled into FY 2024-25 resulting in a larger recoupment for FY 2024-25 compared to FY 2025-26.

Methodology:
1. Assume recoupments for both psychiatric inpatient claims and Medi-Cal members with UIS will occur over three state fiscal years beginning FY 2024-25. The first recoupments will begin in the third quarter of FY 2024-25.

2. The psychiatric inpatient claim recoupments total $190,277,000. The total recoupments are estimated to be $95,139,000 in FY 2024-25 and $47,568,000 in FY 2025-26.

3. The recoupment for claims related to Medi-Cal members with UIS is $66,361,000. The total recoupments are estimated to be $33,180,000 in FY 2024-25 and $16,592,000 in FY 2025-26.

4. The Department will recoup funds over a three-year period.

COUNTY BH RECOUPMENTS

REGULAR POLICY CHANGE NUMBER: 199

(Dollars in Thousands)

Estimated Recoupment Schedule	Total	Psychiatric Inpatient	Specialty Mental Health UIS	Drug Medi-Cal UIS
FY 2024-25 – Q3	$64,159	$47,569	$16,036	$554
FY 2024-25 – Q4	$64,160	$47,570	$16,036	$554
Subtotal for FY 2024-25	$128,319	$95,139	$32,072	$1,108
FY 2025-26 – Q1	$16,040	$11,892	$4,009	$139
FY 2025-26 – Q2	$16,040	$11,892	$4,009	$139
FY 2025-26 – Q3	$16,040	$11,892	$4,009	$139
FY 2025-26 – Q4	$16,040	$11,892	$4,009	$139
Subtotal for FY 2025-26	$64,160	$47,568	$16,036	$556
Total	$192,480	$142,709	$48,107	$1,664

(Dollars in Thousands)

BH Recoupments	TF	GF
FY 2024-25	**($128,319)**	**($128,319)**
FY 2025-26	**($64,160)**	**($64,160)**

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

SB 525 MINIMUM WAGE - CASELOAD IMPACT

REGULAR POLICY CHANGE NUMBER: 201
IMPLEMENTATION DATE: 10/2024
ANALYST: Ryan Woolsey
FISCAL REFERENCE NUMBER: 2500

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	-$79,031,000	-$188,536,000
- STATE FUNDS	-$31,612,300	-$75,414,400
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$79,031,000	-$188,536,000
STATE FUNDS	-$31,612,300	-$75,414,400
FEDERAL FUNDS	-$47,418,700	-$113,121,600

Purpose:
This policy change estimates the impact of members leaving Medi-Cal due to increased wages pursuant to the provisions of Senate Bill (SB) 525.

Authority:
SB 525 (Chapter 890, Statues of 2023)
SB 159 (Chapter 40, Statutes of 2024)

Interdependent Policy Changes:
Not Applicable

Background:
SB 525, as amended by SB 159, increases the minimum wage for certain health care workers, beginning October 15, 2024. Wages for affected workers are scheduled to progressively increase to $25 per hour by July 1, 2027.

Eligibility to enroll in Medi-Cal depends, in part, on household income. Some workers impacted by SB 525 are enrolled in Medi-Cal and some of these workers are expected, as a result of SB 525 implementation, to have increased income that makes them no longer eligible to be enrolled in Medi-Cal. Medi-Cal spending is expected to decrease as a result of these members no longer utilizing Medi-Cal services.

Reason for Change:
This is a new policy change.

Methodology:
1. The number of Medi-Cal members that will leave Medi-Cal as SB 525 is implemented is uncertain. This estimate assumes that 98,847 individuals will ultimately leave Medi-Cal due SB 525 implementation.

SB 525 MINIMUM WAGE - CASELOAD IMPACT

REGULAR POLICY CHANGE NUMBER: 201

2. As SB 525 implementation is rolling out, assume that a monthly average of 40,000 individuals leave Medi-Cal during FY 2024-25, growing to 53,800 individuals leaving Medi-Cal in 2025-26.

3. Assume an average cost per member per month of $329 in 2024-25 and $349 in 2025-26.

4. Assume that on a cash basis, half of the FY 2024-25 impacts are delayed in FY 2025-26 and half of the 2025-26 impacts are delayed to 2026-27 due to lags in enrollment processing and payment timing.

5. The estimated impact of SB 525 related to reduced caseload is:

	TF	GF	FF
FY 2024-25	-$79,031,000	-$31,613,000	-$47,418,000
FY 2025-26	-$188,536,000	-$75,414,000	-$113,122,000

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX / 10% GF (4260-101-0001/0890)

HCBS SP - HOUSING AND HOMELESSNESS INCENTIVE PROG

REGULAR POLICY CHANGE NUMBER: 202
IMPLEMENTATION DATE: 7/2024
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 2325

	FY 2024-25	FY 2025-26
FULL YEAR COST - TOTAL FUNDS	$1,838,000	$0
- STATE FUNDS	$849,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,838,000	$0
STATE FUNDS	$849,000	$0
FEDERAL FUNDS	$989,000	$0

Purpose:
This policy change estimates payments to Medi-Cal managed care plans (MCP) made through the Housing and Homelessness Incentive Program (HHIP) using enhanced federal funding under Section 9817 of the American Rescue Plan Act (ARPA) of 2021. The estimated payments are intended to incentivize investments and progress in addressing homelessness and keeping people housed within the Medi-Cal Managed Care program.

Authority:
American Rescue Plan Act (2021)
Section 11.95, Budget Act of 2021
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
American Rescue Plan Increased FMAP for HCBS

Background:
The ARPA of 2021 provides additional Coronavirus Disease 2019 (COVID-19) relief to states. Section 9817 of the ARPA provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS). Increased FMAP is available from April 1, 2021, through March 31, 2025. States must use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021, and states must use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. State funds equivalent to the amount of federal funds attributable to the increased FMAP are deposited in the Home and Community-Based Services American Rescue Plan Fund pursuant to Section 11.95 of the Budget Act of 2021. Section 11.95 appropriates this funding to eligible HCBS activities identified in the HCBS Spending Plan.

HCBS SP - HOUSING AND HOMELESSNESS INCENTIVE PROG

REGULAR POLICY CHANGE NUMBER: 202

The HHIP allows MCPs to earn incentive funds, up to $1.288 billion TF over the duration of the program, for achieving progress in addressing homelessness and keeping people housed and developing the necessary capacity and partnerships to connect their members to needed housing service. The MCPs submitted plans to the Department that map the continuum of services with a focus on homelessness prevention, interim housing (particularly for the aging and/or disabled population), rapid re-housing (families and youth), and permanent supportive housing. Funds are made available based on point in time counts of homeless individuals and other factors determined by the Department. MCPs must meet specified metrics to earn available funds.

As a result of the COVID-19 national public health emergency, increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase due to an additional payment of $1.8 million TF pertaining to a recalculation of the submission-two measures for one MCP. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due to the final payment occurring in FY 2024-25.

Methodology:
1. Phase I of HHIP (Planning phase) began effective January 1, 2022. Plans were able to earn incentive payments for completion of Local Homelessness Plans (LHP) and Investment Plans for their respective counties, which were subject to review and acceptance by the Department.
2. In Phase II of HHIP (Outcome/Performance phase), plans may earn incentive payments based on achievement of specified metrics and measures.
3. Incentive payments began in October 2022.
4. The Title XIX FFCRA increased FMAP is assumed for expenditures through October 31, 2023, for this policy change.
5. The last payment for this program is expected to be paid out in FY 2024-25.
6. The costs for this PC on a cash basis for FY 2024-25 are expected to be:

FY 2024-25	TF	SF	FF	FFCRA
50% Title XIX FF (4260-101-0890)	$919,000	$0	$919,000	$0
HCBS ARP Fund	$919,000	$919,000	$0	$0
COVID-19 Title XIX Increased FMAP	$0	($70,000)	$0	$70,000
Total FY 2024-25	**$1,838,000**	**$849,000**	**$989,000**	**$70,000**

Funding:
100% Title XIX FF (4260-101-0890)
Home and Community-Based Services American Rescue Plan Fund (4260-101-8507)
COVID-19 Title XIX Increased FFP (4260-101-0890)

PROP 35 - PROVIDER PAYMENT INCREASE FUNDING

REGULAR POLICY CHANGE NUMBER: 203
IMPLEMENTATION DATE: 1/2025
ANALYST: Erik Stacey
FISCAL REFERENCE NUMBER: 2509

	FY 2024-25	FY 2025-26
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

Purpose:
This policy change estimates the funding to be spent from the Health Care Oversight & Accountability Subfund (Fund 3443) for provider payment increases.

Authority:
Protect Access to Health Care Act of 2024 (Proposition 35)

Interdependent Policy Changes:
Medi-Cal Provider Payment Increase
Medi-Cal Provider Payment Increases 2025 & Later

Background:
In November 2024, voters approved the Protect Access to Health Care Act of 2024 (Proposition 35), which makes the managed care organization (MCO) tax permanent, subject to continued federal approval for future tax periods, and specifies how revenues from the current period tax as it existed on July 1, 2023, are to be allocated, beginning with taxes collected in calendar year 2025. Proposition 35 allocates revenues to cover the non-federal share of costs for increased capitation costs to Medi-Cal managed care plans that pay the tax, increases payments to Medi-Cal providers, and supports existing Medi-Cal costs. Proposition 35 creates additional funds into which specified MCO tax revenues are deposited, appropriated, and spent.

The Health Care Oversight & Accountability (HCO&A) Subfund receives revenues from the MCO Tax to be used to support provider payments. For display purposes in the Medi-Cal Estimate, the cost of provider payment increases is budgeted in the Medi-Cal Provider Payment Increase and Medi-Cal Provider Payment Increases 2025 & Later policy changes using General Fund as non-federal share. This policy change replaces General Fund budgeted for provider payment increases with HCO&A Subfund, so that the non-federal share of costs for the increases is ultimately covered by the HCO&A Subfund. The HCO&A Subfund is also used to support the non-federal share of increased capitation payments to managed care plans (in the 2023 MCO Enrollment Tax Mgd. Care Plans-Funding Adj. policy change) and to pay for existing Medi-Cal costs (in the 2023 MCO Enrollment Tax Managed Care Plans policy change).

PROP 35 - PROVIDER PAYMENT INCREASE FUNDING
REGULAR POLICY CHANGE NUMBER: 203

Reason for Change:
This is a new policy change.

Methodology:
1. Pursuant to Proposition 35, the HCO&A Subfund is assumed to support the non-federal share of increasing provider rates for Primary Care, non-specialty mental health services, and Obstetric Care services, including mid-level practitioners and doula services, to at least 87.5% of Medicare rates effective for dates of service beginning on January 1, 2024. These costs are budgeted in the Medi-Cal Provider Payment Increase and Medi-Cal Provider Payment Increase policy change using General Fund as the non-federal share. This policy change replaces General Fund spending on these rate increases with spending from the Health Care Oversight & Accountability Subfund for services after January 1, 2025.

2. The HCO&A Subfund is also assumed to support the non-federal share of additional increases to provider rates to take effect January 1, 2025, subject to consultation with the Protect Access to Health Care Act Stakeholder Advisory Committee, as specified in Proposition 35. These costs are budgeted in the Medi-Cal Provider Payment Increases 2025 & Later policy change using General Fund as the non-federal share. This policy change replaces General Fund spending on these rate increases with spending from the HCO&A Subfund.

3. Allocations from the HCO&A Subfund in FY 2024-25 are summarized below:

(Dollars in Thousands)

FY 2024-25	TF	GF	SF
Medi-Cal Provider Payment Increase	$0	-$124,551	$124,551
Medi-Cal Provider Payment Increases 2025 & Later	$0	-$61,592	$61,592
Total	**$0**	**-$186,143**	**$186,143**

4. Allocations from the HCO&A Subfund in FY 2025-26 are summarized below:

(Dollars in Thousands)

FY 2025-26	TF	GF	SF
Medi-Cal Provider Payment Increase	$0	-$291,000	$291,000
Medi-Cal Provider Payment Increases 2025 & Later	$0	-$2,967,153	$2,967,153
Total	**$0**	**-$3,258,153**	**$3,258,153**

Funding:
Health Care Oversight & Accountability Subfund (4260-601-3443)
100% General Fund (4260-101-0001)

L.A. CARE SANCTIONS LEGAL AID GRANTS

REGULAR POLICY CHANGE NUMBER: 204
IMPLEMENTATION DATE: 2/2025
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2510

	FY 2024-25	FY 2025-26
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

Purpose:
This policy change estimates the monetary sanctions amount that the Department received from L.A. Care Health Plan (L.A. Care), to be available for the Department to award grants to qualifying, non-profit legal aid programs and organizations.

Authority:
Welfare & Institutions Code Section 14197.7
AB 157 (Chapter 994, Statutes of 2024)

Interdependent Policy Changes:
Not Applicable

Background:
Welfare & Institutions Code Section 14197.7 provides for the Department to impose sanctions on Medi-Cal managed care plans (MCPs) for failure to comply with contract requirements, state or federal law or regulations, or the state plan or approved waivers. Section 14197.7(q)(1) provides that the nonfederal share of any monetary penalty collected by the Department from MCPs shall be deposited into the General Fund to, upon appropriation by the Legislature, address workforce issues in the Medi-Cal program and to improve access to care in the Medi-Cal program, notwithstanding any other law.

On March 4, 2022, the Department issued a notice of intent to impose monetary sanctions in the amount of $20,000,000 to L.A. Care for failure to comply with its legal and contractual obligations. The Department and L.A. Care entered into a settlement agreement whereby L.A. Care agreed, among other items, to pay the Department a monetary sanction of $13,500,000. The final monetary penalty amount of $13,500,000 was paid to the Department on October 28, 2024.

The Budget Act of 2024 (AB 157) requires the nonfederal share of sanctions collected in 2024-25 to be deposited into the General Fund, and subsequently expended by June 30, 2026, for the Department to award grants to qualifying, non-profit legal aid programs and organizations that serve Medi-Cal managed care members, thereby superseding the

L.A. CARE SANCTIONS LEGAL AID GRANTS
REGULAR POLICY CHANGE NUMBER: 204

provisions of Section 14197.7(q). The sanctions collected from L.A. Care Health Plan will be awarded as grants to organizations supporting Medi-Cal managed care members in the County of Los Angeles or other impacted counties, as necessary.

Reason for Change:
This is a new policy change.

Methodology:
1. $6,750,000 in non-federal share of sanctions has been collected from L.A. Care Health Plan, to be awarded as grants to qualifying non-profit legal aid programs and organizations.

(Dollars in Thousands)

FY 2024-25	GF
Sanction collection	-$6,750,000
Grants expenditures	$6,750,000

Funding:
100% General Fund (4260-101-0001)

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COUNTY ADMINISTRATION

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

November 2024 Medi-Cal Estimate

COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION FUNDING SUMMARY

Amounts in the County Administration and Other Administration sections of the Medi-Cal Local Assistance Estimate are combined in the Management Summary and the annual Budget Act as "County and Other Local Assistance Administration." The displays below summarize County and Other Local Assistance Administration, including amounts from County Administration and Other Administration policy changes.

FY 2024-2025 Estimate:	Total Funds	Federal Funds	General Funds	Other State Funds
County Administration	$2,779,516,000	$2,070,340,000	$709,176,000	$0
Other Administration	$4,830,020,000	$4,031,540,000	$742,833,000	$55,647,000
Total	**$7,609,536,000**	**$6,101,880,000**	**$1,452,009,000**	**$55,647,000**

FY 2025-2026 Estimate:	Total Funds	Federal Funds	General Funds	Other State Funds
County Administration	$2,792,706,000	$2,069,802,000	$722,905,000	$0
Other Administration	$4,884,759,000	$3,867,414,000	$754,839,000	$262,506,000
Total	**$7,677,465,000**	**$5,937,216,000**	**$1,477,744,000**	**$262,506,000**

SUMMARY OF COUNTY ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2024-25

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER				
1	COUNTY ADMINISTRATION ALLOCATION	$2,377,805,000	$1,188,902,500	$1,188,902,500	$0
2	SAWS	$208,824,000	$208,466,000	$358,000	$0
3	CALWORKS APPLICATIONS	$95,906,000	$47,953,000	$47,953,000	$0
4	CASE MANAGEMENT FOR OTLICP	$42,215,000	$21,107,500	$21,107,500	$0
5	LOS ANGELES COUNTY HOSPITAL INTAKES	$37,336,000	$35,538,500	$1,797,500	$0
6	COVID-19 FUNDING FOR COUNTY REDETERMINATIONS	$17,430,000	$8,715,000	$8,715,000	$0
7	ENHANCED FEDERAL FUNDING	$0	$555,657,250	($555,657,250)	$0
8	SAVE	$0	$4,000,000	($4,000,000)	$0
	OTHER SUBTOTAL	**$2,779,516,000**	**$2,070,339,750**	**$709,176,250**	**$0**
	GRAND TOTAL	**$2,779,516,000**	**$2,070,339,750**	**$709,176,250**	**$0**

MEDI-CAL COUNTY ADMINISTRATION
POLICY CHANGE COST BREAKDOWN
FISCAL YEAR 2024-25

NO.	POLICY CHANGE TITLE	ONE-TIME CHANGES		ON-GOING CHANGES		TOTAL POLICY CHANGES	GENERAL FUNDS
		PROCEDURAL	CASELOAD	PROCEDURAL	CASELOAD		
	OTHER						
1	COUNTY ADMINISTRATION ALLOCATION	$0	$0	$2,377,805,000	$0	$2,377,805,000	$1,188,902,500
2	SAWS	$208,824,000	$0	$0	$0	$208,824,000	$358,000
3	CALWORKS APPLICATIONS	$0	$0	$95,906,000	$0	$95,906,000	$47,953,000
4	CASE MANAGEMENT FOR OTLICP	$0	$0	$0	$42,215,000	$42,215,000	$21,107,500
5	LOS ANGELES COUNTY HOSPITAL INTAKES	$0	$0	$0	$37,336,000	$37,336,000	$1,797,500
6	COVID-19 FUNDING FOR COUNTY REDETERMINATIONS	$17,430,000	$0	$0	$0	$17,430,000	$8,715,000
7	ENHANCED FEDERAL FUNDING	$0	$0	$0	$0	$0	($555,657,250)
8	SAVE	$0	$0	$0	$0	$0	($4,000,000)
	OTHER SUBTOTAL	**$226,254,000**	**$0**	**$2,473,711,000**	**$79,551,000**	**$2,779,516,000**	**$709,176,250**
	GRAND TOTAL	**$226,254,000**	**$0**	**$2,473,711,000**	**$79,551,000**	**$2,779,516,000**	**$709,176,250**

SUMMARY OF COUNTY ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2025-26

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER				
1	COUNTY ADMINISTRATION ALLOCATION	$2,377,805,000	$1,188,902,500	$1,188,902,500	$0
2	SAWS	$238,596,000	$238,596,000	$0	$0
3	CALWORKS APPLICATIONS	$95,906,000	$47,953,000	$47,953,000	$0
4	CASE MANAGEMENT FOR OTLICP	$43,063,000	$21,531,500	$21,531,500	$0
5	LOS ANGELES COUNTY HOSPITAL INTAKES	$37,336,000	$35,538,500	$1,797,500	$0
7	ENHANCED FEDERAL FUNDING	$0	$533,280,000	($533,280,000)	$0
8	SAVE	$0	$4,000,000	($4,000,000)	$0
	OTHER SUBTOTAL	**$2,792,706,000**	**$2,069,801,500**	**$722,904,500**	**$0**
	GRAND TOTAL	**$2,792,706,000**	**$2,069,801,500**	**$722,904,500**	**$0**

MEDI-CAL COUNTY ADMINISTRATION
POLICY CHANGE COST BREAKDOWN
FISCAL YEAR 2025-26

NO.	POLICY CHANGE TITLE	ONE-TIME CHANGES		ON-GOING CHANGES		TOTAL POLICY CHANGES	GENERAL FUNDS
		PROCEDURAL	CASELOAD	PROCEDURAL	CASELOAD		
	OTHER						
1	COUNTY ADMINISTRATION ALLOCATION	$0	$0	$2,377,805,000	$0	$2,377,805,000	$1,188,902,500
2	SAWS	$238,596,000	$0	$0	$0	$238,596,000	$0
3	CALWORKS APPLICATIONS	$0	$0	$95,906,000	$0	$95,906,000	$47,953,000
4	CASE MANAGEMENT FOR OTLICP	$0	$0	$0	$43,063,000	$43,063,000	$21,531,500
5	LOS ANGELES COUNTY HOSPITAL INTAKES	$0	$0	$0	$37,336,000	$37,336,000	$1,797,500
7	ENHANCED FEDERAL FUNDING	$0	$0	$0	$0	$0	($533,280,000)
8	SAVE	$0	$0	$0	$0	$0	($4,000,000)
	OTHER SUBTOTAL	**$238,596,000**	**$0**	**$2,473,711,000**	**$80,399,000**	**$2,792,706,000**	**$722,904,500**
	GRAND TOTAL	**$238,596,000**	**$0**	**$2,473,711,000**	**$80,399,000**	**$2,792,706,000**	**$722,904,500**

COMPARISON OF FISCAL IMPACTS OF COUNTY ADMINISTRATION POLICY CHANGES
NOVEMBER 2024 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2024-25

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2024-25 APPROPRIATION		NOV. 2024 EST. FOR 2024-25		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER						
1	1	COUNTY ADMINISTRATION ALLOCATION	$2,418,615,000	$1,209,307,500	$2,377,805,000	$1,188,902,500	($40,810,000)	($20,405,000)
2	2	SAWS	$189,099,000	$0	$208,824,000	$358,000	$19,725,000	$358,000
4	3	CALWORKS APPLICATIONS	$96,775,000	$48,387,500	$95,906,000	$47,953,000	($869,000)	($434,500)
5	4	CASE MANAGEMENT FOR OTLICP	$42,215,000	$21,107,500	$42,215,000	$21,107,500	$0	$0
6	5	LOS ANGELES COUNTY HOSPITAL INTAKES	$38,261,000	$2,583,500	$37,336,000	$1,797,500	($925,000)	($786,000)
--	6	COVID-19 FUNDING FOR COUNTY REDETERMINATIONS	$0	$0	$17,430,000	$8,715,000	$17,430,000	$8,715,000
7	7	ENHANCED FEDERAL FUNDING	$0	($502,884,750)	$0	($555,657,250)	$0	($52,772,500)
8	8	SAVE	$0	($4,000,000)	$0	($4,000,000)	$0	$0
9	--	FREEZE MEDI-CAL COUNTY ADMINISTRATION INCREASE	($20,405,000)	($20,405,000)	$0	$0	$20,405,000	$20,405,000
		OTHER SUBTOTAL	**$2,764,560,000**	**$754,096,250**	**$2,779,516,000**	**$709,176,250**	**$14,956,000**	**($44,920,000)**
		COUNTY ADMINISTRATION GRAND TOTAL	**$2,764,560,000**	**$754,096,250**	**$2,779,516,000**	**$709,176,250**	**$14,956,000**	**($44,920,000)**

COMPARISON OF FISCAL IMPACTS OF COUNTY ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2024-25 AND 2025-26

NO.	POLICY CHANGE TITLE	NOV. 2024 EST. FOR 2024-25		NOV. 2024 EST. FOR 2025-26		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER						
1	COUNTY ADMINISTRATION ALLOCATION	$2,377,805,000	$1,188,902,500	$2,377,805,000	$1,188,902,500	$0	$0
2	SAWS	$208,824,000	$358,000	$238,596,000	$0	$29,772,000	($358,000)
3	CALWORKS APPLICATIONS	$95,906,000	$47,953,000	$95,906,000	$47,953,000	$0	$0
4	CASE MANAGEMENT FOR OTLICP	$42,215,000	$21,107,500	$43,063,000	$21,531,500	$848,000	$424,000
5	LOS ANGELES COUNTY HOSPITAL INTAKES	$37,336,000	$1,797,500	$37,336,000	$1,797,500	$0	$0
6	COVID-19 FUNDING FOR COUNTY REDETERMINATIONS	$17,430,000	$8,715,000	$0	$0	($17,430,000)	($8,715,000)
7	ENHANCED FEDERAL FUNDING	$0	($555,657,250)	$0	($533,280,000)	$0	$22,377,250
8	SAVE	$0	($4,000,000)	$0	($4,000,000)	$0	$0
	OTHER SUBTOTAL	**$2,779,516,000**	**$709,176,250**	**$2,792,706,000**	**$722,904,500**	**$13,190,000**	**$13,728,250**
	COUNTY ADMINISTRATION GRAND TOTAL	**$2,779,516,000**	**$709,176,250**	**$2,792,706,000**	**$722,904,500**	**$13,190,000**	**$13,728,250**

MEDI-CAL COUNTY ADMINISTRATION
POLICY CHANGE INDEX

COUNTY ADMINISTRATION ALLOCATION

COUNTY ADMIN. POLICY CHANGE NUMBER: 1
IMPLEMENTATION DATE: 7/2012
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 1704

	FY 2024-25		FY 2025-26	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$2,377,805,000	$0	$2,377,805,000
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$2,377,805,000	$0	$2,377,805,000
STATE FUNDS	$0	$1,188,902,500	$0	$1,188,902,500
% 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	$2,377,805,000	$0	$2,377,805,000
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$2,377,805,000	$0	$2,377,805,000
STATE FUNDS	$0	$1,188,902,500	$0	$1,188,902,500

Purpose:
This policy change reflects the allocation funded to counties for costs associated with Medi-Cal eligibility determination activities.

Authority:
Welfare & Institutions Code 14154
SB 159 (Chapter 40, statutes of 2024)

Interdependent Policy Changes:
Not Applicable

Background:
The Department is responsible for determining the appropriate allocation for funding county welfare department costs associated with Medi-Cal eligibility determinations. The Department establishes and maintains a cost control plan. The plan provides for the administrative costs that the counties incur for Medi-Cal eligibility determination activities. This estimate reflects the allocation to the counties utilizing recent workload data, county expenditure data, and other county-submitted information.

COUNTY ADMINISTRATION ALLOCATION
COUNTY ADMIN. POLICY CHANGE NUMBER: 1

In FY 2018-19, the Department began including funding to implement the Affordable Care Act in this policy change. The Department uses the projected California Consumer Price index (CPI) change to adjust the total dollars available and applies similar adjustments as the county eligibility systems move to a single Statewide Automated Welfare System. With this increase, counties work to place members into the correct aid codes based on changes in circumstances, increase the percentage of completed and accurate eligibility determinations and annual redeterminations, and provide timely eligibility and enrollment data and reports to the Department.

In FY 2024-25, the Department implemented a freeze on California CPI increase adjustments for the allocation funded to the counties for costs associated with Medi-Cal eligibility determination activities. Costs associated with the California CPI freeze for county allocations were previously budgeted in the Freeze Medi-Cal County Administration Increase policy change. Those costs are now budgeted in the County Administration Allocation policy change.

Reason for Change:
The change from the prior estimate for FY 2024-25 is a decrease due to shifting funds from the Freeze Medi-Cal County Administration Increase policy change into this policy change for payment. A freeze on California CPI increase adjustments for county allocations was incorporated because of this funding shift. This caused the FY 2024-25 total allocation to decrease by 1.69% for the projected California CPI, resulting in a $41 million dollar change.

There is no change from FY 2024-25 to FY 2025-26 in the current estimate.

Methodology:
1. The total rounded estimated FY 2024-25 and FY 2025-26 county administration costs are:

(Dollars in Thousands)

Total Allocation	TF	GF	FF
FY 2024-25	$2,377,805	$1,188,903	$1,188,903
FY 2025-26	$2,377,805	$1,188,903	$1,188,903

* Totals may differ due to rounding.

Funding:
50% Title XIX FF / 50% GF (4260-101-0890/0001)
Medicaid Management Information Systems Enhanced Funding identified in the Enhanced Federal Funding policy change

SAWS

COUNTY ADMIN. POLICY CHANGE NUMBER: 2
IMPLEMENTATION DATE: 7/1987
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 214

	FY 2024-25		FY 2025-26	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$208,824,000	$0	$238,596,000	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$208,824,000	$0	$238,596,000	$0
STATE FUNDS	$358,000	$0	$0	$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	$208,824,000	$0	$238,596,000	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$208,824,000	$0	$238,596,000	$0
STATE FUNDS	$358,000	$0	$0	$0

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.

Authority:
Welfare & Institutions Code 14154
Interagency Agreement # 04-35639
Interagency Agreement CalHEERS # 14-90510
Affordable Care Act (ACA)
SIRFRA 1099

Interdependent Policy Changes:
Not Applicable

Background:
The Statewide Automated Welfare Systems (SAWS) consists of one county consortium system: California Statewide Automated Welfare System (CalSAWS). SAWS project management is now the responsibility of the Office of Technology and Solutions Integration (OTSI) within the Health and Human Services Agency. The Department provides expertise to OTSI on program and technical system requirements for the Medi-Cal program and the Medi-Cal Eligibility Data System interfaces.

CalSAWS is the automated system used in all 58 Counties. The CalWIN was decommissioned after its final member counties migrated to CalSAWS in October 2023.

SAWS
COUNTY ADMIN. POLICY CHANGE NUMBER: 2

The Appeals Case Management System cost was removed from this policy change and is now located in the Department of Social Services Administrative Cost, Other Administration policy change.

Reason for Change:
There is a Total Fund (TF) increase for FY 2024-25, from the prior estimate, due to updated expenditure data provided by CDSS. There is a General Fund (GF) decrease from the prior estimate for FY 2024-25 due to some projects ending.

There is a TF increase and a GF decrease from FY 2024-25 to FY 2025-26, in the current estimate, due to new project costs.

Methodology:
1. The following estimate was provided by CDSS on a cash basis:

Line Item	FY 2024-25	FY 2025-26
AB 1163 LGBT Disparities Reduction Act	$1,286,000	$0
Alternate Formats	$20,202,000	$71,077,000
Automated Renewal for Income Sources	$859,000	$0
CalSAWS Project	$160,672,000	$164,006,000
Changes to 90 Day Cure	$232,000	$0
Child Health and Disability Prevention Program	$1,432,000	$0
Cost of Annual Redetermination Forms	$3,142,000	$0
Incarceration Automated Reporting to Counties	$2,787,000	$0
Medi-Cal Renewal Packet Printing	$935,000	$935,000
Medi-Cal Text Messaging Campaign	$4,310,000	$0
PHE Additional Contact Attempt	$1,211,000	$0
Post-Eligibility Treatment of Income	$429,000	$0
Resume Pre-Pandemic Medi-Cal Operations	$480,000	$0
SB 242 HOPE Trust Accounts	$58,000	$0
SB 311 Medicare Part A Buy-In	$682,000	$0
SB 1341 Medi-Cal/SAWS	$4,160,000	$0
Shared Application Forms Revisions	$1,441,000	$0
Statewide Project Management	$4,505,000	$2,578,000
Total	**$208,824,000**	**$238,596,000**

*Totals may differ due to rounding.

2. There is a $358,000 GF expenditure in FY 2024-25 for the Child Health and Disability Prevention Program line item.

3. Assume an estimated cost of **$208,824,000 TF ($358,000 GF)** in **FY 2024-25** and **$238,596,000 TF** in **FY 2025-26**.

SAWS
COUNTY ADMIN. POLICY CHANGE NUMBER: 2

Funding:
100% Title XIX FF (4260-101-0890)
100% State GF (4260-101-0001)
Enhanced CA 75/25 (4260-101-0890/0001)

CALWORKS APPLICATIONS

COUNTY ADMIN. POLICY CHANGE NUMBER: 3
IMPLEMENTATION DATE: 7/1998
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 217

	FY 2024-25		FY 2025-26	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$95,906,000	$0	$95,906,000
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$95,906,000	$0	$95,906,000
STATE FUNDS	$0	$47,953,000	$0	$47,953,000
% 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	$95,906,000	$0	$95,906,000
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$95,906,000	$0	$95,906,000
STATE FUNDS	$0	$47,953,000	$0	$47,953,000

Purpose:
This policy change estimates the Medi-Cal portion of the shared costs for processing applications which are submitted through the CalWORKs and/or CalFresh programs. These costs include staff and support costs.

Authority:
Welfare & Institutions Code 14154

Interdependent Policy Changes:
Not Applicable

Background:
Since 1998, the Department has shared in the costs for CalWORKs applications with the California Department of Social Services (CDSS). CDSS amended the claim forms and time study documents completed by the counties to allow CalWORKs application costs that are also necessary for Medi-Cal and CalFresh eligibility, to be shared between the three programs.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is a slight decrease due to the most recent quarters of available data provided by CDSS. There is no change from FY 2024-25 to FY 2025-26 in the current estimate.

CALWORKS APPLICATIONS
COUNTY ADMIN. POLICY CHANGE NUMBER: 3

Methodology:
1. The estimated costs for FY 2024-25 and FY 2025-26 are provided on a cash basis by CDSS:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2024-25	$95,906	$47,953	$47,953
FY 2025-26	$95,906	$47,953	$47,953

*Totals may differ due to rounding.

Funding:
50% Title XIX FF / 50% GF (4260-101-0890/0001)
Medicaid Management Information Systems Enhanced Funding identified in the Enhanced Federal Funding policy change.

CASE MANAGEMENT FOR OTLICP

COUNTY ADMIN. POLICY CHANGE NUMBER: 4
IMPLEMENTATION DATE: 12/2012
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 1598

	FY 2024-25		FY 2025-26	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$42,215,000	$0	$43,063,000
TOTAL FUNDS	$0	$42,215,000	$0	$43,063,000
STATE FUNDS	$0	$21,107,500	$0	$21,531,500
% 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	$42,215,000	$0	$43,063,000
TOTAL FUNDS	$0	$42,215,000	$0	$43,063,000
STATE FUNDS	$0	$21,107,500	$0	$21,531,500

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) members.

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:
There is no change in FY 2024-25 from the prior estimate. The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to projecting growth for this population.

Methodology:
1. The Department currently estimates the case management and redetermination for the former OTLICP members at $4.00 Per Member Per Month.

CASE MANAGEMENT FOR OTLICP
COUNTY ADMIN. POLICY CHANGE NUMBER: 4

2. The estimated average monthly OTLICP members for FY 2024-25 are 879,477 and 897,138 for FY 2025-26.

3. The estimated costs are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2024-25	$42,215	$21,108	$21,108
FY 2025-26	$43,063	$21,532	$21,532

*Totals differ due to rounding.

Funding:
50% Title XIX / 50% GF (4260-101-0890/0001)
Medicaid Management Information Systems Enhanced Funding identified in the Enhanced Federal Funding policy change

LOS ANGELES COUNTY HOSPITAL INTAKES

COUNTY ADMIN. POLICY CHANGE NUMBER: 5
IMPLEMENTATION DATE: 7/1994
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 213

	FY 2024-25		FY 2025-26	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$37,336,000	$0	$37,336,000
TOTAL FUNDS	$0	$37,336,000	$0	$37,336,000
STATE FUNDS	$0	$1,797,500	$0	$1,797,500
% 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	$37,336,000	$0	$37,336,000
TOTAL FUNDS	$0	$37,336,000	$0	$37,336,000
STATE FUNDS	$0	$1,797,500	$0	$1,797,500

Purpose:
The policy change estimates the costs for Patient Financial Services Workers (PFSWs) to process Medi-Cal applications taken in Los Angeles County hospitals.

Authority:
Welfare & Institutions Code (W&I) 14154

Interdependent Policy Changes:
Not Applicable

Background:
Los Angeles County uses PFSWs to collect and process Medi-Cal applications taken in Los Angeles County hospitals. Los Angeles County hospitals send applications processed by the PFSWs to the Los Angeles County Human Services Agency for final eligibility determination. W&I Section 14154 limits the reimbursement amount for PFSW intakes to the amount paid to Los Angeles County Department of Social Services (DPSS) eligibility workers for regular Medi-Cal intakes. The Department passes through the federal share for any costs not covered by the DPSS rate to the county.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a decrease due to lower actual expenditure data for FY 2022-23 reconciliations. There is no change from FY 2024-25 to FY 2025-26 in the current estimate.

LOS ANGELES COUNTY HOSPITAL INTAKES

COUNTY ADMIN. POLICY CHANGE NUMBER: 5

Methodology:

1. The reimbursement rate is $268 for both current year and budget year. Assume in FY 2024-25 and FY 2025-26, PFSWs will continue processing a base caseload of 2,215 per month.

   FY 2024-25: 2,215 x $268 x 12 = $7,123,000 TF ($3,562,000 GF)
   FY 2025-26: 2,215 x $268 x 12 = $7,123,000 TF ($3,562,000 GF)

2. The Department completed the FY 2022-23 reconciliation in FY 2024-25. The FY 2022-23 reconciliation amounts are final, and the FY 2023-24 reconciliation amounts are placeholders.

(Dollars in Thousands)

Line Item	FY 2024-25			FY 2025-26		
	TF	GF	FF	TF	GF	FF
PFSW Base	$7,123	$3,562	$3,562	$7,123	$3,562	$3,562
2022-23 Recon.	$14,224	($1,764)	$15,988			
2022-23 Pass.	$15,988	$0	$15,988			
2023-24 Recon.				$14,224	($1,764)	$15,988
2023-24 Pass.				$15,988	$0	$15,988
Total	**$37,336**	**$1,797**	**$35,539**	**$37,336**	**$1,797**	**$35,539**

* Totals may differ due to rounding.

Funding:

(Dollars in Thousands)

FY 2024-25	Fund Number	TF	GF	FF
50% Title XIX FF/ 50% GF	4260-101-0890/0001	$7,123	$3,562	$3,562
100% Title XIX FF	4260-101-0890	$31,977	$0	$31,977
100% GF	4260-101-0001	($1,764)	($1,764)	$0
Total		**$37,336**	**$1,797**	**$35,539**

FY 2025-26	Fund Number	TF	GF	FF
50% Title XIX FF/ 50% GF	4260-101-0890/0001	$7,123	$3,562	$3,562
100% Title XIX FF	4260-101-0890	$31,977	$0	$31,977
100% GF	4260-101-0001	($1,764)	($1,764)	$0
Total		**$37,336**	**$1,797**	**$35,539**

* Totals may differ due to rounding.

COVID-19 FUNDING FOR COUNTY REDETERMINATIONS

COUNTY ADMIN. POLICY CHANGE NUMBER: 6
IMPLEMENTATION DATE: 7/2022
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 2282

	FY 2024-25		FY 2025-26	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$17,430,000	$0	$0	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$17,430,000	$0	$0	$0
STATE FUNDS	$8,715,000	$0	$0	$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	$17,430,000	$0	$0	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$17,430,000	$0	$0	$0
STATE FUNDS	$8,715,000	$0	$0	$0

Purpose:
This policy change estimates the one-time costs for counties resuming annual Medi-Cal redeterminations within 12 months at the end of the Coronavirus Disease 2019 (COVID-19) public health emergency (PHE).

Authority:
Families First Coronavirus Response Act (FFCRA)
Coronavirus Aid, Relief, and Economic Security (CARES) Act
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
On March 4, 2020, Governor Newsom declared a state of emergency in response to the developing pandemic of COVID-19. A statewide stay at home order was introduced on March 19, 2020. The federal government declared a national public health emergency on January 31, 2020, and a national emergency on March 13, 2020. These actions triggered the availability of Medicaid and Children's Health Insurance Program flexibilities, including under Section 1135 of the Social Security Act. Additionally, the President signed major federal legislation—including the FFCRA and the CARES Act—that provided increased federal funding in Medicaid and created new options for states to address the COVID-19 pandemic.

COVID-19 FUNDING FOR COUNTY REDETERMINATIONS

COUNTY ADMIN. POLICY CHANGE NUMBER: 6

The FFCRA included a "continuous coverage requirement." Under the continuous coverage requirement, states halted most disenrollment for Medicaid members. Those enrolled at the beginning of the enrollment period or those who would have enrolled during the emergency period could not be disenrolled until the end of the month the PHE ended if the Department was to receive a temporary increase in the federal medical assistance percentage (FMAP). When the Consolidated Appropriations Act of 2023, was passed on December 29, 2022, the caseload redeterminations were de-coupled from the FFCRA increased FMAP timeline. Counties started redetermination work effective April 1, 2023, based on a new March 31, 2023, unwinding date.

Reason for Change:
The change for FY 2024-25 from the prior estimate, is an increase due to the final county disbursements shifting from FY 2023-24 into FY 2024-25 for payment. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due to the final payment being disbursed in FY 2024-25.

Methodology:
1. Assume the PHE continued through May 11, 2023.

2. Assume all Medi-Cal redeterminations that were paused since the onset of the COVID-19 PHE were resumed and began processing per Department policies.

3. Assume the cost associated with processing the redeterminations caseload is:

(Dollars in Thousands)

Fiscal Years	TF	GF	FF
FY 2024-25	$17,430	$8,715	$8,715

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

ENHANCED FEDERAL FUNDING

COUNTY ADMIN. POLICY CHANGE NUMBER: 7
IMPLEMENTATION DATE: 7/2022
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 1835

	FY 2024-25		FY 2025-26	
	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	-$555,657,250	$0	-$533,280,000	$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	-$555,657,250	$0	-$533,280,000	$0

Purpose:
This policy change estimates the savings from enhanced federal funding for certain eligibility determination functions.

Authority:
Not Applicable

Interdependent Policy Changes:
County Administration Allocation
CalWORKs Applications
Case Management for OTLICP

Background:
Generally, payments to counties for making Medi-Cal eligibility determinations are budgeted at 50% federal funding. However, the Centers for Medicare & 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.

ENHANCED FEDERAL FUNDING
COUNTY ADMIN. POLICY CHANGE NUMBER: 7

There are various conditions required of a MMIS to secure the enhanced funding. There are also minimum critical success factors for accepting the new applications, making modified adjusted gross income determinations and coordination with Covered California. The Department submitted an Advanced Planning Document (APD) to secure CMS approval in January 2014, and received approval on September 29, 2014. The Department conducts an annual APD review and submits an update to CMS. CMS approved the APD for Federal Fiscal Year (FFY) 2024 on September 13, 2023.

Reason for Change:
The change from the prior estimate, FY 2024-25, is an increase in General Fund (GF) savings due to receiving more quarters of actual, audited, and updated claimed expenditure data from the California Department of Social Services (CDSS), which is used to identify and claim enhanced federal funding.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is a slight decrease in GF savings due to updated estimated claim funding projections that utilize the expenditure trends from two quarters in FY 2022-23 and two quarters in FY 2023-24.

Methodology:
1. The effective date for the Department's APD was July 24, 2023.

2. The Department receives reports from CDSS identifying actual expenditure costs eligible for enhanced funding.

3. The Department utilizes actual, audited, and claimed expenditure data provided by CDSS to identify and claim Enhanced FFP and to estimate FFP for future quarters.

4. In FY 2024-25, the Department will claim payments for FY 2023-24 Quarters 2 through 4 and FY 2024-25 Quarter 1. In FY 2025-26, the Department will claim payments for FY 2024-25 Quarters 2 through 4 and FY 2025-26 Quarter 1.

5. The savings are estimated to be:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
Title XIX at 50% FFP	($2,222,629)	($1,111,315)	($1,111,315)
Title XIX at 75% FFP	$2,222,629	$555,657	$1,666,972
Total	**$0**	**($555,657)**	**$555,657**

ENHANCED FEDERAL FUNDING
COUNTY ADMIN. POLICY CHANGE NUMBER: 7

FY 2025-26	TF	GF	FF
Title XIX at 50% FFP	($2,133,120)	($1,066,560)	($1,066,560)
Title XIX at 75% FFP	$2,133,120	$533,280	$1,599,840
Total	**$0**	**($533,280)**	**$533,280**

*Totals may differ due to rounding.

Funding:
50% Title XIX FF/ 50% GF (4260-101-0890/0001)
75% Title XIX FF/ 25% GF (4260-101-0890/0001)

SAVE

COUNTY ADMIN. POLICY CHANGE NUMBER: 8
IMPLEMENTATION DATE: 10/1988
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 215

	FY 2024-25		FY 2025-26	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$0	$0	$0
STATE FUNDS	-$4,000,000	$0	-$4,000,000	$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$0	$0	$0
STATE FUNDS	-$4,000,000	$0	-$4,000,000	$0

Purpose:
The policy change estimates the technical adjustment in funding from Title XIX 50% Federal Financial Participation (FFP) to Title XIX 100% FFP for the Systematic Alien Verification for Entitlements (SAVE) system.

Authority:
Welfare & Institutions Code 14154

Interdependent Policy Changes:
Not Applicable

Background:
The Immigration Reform and Control Act of 1986 required states to use the SAVE system to verify immigrant status for Medi-Cal applicants beginning in October 1988. The counties complete time studies for eligibility workers and supervisors based on time spent for SAVE verifications. Beginning May of 2018, counties are federally required to use the web-based SAVE system for the third step of the SAVE process.

Reason for Change:
There is no change from the prior estimate for FY 2024-25, or in the current estimate from FY 2024-25 to FY 2025-26.

Methodology:
1. A reconciliation is completed 18 months after the end of each fiscal year to adjust funding received by counties from 50% FFP to 100% FFP.

SAVE
COUNTY ADMIN. POLICY CHANGE NUMBER: 8

2. The Medi-Cal accrual costs for SAVE reported over the last three years by the counties were:

Fiscal Year	Actual	Fiscal Year	Estimated
FY 2020-21	$6,311,532	FY 2023-24	$8,000,000
FY 2021-22	$8,890,711	FY 2024-25	$8,000,000
FY 2022-23	$8,000,000	FY 2025-26	$8,000,000

3. Based on claims through June 2021, federal funds will be:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
50% Title XIX /50% GF 4260-101-0001/0890	($8,000)	($4,000)	($4,000)
100 % Title XIX FFP 4260-101-0890	$8,000	$0	$8,000
Net Impact	**$0**	**($4,000)**	**$4,000**

FY 2025-26	TF	GF	FF
50% Title XIX /50% GF 4260-101-0001/0890	($8,000)	($4,000)	($4,000)
100% Title XIX FFP 4260-101-0890	$8,000	$0	$8,000
Net Impact	**$0**	**($4,000)**	**$4,000**

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

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OTHER ADMINISTRATION

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

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2024-25

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	DHCS-OTHER				
1	CALAIM - PATH	$561,551,000	$307,537,000	$236,184,000	$17,830,000
2	INTERIM AND FINAL COST SETTLEMENTS-SMHS	$356,424,000	$356,424,000	$0	$0
3	COUNTY SPECIALTY MENTAL HEALTH ADMIN	$272,433,000	$263,346,000	$9,087,000	$0
4	CYBHI - BH SERVICES AND SUPPORTS PLATFORM	$254,120,000	$0	$254,120,000	$0
5	CCS CASE MANAGEMENT	$196,060,000	$126,502,850	$69,557,150	$0
6	MEDI-CAL RX - ADMINISTRATIVE COSTS	$172,650,000	$128,466,900	$44,183,100	$0
7	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	$114,671,000	$114,671,000	$0	$0
8	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	$110,049,000	$110,049,000	$0	$0
9	BH TRANSFORMATION FUNDING FOR COUNTY BH DEPTS.	$85,000,000	$35,000,000	$50,000,000	$0
10	COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE	$82,745,000	$49,744,000	$33,001,000	$0
11	CALAIM - POPULATION HEALTH MANAGEMENT	$77,831,000	$70,047,900	$7,783,100	$0
12	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	$63,066,000	$31,494,400	$31,571,600	$0
13	SMH MAA	$60,944,000	$60,944,000	$0	$0
14	DRUG MEDI-CAL COUNTY ADMINISTRATION	$57,794,000	$57,794,000	$0	$0
15	BHSF - PROVIDER ACES TRAININGS	$44,780,000	$22,390,000	$0	$22,390,000
16	ENTERPRISE DATA ENVIRONMENT	$39,250,000	$28,751,400	$10,498,600	$0
17	POSTAGE & PRINTING	$38,763,000	$19,253,000	$19,510,000	$0
18	ACTUARIAL COSTS FOR RATE DEVELOPMENT	$37,275,000	$18,637,500	$18,487,500	$150,000
19	MEDI-CAL RECOVERY CONTRACTS	$30,303,000	$22,727,250	$7,575,750	$0
20	HCBA WAIVER ADMINISTRATIVE COST	$21,612,000	$10,762,000	$10,850,000	$0
21	EMSA - CALIFORNIA POISON CONTROL SYSTEM SVCS.	$21,573,000	$21,573,000	$0	$0
22	CAPMAN	$20,100,000	$14,900,800	$5,199,200	$0
23	PAVE SYSTEM	$17,168,000	$12,464,000	$4,704,000	$0
24	MITA	$16,744,000	$14,617,600	$2,126,400	$0
25	CALAIM - JUSTICE INVOLVED MAA	$12,000,000	$6,000,000	$6,000,000	$0
26	HEALTH ENROLLMENT NAVIGATORS	$9,362,000	$4,681,000	$4,681,000	$0
27	PASRR	$8,891,000	$6,668,250	$2,222,750	$0
28	NEWBORN HEARING SCREENING PROGRAM	$6,128,000	$3,064,000	$3,064,000	$0
29	MEDCOMPASS SOLUTION	$5,288,000	$3,897,450	$1,390,550	$0

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2024-25

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	DHCS-OTHER				
30	ELECTRONIC ASSET VERIFICATION PROGRAM	$4,556,000	$2,278,000	$2,278,000	$0
31	PUBLIC HEALTH REGISTRIES SUPPORT	$4,441,000	$4,441,000	$0	$0
32	DRUG MEDI-CAL PARITY RULE ADMINISTRATION	$4,407,000	$2,938,000	$1,469,000	$0
33	PROTECTION OF PHI DATA	$4,148,000	$2,074,000	$2,074,000	$0
34	PACES	$3,618,000	$2,666,400	$951,600	$0
35	SDMC SYSTEM M&O SUPPORT	$3,574,000	$1,787,000	$1,787,000	$0
36	CALAIM - INMATE PRE-RELEASE PROGRAM ADMIN	$2,746,000	$1,373,000	$1,373,000	$0
37	STATEWIDE VERIFICATION HUB	$2,596,000	$2,336,400	$259,600	$0
38	MOBILE VISION SERVICES	$3,936,000	$2,558,000	$0	$1,378,000
39	HCBS SP - CONTINGENCY MANAGEMENT ADMIN	$2,410,000	$2,408,000	$0	$2,000
40	CALIFORNIA HEALTH INTERVIEW SURVEY	$2,142,000	$1,771,000	$371,000	$0
41	MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM	$2,000,000	$1,000,000	$1,000,000	$0
42	OUTREACH & ENROLLMENT ASSIST. FOR DUAL MEMBERS	$2,000,000	$1,000,000	$1,000,000	$0
43	T-MSIS	$1,913,000	$1,630,400	$282,600	$0
44	MFP/CCT SUPPLEMENTAL FUNDING	$1,773,000	$1,773,000	$0	$0
45	SSA COSTS FOR HEALTH COVERAGE INFO.	$1,480,000	$740,000	$740,000	$0
46	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$1,199,000	$783,750	$415,250	$0
47	FAMILY PACT PROGRAM ADMIN.	$1,006,000	$905,400	$100,600	$0
48	CALAIM - BH - CONNECT DEMONSTRATION ADMIN	$946,000	$774,000	$38,000	$134,000
49	MMA - DSH ANNUAL INDEPENDENT AUDIT	$769,000	$384,500	$384,500	$0
50	HEALTH INFORMATION EXCHANGE INTEROPERABILITY	$500,000	$450,000	$50,000	$0
51	CCT OUTREACH - ADMINISTRATIVE COSTS	$340,000	$340,000	$0	$0
52	HEALTH PLAN OF SAN MATEO DENTAL INTEGRATION EVAL	$162,000	$81,000	$0	$81,000
55	DESIGNATED STATE HEALTH PROGRAMS	$0	$323,213,000	($323,213,000)	$0
	DHCS-OTHER SUBTOTAL	**$2,847,237,000**	**$2,282,114,150**	**$523,157,850**	**$41,965,000**
	DHCS-MEDICAL FI				
56	MEDICAL FI BO & IT COST REIMBURSEMENT	$55,485,000	$40,068,150	$15,416,850	$0
57	MEDICAL FI BO & IT CHANGE ORDERS	$52,893,000	$38,990,550	$13,902,450	$0

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2024-25

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	DHCS-MEDICAL FI				
58	MEDICAL INFRASTRUCTURE & DATA MGT SVCS	$44,470,000	$32,781,100	$11,688,900	$0
59	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	$39,925,000	$29,430,000	$10,495,000	$0
60	MEDICAL FI BO OTHER ESTIMATED COSTS	$25,766,000	$18,027,500	$7,738,500	$0
61	MEDICAL FI BO TELEPHONE SERVICE CENTER	$18,805,000	$13,176,200	$5,628,800	$0
62	MEDICAL FI BUSINESS OPERATIONS	$17,141,000	$12,627,350	$4,502,650	$11,000
63	MEDICAL FI BO HOURLY REIMBURSEMENT	$12,397,000	$9,139,000	$3,258,000	$0
64	MEDICAL FI BO MISCELLANEOUS EXPENSES	$328,000	$242,350	$85,650	$0
	DHCS-MEDICAL FI SUBTOTAL	**$267,210,000**	**$194,482,200**	**$72,716,800**	**$11,000**
	DHCS-HEALTH CARE OPT				
65	HCO OPERATIONS 2017 CONTRACT	$44,591,000	$22,629,850	$21,961,150	$0
66	HCO COST REIMBURSEMENT 2017 CONTRACT	$36,903,000	$18,728,250	$18,174,750	$0
67	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	$15,210,000	$7,719,000	$7,491,000	$0
	DHCS-HEALTH CARE OPT SUBTOTAL	**$96,704,000**	**$49,077,100**	**$47,626,900**	**$0**
	DHCS-DENTAL FI				
68	DENTAL FI-DBO ADMIN 2022 CONTRACT	$90,286,000	$67,238,750	$23,047,250	$0
69	DENTAL ASO ADMINISTRATION 2016 CONTRACT	$29,430,000	$20,357,000	$9,073,000	$0
70	DENTAL FI ADMINISTRATION 2016 CONTRACT	$20,406,000	$15,215,000	$5,191,000	$0
	DHCS-DENTAL FI SUBTOTAL	**$140,122,000**	**$102,810,750**	**$37,311,250**	**$0**
	OTHER DEPARTMENTS				
71	PERSONAL CARE SERVICES	$514,725,000	$514,725,000	$0	$0
72	HEALTH-RELATED ACTIVITIES - CDSS	$434,236,000	$434,236,000	$0	$0
73	CALHEERS DEVELOPMENT	$192,225,000	$143,342,250	$48,882,750	$0
74	MATERNAL AND CHILD HEALTH	$70,496,000	$70,496,000	$0	$0
75	CDDS ADMINISTRATIVE COSTS	$93,199,000	$93,199,000	$0	$0
76	HCPCFC CASE MANAGEMENT	$54,682,000	$41,011,000	$0	$13,671,000
77	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$50,501,000	$50,501,000	$0	$0
78	HCPCFC ADMIN COSTS	$23,757,000	$11,878,500	$11,878,500	$0

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2024-25

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER DEPARTMENTS				
79	FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG	$9,657,000	$9,657,000	$0	$0
80	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$8,124,000	$8,124,000	$0	$0
81	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	$12,722,000	$12,722,000	$0	$0
82	CLPP CASE MANAGEMENT SERVICES	$4,936,000	$4,936,000	$0	$0
83	CALIFORNIA SMOKERS' HELPLINE	$2,954,000	$2,954,000	$0	$0
84	HCBS SP CDDS - OTHER ADMIN	$245,000	$245,000	$0	$0
85	CALHHS AGENCY HIPAA FUNDING	$1,376,000	$688,000	$688,000	$0
86	MEDI-CAL INPATIENT SERVICES FOR INMATES	$1,212,000	$1,212,000	$0	$0
87	VETERANS BENEFITS	$1,100,000	$1,100,000	$0	$0
88	VITAL RECORDS	$883,000	$879,000	$4,000	$0
89	KIT FOR NEW PARENTS	$583,000	$583,000	$0	$0
90	MERIT SYSTEM SERVICES FOR COUNTIES	$190,000	$95,000	$95,000	$0
91	PIA EYEWEAR COURIER SERVICE	$944,000	$472,000	$472,000	$0
	OTHER DEPARTMENTS SUBTOTAL	**$1,478,747,000**	**$1,403,055,750**	**$62,020,250**	**$13,671,000**
	GRAND TOTAL	**$4,830,020,000**	**$4,031,539,950**	**$742,833,050**	**$55,647,000**

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2025-26

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	DHCS-OTHER				
1	CALAIM - PATH	$475,992,000	$237,996,000	$194,122,000	$43,874,000
2	INTERIM AND FINAL COST SETTLEMENTS-SMHS	$180,367,000	$180,367,000	$0	$0
3	COUNTY SPECIALTY MENTAL HEALTH ADMIN	$286,048,000	$276,380,000	$9,668,000	$0
4	CYBHI - BH SERVICES AND SUPPORTS PLATFORM	$181,164,000	$0	$181,164,000	$0
5	CCS CASE MANAGEMENT	$195,882,000	$126,410,100	$69,471,900	$0
6	MEDI-CAL RX - ADMINISTRATIVE COSTS	$120,934,000	$89,930,150	$31,003,850	$0
7	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	$113,194,000	$113,194,000	$0	$0
8	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	$112,880,000	$112,880,000	$0	$0
9	BH TRANSFORMATION FUNDING FOR COUNTY BH DEPTS.	$93,508,000	$38,508,000	$55,000,000	$0
10	COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE	$21,062,000	$12,662,000	$8,400,000	$0
11	CALAIM - POPULATION HEALTH MANAGEMENT	$61,148,000	$55,033,200	$6,114,800	$0
12	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	$58,784,000	$29,385,400	$29,398,600	$0
13	SMH MAA	$53,425,000	$53,425,000	$0	$0
14	DRUG MEDI-CAL COUNTY ADMINISTRATION	$65,734,000	$65,734,000	$0	$0
15	BHSF - PROVIDER ACES TRAININGS	$5,415,000	$2,707,000	$0	$2,708,000
16	ENTERPRISE DATA ENVIRONMENT	$37,902,000	$27,922,300	$9,979,700	$0
17	POSTAGE & PRINTING	$38,763,000	$19,253,000	$19,510,000	$0
18	ACTUARIAL COSTS FOR RATE DEVELOPMENT	$41,000,000	$20,500,000	$20,350,000	$150,000
19	MEDI-CAL RECOVERY CONTRACTS	$32,745,000	$24,558,750	$8,186,250	$0
20	HCBA WAIVER ADMINISTRATIVE COST	$24,714,000	$12,307,000	$12,407,000	$0
21	EMSA - CALIFORNIA POISON CONTROL SYSTEM SVCS.	$17,961,000	$17,961,000	$0	$0
22	CAPMAN	$20,819,000	$15,492,550	$5,326,450	$0
23	PAVE SYSTEM	$17,958,000	$13,063,400	$4,894,600	$0
24	MITA	$34,051,000	$29,726,050	$4,324,950	$0
25	CALAIM - JUSTICE INVOLVED MAA	$68,000,000	$34,000,000	$34,000,000	$0
27	PASRR	$8,946,000	$6,709,500	$2,236,500	$0
28	NEWBORN HEARING SCREENING PROGRAM	$6,220,000	$3,110,000	$3,110,000	$0
29	MEDCOMPASS SOLUTION	$5,412,000	$3,989,250	$1,422,750	$0
30	ELECTRONIC ASSET VERIFICATION PROGRAM	$4,613,000	$2,306,500	$2,306,500	$0

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2025-26

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	DHCS-OTHER				
31	PUBLIC HEALTH REGISTRIES SUPPORT	$4,441,000	$4,441,000	$0	$0
32	DRUG MEDI-CAL PARITY RULE ADMINISTRATION	$5,875,000	$3,917,000	$1,958,000	$0
33	PROTECTION OF PHI DATA	$5,216,000	$2,608,000	$2,608,000	$0
34	PACES	$3,651,000	$2,690,950	$960,050	$0
35	SDMC SYSTEM M&O SUPPORT	$2,397,000	$1,198,500	$1,198,500	$0
36	CALAIM - INMATE PRE-RELEASE PROGRAM ADMIN	$2,746,000	$1,373,000	$1,373,000	$0
37	STATEWIDE VERIFICATION HUB	$1,018,000	$916,200	$101,800	$0
38	MOBILE VISION SERVICES	$7,872,000	$5,117,000	$0	$2,755,000
39	HCBS SP - CONTINGENCY MANAGEMENT ADMIN	$3,937,000	$3,937,000	$0	$0
40	CALIFORNIA HEALTH INTERVIEW SURVEY	$1,785,000	$1,592,500	$192,500	$0
41	MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM	$2,200,000	$1,100,000	$1,100,000	$0
43	T-MSIS	$1,800,000	$1,529,700	$270,300	$0
44	MFP/CCT SUPPLEMENTAL FUNDING	$5,319,000	$5,319,000	$0	$0
45	SSA COSTS FOR HEALTH COVERAGE INFO.	$1,559,000	$779,500	$779,500	$0
46	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$1,199,000	$783,750	$415,250	$0
47	FAMILY PACT PROGRAM ADMIN.	$1,006,000	$905,400	$100,600	$0
48	CALAIM - BH - CONNECT DEMONSTRATION ADMIN	$416,556,000	$208,278,000	$9,034,000	$199,244,000
49	MMA - DSH ANNUAL INDEPENDENT AUDIT	$800,000	$400,000	$400,000	$0
50	HEALTH INFORMATION EXCHANGE INTEROPERABILITY	$500,000	$450,000	$50,000	$0
51	CCT OUTREACH - ADMINISTRATIVE COSTS	$340,000	$340,000	$0	$0
52	HEALTH PLAN OF SAN MATEO DENTAL INTEGRATION EVAL	$186,000	$93,000	$0	$93,000
53	ELECTRONIC VISIT VERIFICATION M&O COSTS	$26,299,000	$26,299,000	$0	$0
55	DESIGNATED STATE HEALTH PROGRAMS	$0	$178,255,000	($178,255,000)	$0
	DHCS-OTHER SUBTOTAL	**$2,881,343,000**	**$2,077,834,650**	**$554,684,350**	**$248,824,000**
	DHCS-MEDICAL FI				
56	MEDICAL FI BO & IT COST REIMBURSEMENT	$55,435,000	$39,937,550	$15,497,450	$0
57	MEDICAL FI BO & IT CHANGE ORDERS	$39,146,000	$28,856,300	$10,289,700	$0
58	MEDICAL INFRASTRUCTURE & DATA MGT SVCS	$44,701,000	$32,951,500	$11,749,500	$0

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2025-26

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	DHCS-MEDICAL FI				
59	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	$40,544,000	$29,887,150	$10,656,850	$0
60	MEDICAL FI BO OTHER ESTIMATED COSTS	$26,545,000	$18,572,600	$7,972,400	$0
61	MEDICAL FI BO TELEPHONE SERVICE CENTER	$19,371,000	$13,572,950	$5,798,050	$0
62	MEDICAL FI BUSINESS OPERATIONS	$17,655,000	$13,006,000	$4,638,000	$11,000
63	MEDICAL FI BO HOURLY REIMBURSEMENT	$12,768,000	$9,411,800	$3,356,200	$0
64	MEDICAL FI BO MISCELLANEOUS EXPENSES	$268,000	$197,850	$70,150	$0
	DHCS-MEDICAL FI SUBTOTAL	**$256,433,000**	**$186,393,700**	**$70,028,300**	**$11,000**
	DHCS-HEALTH CARE OPT				
65	HCO OPERATIONS 2017 CONTRACT	$45,204,000	$22,941,000	$22,263,000	$0
66	HCO COST REIMBURSEMENT 2017 CONTRACT	$29,646,000	$15,045,300	$14,600,700	$0
67	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	$14,975,000	$7,599,850	$7,375,150	$0
	DHCS-HEALTH CARE OPT SUBTOTAL	**$89,825,000**	**$45,586,150**	**$44,238,850**	**$0**
	DHCS-DENTAL FI				
68	DENTAL FI-DBO ADMIN 2022 CONTRACT	$84,310,000	$61,856,750	$22,453,250	$0
70	DENTAL FI ADMINISTRATION 2016 CONTRACT	$22,038,000	$16,433,750	$5,604,250	$0
	DHCS-DENTAL FI SUBTOTAL	**$106,348,000**	**$78,290,500**	**$28,057,500**	**$0**
	OTHER DEPARTMENTS				
71	PERSONAL CARE SERVICES	$561,679,000	$561,679,000	$0	$0
72	HEALTH-RELATED ACTIVITIES - CDSS	$496,442,000	$496,442,000	$0	$0
73	CALHEERS DEVELOPMENT	$168,235,000	$123,557,900	$44,677,100	$0
74	MATERNAL AND CHILD HEALTH	$87,327,000	$87,327,000	$0	$0
75	CDDS ADMINISTRATIVE COSTS	$74,097,000	$74,097,000	$0	$0
76	HCPCFC CASE MANAGEMENT	$54,682,000	$41,011,000	$0	$13,671,000
77	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$47,501,000	$47,501,000	$0	$0
78	HCPCFC ADMIN COSTS	$23,757,000	$11,878,500	$11,878,500	$0
79	FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG	$8,064,000	$8,064,000	$0	$0
80	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$7,896,000	$7,896,000	$0	$0

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2025-26

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER DEPARTMENTS				
81	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	$7,442,000	$7,442,000	$0	$0
82	CLPP CASE MANAGEMENT SERVICES	$4,494,000	$4,494,000	$0	$0
83	CALIFORNIA SMOKERS' HELPLINE	$2,875,000	$2,875,000	$0	$0
85	CALHHS AGENCY HIPAA FUNDING	$1,407,000	$703,500	$703,500	$0
86	MEDI-CAL INPATIENT SERVICES FOR INMATES	$1,212,000	$1,212,000	$0	$0
87	VETERANS BENEFITS	$1,100,000	$1,100,000	$0	$0
88	VITAL RECORDS	$883,000	$879,000	$4,000	$0
89	KIT FOR NEW PARENTS	$583,000	$583,000	$0	$0
90	MERIT SYSTEM SERVICES FOR COUNTIES	$190,000	$95,000	$95,000	$0
91	PIA EYEWEAR COURIER SERVICE	$944,000	$472,000	$472,000	$0
	OTHER DEPARTMENTS SUBTOTAL	**$1,550,810,000**	**$1,479,308,900**	**$57,830,100**	**$13,671,000**
	GRAND TOTAL	**$4,884,759,000**	**$3,867,413,900**	**$754,839,100**	**$262,506,000**

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2024 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2024-25

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2024-25 APPROPRIATION		NOV. 2024 EST. FOR 2024-25		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		DHCS-OTHER						
1	1	CALAIM - PATH	$584,858,000	$260,876,000	$561,551,000	$236,184,000	($23,307,000)	($24,692,000)
14	2	INTERIM AND FINAL COST SETTLEMENTS-SMHS	$211,829,000	$0	$356,424,000	$0	$144,595,000	$0
2	3	COUNTY SPECIALTY MENTAL HEALTH ADMIN	$271,792,000	$8,910,000	$272,433,000	$9,087,000	$641,000	$177,000
3	4	CYBHI - BH SERVICES AND SUPPORTS PLATFORM	$359,545,000	$359,545,000	$254,120,000	$254,120,000	($105,425,000)	($105,425,000)
4	5	CCS CASE MANAGEMENT	$185,456,000	$65,659,250	$196,060,000	$69,557,150	$10,604,000	$3,897,900
7	6	MEDI-CAL RX - ADMINISTRATIVE COSTS	$99,048,000	$28,283,450	$172,650,000	$44,183,100	$73,602,000	$15,899,650
6	7	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	$104,844,000	$0	$114,671,000	$0	$9,827,000	$0
5	8	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	$116,854,000	$0	$110,049,000	$0	($6,805,000)	$0
106	9	BH TRANSFORMATION FUNDING FOR COUNTY BH DEPTS.	$85,000,000	$50,000,000	$85,000,000	$50,000,000	$0	$0
12	10	COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE	$51,152,000	$20,401,000	$82,745,000	$33,001,000	$31,593,000	$12,600,000
11	11	CALAIM - POPULATION HEALTH MANAGEMENT	$57,988,000	$5,798,800	$77,831,000	$7,783,100	$19,843,000	$1,984,300
13	12	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	$45,894,000	$22,956,750	$63,066,000	$31,571,600	$17,172,000	$8,614,850
8	13	SMH MAA	$63,017,000	$0	$60,944,000	$0	($2,073,000)	$0
10	14	DRUG MEDI-CAL COUNTY ADMINISTRATION	$63,860,000	$0	$57,794,000	$0	($6,066,000)	$0
9	15	BHSF - PROVIDER ACES TRAININGS	$50,195,000	$0	$44,780,000	$0	($5,415,000)	$0
17	16	ENTERPRISE DATA ENVIRONMENT	$36,178,000	$9,729,900	$39,250,000	$10,498,600	$3,072,000	$768,700
18	17	POSTAGE & PRINTING	$34,638,000	$17,447,500	$38,763,000	$19,510,000	$4,125,000	$2,062,500
15	18	ACTUARIAL COSTS FOR RATE DEVELOPMENT	$37,275,000	$18,487,500	$37,275,000	$18,487,500	$0	$0
19	19	MEDI-CAL RECOVERY CONTRACTS	$26,557,000	$6,639,250	$30,303,000	$7,575,750	$3,746,000	$936,500
20	20	HCBA WAIVER ADMINISTRATIVE COST	$23,996,000	$13,802,000	$21,612,000	$10,850,000	($2,384,000)	($2,952,000)
24	21	EMSA - CALIFORNIA POISON CONTROL SYSTEM SVCS.	$15,905,000	$0	$21,573,000	$0	$5,668,000	$0

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2024 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2024-25

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2024-25 APPROPRIATION		NOV. 2024 EST. FOR 2024-25		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		DHCS-OTHER						
21	22	CAPMAN	$18,682,000	$4,765,000	$20,100,000	$5,199,200	$1,418,000	$434,200
22	23	PAVE SYSTEM	$13,950,000	$3,844,250	$17,168,000	$4,704,000	$3,218,000	$859,750
26	24	MITA	$16,877,000	$2,143,350	$16,744,000	$2,126,400	($133,000)	($16,950)
56	25	CALAIM - JUSTICE INVOLVED MAA	$12,000,000	$6,000,000	$12,000,000	$6,000,000	$0	$0
23	26	HEALTH ENROLLMENT NAVIGATORS	$36,605,000	$18,302,500	$9,362,000	$4,681,000	($27,243,000)	($13,621,500)
27	27	PASRR	$7,458,000	$1,864,500	$8,891,000	$2,222,750	$1,433,000	$358,250
31	28	NEWBORN HEARING SCREENING PROGRAM	$6,392,000	$3,196,000	$6,128,000	$3,064,000	($264,000)	($132,000)
49	29	MEDCOMPASS SOLUTION	$5,288,000	$1,390,550	$5,288,000	$1,390,550	$0	$0
34	30	ELECTRONIC ASSET VERIFICATION PROGRAM	$3,649,000	$1,824,500	$4,556,000	$2,278,000	$907,000	$453,500
39	31	PUBLIC HEALTH REGISTRIES SUPPORT	$4,106,000	$0	$4,441,000	$0	$335,000	$0
33	32	DRUG MEDI-CAL PARITY RULE ADMINISTRATION	$5,875,000	$1,958,000	$4,407,000	$1,469,000	($1,468,000)	($489,000)
47	33	PROTECTION OF PHI DATA	$4,920,000	$2,460,000	$4,148,000	$2,074,000	($772,000)	($386,000)
36	34	PACES	$3,604,000	$947,150	$3,618,000	$951,600	$14,000	$4,450
35	35	SDMC SYSTEM M&O SUPPORT	$2,756,000	$1,378,000	$3,574,000	$1,787,000	$818,000	$409,000
38	36	CALAIM - INMATE PRE-RELEASE PROGRAM ADMIN	$2,746,000	$1,373,000	$2,746,000	$1,373,000	$0	$0
32	37	STATEWIDE VERIFICATION HUB	$2,574,000	$257,400	$2,596,000	$259,600	$22,000	$2,200
--	38	MOBILE VISION SERVICES	$0	$0	$3,936,000	$0	$3,936,000	$0
37	39	HCBS SP - CONTINGENCY MANAGEMENT ADMIN	$4,842,000	$0	$2,410,000	$0	($2,432,000)	$0
46	40	CALIFORNIA HEALTH INTERVIEW SURVEY	$1,785,000	$192,500	$2,142,000	$371,000	$357,000	$178,500
42	41	MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM	$2,000,000	$1,000,000	$2,000,000	$1,000,000	$0	$0
28	42	OUTREACH & ENROLLMENT ASSIST. FOR DUAL MEMBERS	$2,000,000	$1,000,000	$2,000,000	$1,000,000	$0	$0
40	43	T-MSIS	$1,724,000	$259,250	$1,913,000	$282,600	$189,000	$23,350
45	44	MFP/CCT SUPPLEMENTAL FUNDING	$2,048,000	$0	$1,773,000	$0	($275,000)	$0

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2024 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2024-25

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2024-25 APPROPRIATION		NOV. 2024 EST. FOR 2024-25		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		DHCS-OTHER						
50	45	SSA COSTS FOR HEALTH COVERAGE INFO.	$1,419,000	$709,500	$1,480,000	$740,000	$61,000	$30,500
44	46	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$1,408,000	$504,000	$1,199,000	$415,250	($209,000)	($88,750)
51	47	FAMILY PACT PROGRAM ADMIN.	$964,000	$96,400	$1,006,000	$100,600	$42,000	$4,200
57	48	CALAIM - BH - CONNECT DEMONSTRATION ADMIN	$946,000	$38,000	$946,000	$38,000	$0	$0
52	49	MMA - DSH ANNUAL INDEPENDENT AUDIT	$800,000	$400,000	$769,000	$384,500	($31,000)	($15,500)
--	50	HEALTH INFORMATION EXCHANGE INTEROPERABILITY	$0	$0	$500,000	$50,000	$500,000	$50,000
53	51	CCT OUTREACH - ADMINISTRATIVE COSTS	$340,000	$0	$340,000	$0	$0	$0
54	52	HEALTH PLAN OF SAN MATEO DENTAL INTEGRATION EVAL	$164,000	$0	$162,000	$0	($2,000)	$0
98	55	DESIGNATED STATE HEALTH PROGRAMS	$0	($189,939,000)	$0	($323,213,000)	$0	($133,274,000)
43	--	FIELD TESTING OF MEDI-CAL MATERIALS	$2,000,000	$1,000,000	$0	$0	($2,000,000)	($1,000,000)
48	--	GENDER-AFFIRMING CARE	$2,500,000	$1,250,000	$0	$0	($2,500,000)	($1,250,000)
97	--	REPRODUCTIVE HEALTH ACCESS DEMO 1115 WAIVER	$200,000,000	$100,000,000	$0	$0	($200,000,000)	($100,000,000)
101	--	QUALITY SANCTIONS	($2,049,000)	($1,024,500)	$0	$0	$2,049,000	$1,024,500
103	--	LGBT DISPARITIES REDUCTION ACT (AB 1163)	$725,000	$132,000	$0	$0	($725,000)	($132,000)
104	--	HEALTH ENROLLMENT NAVIGATORS REDUCTION	($36,000,000)	($18,000,000)	$0	$0	$36,000,000	$18,000,000
105	--	BH SERVICES AND SUPPORTS PLATFORM REDUCTION	($140,000,000)	($140,000,000)	$0	$0	$140,000,000	$140,000,000
107	--	RECONCILIATION - ADMINISTRATION	($19,590,000)	($9,795,000)	$0	$0	$19,590,000	$9,795,000
		DHCS-OTHER SUBTOTAL	**$2,701,389,000**	**$688,063,750**	**$2,847,237,000**	**$523,157,850**	**$145,848,000**	**($164,905,900)**

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2024 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2024-25

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2024-25 APPROPRIATION		NOV. 2024 EST. FOR 2024-25		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		DHCS-MEDICAL FI						
60	56	MEDICAL FI BO & IT COST REIMBURSEMENT	$53,822,000	$14,668,050	$55,485,000	$15,416,850	$1,663,000	$748,800
62	57	MEDICAL FI BO & IT CHANGE ORDERS	$43,055,000	$11,315,150	$52,893,000	$13,902,450	$9,838,000	$2,587,300
63	58	MEDICAL INFRASTRUCTURE & DATA MGT SVCS	$44,543,000	$11,707,100	$44,470,000	$11,688,900	($73,000)	($18,200)
61	59	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	$36,652,000	$9,634,250	$39,925,000	$10,495,000	$3,273,000	$860,750
64	60	MEDICAL FI BO OTHER ESTIMATED COSTS	$25,730,000	$7,728,350	$25,766,000	$7,738,500	$36,000	$10,150
65	61	MEDICAL FI BO TELEPHONE SERVICE CENTER	$18,823,000	$5,633,600	$18,805,000	$5,628,800	($18,000)	($4,800)
66	62	MEDICAL FI BUSINESS OPERATIONS	$17,157,000	$4,506,850	$17,141,000	$4,502,650	($16,000)	($4,200)
67	63	MEDICAL FI BO HOURLY REIMBURSEMENT	$12,408,000	$3,261,600	$12,397,000	$3,258,000	($11,000)	($3,600)
68	64	MEDICAL FI BO MISCELLANEOUS EXPENSES	$2,161,000	$567,600	$328,000	$85,650	($1,833,000)	($481,950)
		DHCS-MEDICAL FI SUBTOTAL	**$254,351,000**	**$69,022,550**	**$267,210,000**	**$72,716,800**	**$12,859,000**	**$3,694,250**
		DHCS-HEALTH CARE OPT						
70	65	HCO OPERATIONS 2017 CONTRACT	$30,903,000	$15,219,750	$44,591,000	$21,961,150	$13,688,000	$6,741,400
69	66	HCO COST REIMBURSEMENT 2017 CONTRACT	$30,521,000	$15,031,600	$36,903,000	$18,174,750	$6,382,000	$3,143,150
71	67	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	$13,335,000	$6,567,450	$15,210,000	$7,491,000	$1,875,000	$923,550
		DHCS-HEALTH CARE OPT SUBTOTAL	**$74,759,000**	**$36,818,800**	**$96,704,000**	**$47,626,900**	**$21,945,000**	**$10,808,100**
		DHCS-DENTAL FI						
72	68	DENTAL FI-DBO ADMIN 2022 CONTRACT	$86,623,000	$21,117,000	$90,286,000	$23,047,250	$3,663,000	$1,930,250
73	69	DENTAL ASO ADMINISTRATION 2016 CONTRACT	$11,352,000	$2,838,000	$29,430,000	$9,073,000	$18,078,000	$6,235,000
74	70	DENTAL FI ADMINISTRATION 2016 CONTRACT	$21,206,000	$6,105,250	$20,406,000	$5,191,000	($800,000)	($914,250)

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2024 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2024-25

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2024-25 APPROPRIATION		NOV. 2024 EST. FOR 2024-25		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		DHCS-DENTAL FI SUBTOTAL	**$119,181,000**	**$30,060,250**	**$140,122,000**	**$37,311,250**	**$20,941,000**	**$7,251,000**
		OTHER DEPARTMENTS						
75	71	PERSONAL CARE SERVICES	$478,998,000	$0	$514,725,000	$0	$35,727,000	$0
76	72	HEALTH-RELATED ACTIVITIES - CDSS	$363,207,000	$0	$434,236,000	$0	$71,029,000	$0
77	73	CALHEERS DEVELOPMENT	$190,416,000	$48,076,050	$192,225,000	$48,882,750	$1,809,000	$806,700
78	74	MATERNAL AND CHILD HEALTH	$90,892,000	$0	$70,496,000	$0	($20,396,000)	$0
79	75	CDDS ADMINISTRATIVE COSTS	$75,076,000	$0	$93,199,000	$0	$18,123,000	$0
81	76	HCPCFC CASE MANAGEMENT	$54,682,000	$0	$54,682,000	$0	$0	$0
80	77	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$50,253,000	$0	$50,501,000	$0	$248,000	$0
95	78	HCPCFC ADMIN COSTS	$23,757,000	$11,878,500	$23,757,000	$11,878,500	$0	$0
82	79	FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG	$8,058,000	$0	$9,657,000	$0	$1,599,000	$0
83	80	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$8,266,000	$0	$8,124,000	$0	($142,000)	$0
84	81	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	$4,958,000	$0	$12,722,000	$0	$7,764,000	$0
85	82	CLPP CASE MANAGEMENT SERVICES	$4,185,000	$0	$4,936,000	$0	$751,000	$0
86	83	CALIFORNIA SMOKERS' HELPLINE	$2,500,000	$0	$2,954,000	$0	$454,000	$0
--	84	HCBS SP CDDS - OTHER ADMIN	$0	$0	$245,000	$0	$245,000	$0
88	85	CALHHS AGENCY HIPAA FUNDING	$1,386,000	$0	$1,376,000	$688,000	($10,000)	$688,000
89	86	MEDI-CAL INPATIENT SERVICES FOR INMATES	$1,212,000	$0	$1,212,000	$0	$0	$0
90	87	VETERANS BENEFITS	$1,100,000	$0	$1,100,000	$0	$0	$0
91	88	VITAL RECORDS	$883,000	$4,000	$883,000	$4,000	$0	$0

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2024 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2024-25

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2024-25 APPROPRIATION		NOV. 2024 EST. FOR 2024-25		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER DEPARTMENTS						
92	89	KIT FOR NEW PARENTS	$593,000	$0	$583,000	$0	($10,000)	$0
93	90	MERIT SYSTEM SERVICES FOR COUNTIES	$190,000	$95,000	$190,000	$95,000	$0	$0
96	91	PIA EYEWEAR COURIER SERVICE	$1,062,000	$531,000	$944,000	$472,000	($118,000)	($59,000)
		OTHER DEPARTMENTS SUBTOTAL	**$1,361,674,000**	**$60,584,550**	**$1,478,747,000**	**$62,020,250**	**$117,073,000**	**$1,435,700**
		OTHER ADMINISTRATION TOTAL	**$4,511,354,000**	**$884,549,900**	**$4,830,020,000**	**$742,833,050**	**$318,666,000**	**($141,716,850)**
		GRAND TOTAL COUNTY AND OTHER ADMINISTRATION	**$7,275,914,000**	**$1,638,646,150**	**$7,609,536,000**	**$1,452,009,300**	**$333,622,000**	**($186,636,850)**

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2024-25 AND 2025-26

NO.	POLICY CHANGE TITLE	NOV. 2024 EST. FOR 2024-25		NOV. 2024 EST. FOR 2025-26		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	DHCS-OTHER						
1	CALAIM - PATH	$561,551,000	$236,184,000	$475,992,000	$194,122,000	($85,559,000)	($42,062,000)
2	INTERIM AND FINAL COST SETTLEMENTS-SMHS	$356,424,000	$0	$180,367,000	$0	($176,057,000)	$0
3	COUNTY SPECIALTY MENTAL HEALTH ADMIN	$272,433,000	$9,087,000	$286,048,000	$9,668,000	$13,615,000	$581,000
4	CYBHI - BH SERVICES AND SUPPORTS PLATFORM	$254,120,000	$254,120,000	$181,164,000	$181,164,000	($72,956,000)	($72,956,000)
5	CCS CASE MANAGEMENT	$196,060,000	$69,557,150	$195,882,000	$69,471,900	($178,000)	($85,250)
6	MEDI-CAL RX - ADMINISTRATIVE COSTS	$172,650,000	$44,183,100	$120,934,000	$31,003,850	($51,716,000)	($13,179,250)
7	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	$114,671,000	$0	$113,194,000	$0	($1,477,000)	$0
8	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	$110,049,000	$0	$112,880,000	$0	$2,831,000	$0
9	BH TRANSFORMATION FUNDING FOR COUNTY BH DEPTS.	$85,000,000	$50,000,000	$93,508,000	$55,000,000	$8,508,000	$5,000,000
10	COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE	$82,745,000	$33,001,000	$21,062,000	$8,400,000	($61,683,000)	($24,601,000)
11	CALAIM - POPULATION HEALTH MANAGEMENT	$77,831,000	$7,783,100	$61,148,000	$6,114,800	($16,683,000)	($1,668,300)
12	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	$63,066,000	$31,571,600	$58,784,000	$29,398,600	($4,282,000)	($2,173,000)
13	SMH MAA	$60,944,000	$0	$53,425,000	$0	($7,519,000)	$0
14	DRUG MEDI-CAL COUNTY ADMINISTRATION	$57,794,000	$0	$65,734,000	$0	$7,940,000	$0
15	BHSF - PROVIDER ACES TRAININGS	$44,780,000	$0	$5,415,000	$0	($39,365,000)	$0
16	ENTERPRISE DATA ENVIRONMENT	$39,250,000	$10,498,600	$37,902,000	$9,979,700	($1,348,000)	($518,900)
17	POSTAGE & PRINTING	$38,763,000	$19,510,000	$38,763,000	$19,510,000	$0	$0
18	ACTUARIAL COSTS FOR RATE DEVELOPMENT	$37,275,000	$18,487,500	$41,000,000	$20,350,000	$3,725,000	$1,862,500
19	MEDI-CAL RECOVERY CONTRACTS	$30,303,000	$7,575,750	$32,745,000	$8,186,250	$2,442,000	$610,500
20	HCBA WAIVER ADMINISTRATIVE COST	$21,612,000	$10,850,000	$24,714,000	$12,407,000	$3,102,000	$1,557,000
21	EMSA - CALIFORNIA POISON CONTROL SYSTEM SVCS.	$21,573,000	$0	$17,961,000	$0	($3,612,000)	$0

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2024-25 AND 2025-26

NO.	POLICY CHANGE TITLE	NOV. 2024 EST. FOR 2024-25 TOTAL FUNDS	NOV. 2024 EST. FOR 2024-25 GENERAL FUNDS	NOV. 2024 EST. FOR 2025-26 TOTAL FUNDS	NOV. 2024 EST. FOR 2025-26 GENERAL FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE GENERAL FUNDS
	DHCS-OTHER						
22	CAPMAN	$20,100,000	$5,199,200	$20,819,000	$5,326,450	$719,000	$127,250
23	PAVE SYSTEM	$17,168,000	$4,704,000	$17,958,000	$4,894,600	$790,000	$190,600
24	MITA	$16,744,000	$2,126,400	$34,051,000	$4,324,950	$17,307,000	$2,198,550
25	CALAIM - JUSTICE INVOLVED MAA	$12,000,000	$6,000,000	$68,000,000	$34,000,000	$56,000,000	$28,000,000
26	HEALTH ENROLLMENT NAVIGATORS	$9,362,000	$4,681,000	$0	$0	($9,362,000)	($4,681,000)
27	PASRR	$8,891,000	$2,222,750	$8,946,000	$2,236,500	$55,000	$13,750
28	NEWBORN HEARING SCREENING PROGRAM	$6,128,000	$3,064,000	$6,220,000	$3,110,000	$92,000	$46,000
29	MEDCOMPASS SOLUTION	$5,288,000	$1,390,550	$5,412,000	$1,422,750	$124,000	$32,200
30	ELECTRONIC ASSET VERIFICATION PROGRAM	$4,556,000	$2,278,000	$4,613,000	$2,306,500	$57,000	$28,500
31	PUBLIC HEALTH REGISTRIES SUPPORT	$4,441,000	$0	$4,441,000	$0	$0	$0
32	DRUG MEDI-CAL PARITY RULE ADMINISTRATION	$4,407,000	$1,469,000	$5,875,000	$1,958,000	$1,468,000	$489,000
33	PROTECTION OF PHI DATA	$4,148,000	$2,074,000	$5,216,000	$2,608,000	$1,068,000	$534,000
34	PACES	$3,618,000	$951,600	$3,651,000	$960,050	$33,000	$8,450
35	SDMC SYSTEM M&O SUPPORT	$3,574,000	$1,787,000	$2,397,000	$1,198,500	($1,177,000)	($588,500)
36	CALAIM - INMATE PRE-RELEASE PROGRAM ADMIN	$2,746,000	$1,373,000	$2,746,000	$1,373,000	$0	$0
37	STATEWIDE VERIFICATION HUB	$2,596,000	$259,600	$1,018,000	$101,800	($1,578,000)	($157,800)
38	MOBILE VISION SERVICES	$3,936,000	$0	$7,872,000	$0	$3,936,000	$0
39	HCBS SP - CONTINGENCY MANAGEMENT ADMIN	$2,410,000	$0	$3,937,000	$0	$1,527,000	$0
40	CALIFORNIA HEALTH INTERVIEW SURVEY	$2,142,000	$371,000	$1,785,000	$192,500	($357,000)	($178,500)
41	MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM	$2,000,000	$1,000,000	$2,200,000	$1,100,000	$200,000	$100,000
42	OUTREACH & ENROLLMENT ASSIST. FOR DUAL MEMBERS	$2,000,000	$1,000,000	$0	$0	($2,000,000)	($1,000,000)
43	T-MSIS	$1,913,000	$282,600	$1,800,000	$270,300	($113,000)	($12,300)
44	MFP/CCT SUPPLEMENTAL FUNDING	$1,773,000	$0	$5,319,000	$0	$3,546,000	$0
45	SSA COSTS FOR HEALTH COVERAGE INFO.	$1,480,000	$740,000	$1,559,000	$779,500	$79,000	$39,500

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2024-25 AND 2025-26

NO.	POLICY CHANGE TITLE	NOV. 2024 EST. FOR 2024-25 TOTAL FUNDS	NOV. 2024 EST. FOR 2024-25 GENERAL FUNDS	NOV. 2024 EST. FOR 2025-26 TOTAL FUNDS	NOV. 2024 EST. FOR 2025-26 GENERAL FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE GENERAL FUNDS
	DHCS-OTHER						
46	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$1,199,000	$415,250	$1,199,000	$415,250	$0	$0
47	FAMILY PACT PROGRAM ADMIN.	$1,006,000	$100,600	$1,006,000	$100,600	$0	$0
48	CALAIM - BH - CONNECT DEMONSTRATION ADMIN	$946,000	$38,000	$416,556,000	$9,034,000	$415,610,000	$8,996,000
49	MMA - DSH ANNUAL INDEPENDENT AUDIT	$769,000	$384,500	$800,000	$400,000	$31,000	$15,500
50	HEALTH INFORMATION EXCHANGE INTEROPERABILITY	$500,000	$50,000	$500,000	$50,000	$0	$0
51	CCT OUTREACH - ADMINISTRATIVE COSTS	$340,000	$0	$340,000	$0	$0	$0
52	HEALTH PLAN OF SAN MATEO DENTAL INTEGRATION EVAL	$162,000	$0	$186,000	$0	$24,000	$0
53	ELECTRONIC VISIT VERIFICATION M&O COSTS	$0	$0	$26,299,000	$0	$26,299,000	$0
55	DESIGNATED STATE HEALTH PROGRAMS	$0	($323,213,000)	$0	($178,255,000)	$0	$144,958,000
	DHCS-OTHER SUBTOTAL	**$2,847,237,000**	**$523,157,850**	**$2,881,343,000**	**$554,684,350**	**$34,106,000**	**$31,526,500**
	DHCS-MEDICAL FI						
56	MEDICAL FI BO & IT COST REIMBURSEMENT	$55,485,000	$15,416,850	$55,435,000	$15,497,450	($50,000)	$80,600
57	MEDICAL FI BO & IT CHANGE ORDERS	$52,893,000	$13,902,450	$39,146,000	$10,289,700	($13,747,000)	($3,612,750)
58	MEDICAL INFRASTRUCTURE & DATA MGT SVCS	$44,470,000	$11,688,900	$44,701,000	$11,749,500	$231,000	$60,600
59	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	$39,925,000	$10,495,000	$40,544,000	$10,656,850	$619,000	$161,850
60	MEDICAL FI BO OTHER ESTIMATED COSTS	$25,766,000	$7,738,500	$26,545,000	$7,972,400	$779,000	$233,900
61	MEDICAL FI BO TELEPHONE SERVICE CENTER	$18,805,000	$5,628,800	$19,371,000	$5,798,050	$566,000	$169,250
62	MEDICAL FI BUSINESS OPERATIONS	$17,141,000	$4,502,650	$17,655,000	$4,638,000	$514,000	$135,350
63	MEDICAL FI BO HOURLY REIMBURSEMENT	$12,397,000	$3,258,000	$12,768,000	$3,356,200	$371,000	$98,200
64	MEDICAL FI BO MISCELLANEOUS EXPENSES	$328,000	$85,650	$268,000	$70,150	($60,000)	($15,500)
	DHCS-MEDICAL FI SUBTOTAL	**$267,210,000**	**$72,716,800**	**$256,433,000**	**$70,028,300**	**($10,777,000)**	**($2,688,500)**

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2024-25 AND 2025-26

NO.	POLICY CHANGE TITLE	NOV. 2024 EST. FOR 2024-25 TOTAL FUNDS	NOV. 2024 EST. FOR 2024-25 GENERAL FUNDS	NOV. 2024 EST. FOR 2025-26 TOTAL FUNDS	NOV. 2024 EST. FOR 2025-26 GENERAL FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE GENERAL FUNDS
	DHCS-HEALTH CARE OPT						
65	HCO OPERATIONS 2017 CONTRACT	$44,591,000	$21,961,150	$45,204,000	$22,263,000	$613,000	$301,850
66	HCO COST REIMBURSEMENT 2017 CONTRACT	$36,903,000	$18,174,750	$29,646,000	$14,600,700	($7,257,000)	($3,574,050)
67	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	$15,210,000	$7,491,000	$14,975,000	$7,375,150	($235,000)	($115,850)
	DHCS-HEALTH CARE OPT SUBTOTAL	**$96,704,000**	**$47,626,900**	**$89,825,000**	**$44,238,850**	**($6,879,000)**	**($3,388,050)**
	DHCS-DENTAL FI						
68	DENTAL FI-DBO ADMIN 2022 CONTRACT	$90,286,000	$23,047,250	$84,310,000	$22,453,250	($5,976,000)	($594,000)
69	DENTAL ASO ADMINISTRATION 2016 CONTRACT	$29,430,000	$9,073,000	$0	$0	($29,430,000)	($9,073,000)
70	DENTAL FI ADMINISTRATION 2016 CONTRACT	$20,406,000	$5,191,000	$22,038,000	$5,604,250	$1,632,000	$413,250
	DHCS-DENTAL FI SUBTOTAL	**$140,122,000**	**$37,311,250**	**$106,348,000**	**$28,057,500**	**($33,774,000)**	**($9,253,750)**
	OTHER DEPARTMENTS						
71	PERSONAL CARE SERVICES	$514,725,000	$0	$561,679,000	$0	$46,954,000	$0
72	HEALTH-RELATED ACTIVITIES - CDSS	$434,236,000	$0	$496,442,000	$0	$62,206,000	$0
73	CALHEERS DEVELOPMENT	$192,225,000	$48,882,750	$168,235,000	$44,677,100	($23,990,000)	($4,205,650)
74	MATERNAL AND CHILD HEALTH	$70,496,000	$0	$87,327,000	$0	$16,831,000	$0
75	CDDS ADMINISTRATIVE COSTS	$93,199,000	$0	$74,097,000	$0	($19,102,000)	$0
76	HCPCFC CASE MANAGEMENT	$54,682,000	$0	$54,682,000	$0	$0	$0
77	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$50,501,000	$0	$47,501,000	$0	($3,000,000)	$0
78	HCPCFC ADMIN COSTS	$23,757,000	$11,878,500	$23,757,000	$11,878,500	$0	$0
79	FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG	$9,657,000	$0	$8,064,000	$0	($1,593,000)	$0
80	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$8,124,000	$0	$7,896,000	$0	($228,000)	$0
81	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	$12,722,000	$0	$7,442,000	$0	($5,280,000)	$0
82	CLPP CASE MANAGEMENT SERVICES	$4,936,000	$0	$4,494,000	$0	($442,000)	$0

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2024-25 AND 2025-26

NO.	POLICY CHANGE TITLE	NOV. 2024 EST. FOR 2024-25 TOTAL FUNDS	NOV. 2024 EST. FOR 2024-25 GENERAL FUNDS	NOV. 2024 EST. FOR 2025-26 TOTAL FUNDS	NOV. 2024 EST. FOR 2025-26 GENERAL FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE GENERAL FUNDS
	OTHER DEPARTMENTS						
83	CALIFORNIA SMOKERS' HELPLINE	$2,954,000	$0	$2,875,000	$0	($79,000)	$0
84	HCBS SP CDDS - OTHER ADMIN	$245,000	$0	$0	$0	($245,000)	$0
85	CALHHS AGENCY HIPAA FUNDING	$1,376,000	$688,000	$1,407,000	$703,500	$31,000	$15,500
86	MEDI-CAL INPATIENT SERVICES FOR INMATES	$1,212,000	$0	$1,212,000	$0	$0	$0
87	VETERANS BENEFITS	$1,100,000	$0	$1,100,000	$0	$0	$0
88	VITAL RECORDS	$883,000	$4,000	$883,000	$4,000	$0	$0
89	KIT FOR NEW PARENTS	$583,000	$0	$583,000	$0	$0	$0
90	MERIT SYSTEM SERVICES FOR COUNTIES	$190,000	$95,000	$190,000	$95,000	$0	$0
91	PIA EYEWEAR COURIER SERVICE	$944,000	$472,000	$944,000	$472,000	$0	$0
	OTHER DEPARTMENTS SUBTOTAL	**$1,478,747,000**	**$62,020,250**	**$1,550,810,000**	**$57,830,100**	**$72,063,000**	**($4,190,150)**
	OTHER ADMINISTRATION TOTAL	**$4,830,020,000**	**$742,833,050**	**$4,884,759,000**	**$754,839,100**	**$54,739,000**	**$12,006,050**
	GRAND TOTAL COUNTY AND OTHER ADMINISTRATION	**$7,609,536,000**	**$1,452,009,300**	**$7,677,465,000**	**$1,477,743,600**	**$67,929,000**	**$25,734,300**

MEDI-CAL OTHER ADMINISTRATION
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POLICY CHANGE NUMBER	POLICY CHANGE TITLE
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2	INTERIM AND FINAL COST SETTLEMENTS-SMHS
3	COUNTY SPECIALTY MENTAL HEALTH ADMIN
4	CYBHI - BH SERVICES AND SUPPORTS PLATFORM
5	CCS CASE MANAGEMENT
6	MEDI-CAL RX - ADMINISTRATIVE COSTS
7	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES
8	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES
9	BH TRANSFORMATION FUNDING FOR COUNTY BH DEPTS.
10	COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE
11	CALAIM - POPULATION HEALTH MANAGEMENT
12	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS
13	SMH MAA
14	DRUG MEDI-CAL COUNTY ADMINISTRATION
15	BHSF - PROVIDER ACES TRAININGS
16	ENTERPRISE DATA ENVIRONMENT
17	POSTAGE & PRINTING
18	ACTUARIAL COSTS FOR RATE DEVELOPMENT
19	MEDI-CAL RECOVERY CONTRACTS
20	HCBA WAIVER ADMINISTRATIVE COST
21	EMSA - CALIFORNIA POISON CONTROL SYSTEM SVCS.
22	CAPMAN
23	PAVE SYSTEM
24	MITA
25	CALAIM - JUSTICE INVOLVED MAA
26	HEALTH ENROLLMENT NAVIGATORS
27	PASRR
28	NEWBORN HEARING SCREENING PROGRAM
29	MEDCOMPASS SOLUTION
30	ELECTRONIC ASSET VERIFICATION PROGRAM
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32	DRUG MEDI-CAL PARITY RULE ADMINISTRATION
33	PROTECTION OF PHI DATA
34	PACES
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MEDI-CAL OTHER ADMINISTRATION
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MEDI-CAL OTHER ADMINISTRATION
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CALAIM - PATH

OTHER ADMIN. POLICY CHANGE NUMBER: 1
IMPLEMENTATION DATE: 1/2022
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2389

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$561,551,000	$475,992,000
STATE FUNDS	$254,014,000	$237,996,000
FEDERAL FUNDS	$307,537,000	$237,996,000

Purpose:
This policy change estimates the funding available for the California Advancing & Innovating Medi-Cal (CalAIM) Providing Access and Transforming Health (PATH) Initiative.

Authority:
Penal Code Section 4011.11
Welfare & Institutions Code Sections 14011.10, 14132.275, 14184.800, and 14186
AB 133 (Chapter 133, Statutes of 2021)
AB 128 (Chapter 21, Statutes of 2021)
CalAIM Section 1115(a) Medicaid Demonstration
AB 107 (Chapter 22, Statutes of 2024)

Interdependent Policy Changes:
Not Applicable

Background:
On December 29, 2021, the Centers for Medicare & Medicaid Services (CMS) approved the CalAIM Section 1115 Wavier Demonstration, which provided funding for the CalAIM PATH Initiative through December 31, 2026. PATH was previously approved for $1.44 billion. On January 26, 2023, the Department received federal approval under its CalAIM Section 1115 Waiver Demonstration for PATH capacity building funds to support the Justice-Involved Reentry Initiative for an additional $410 million in capacity building funds to support the planning and implementation of pre-release and reentry services in the 90 days prior to an individual's release into the community, for a total budget of $1.85 billion. The PATH Initiative is to build up the capacity and infrastructure of on-the-ground partners and providers to successfully participate in CalAIM Enhanced Care Management (ECM) and Community Supports, and Justice Involved Services. PATH is comprised of the following efforts.

ECM and Community Supports Capacity and Infrastructure Building
PATH will provide funding to transition, build, expand, and maintain infrastructure/capacity to support the implementation of ECM and Community Supports. This goal will be achieved through four initiatives:

- Technical Assistance (TA) Initiative: Virtual "marketplace" will be developed to provide technical support and off-the-shelf resources from vendors to establish the infrastructure development.
- Collaborative Planning and Implementation Initiative: Provide funding to regional facilitators approved by the Department. Support for regional collaborative planning and implementation efforts will include among managed care plans, providers,

CALAIM - PATH
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Community-Based Organizations (CBOs), county agencies, hospitals, tribes, and others to assess gaps and promote readiness.

- Capacity and Infrastructure Transition, Expansion and Development (CITED) Initiative: Direct funding to support capacity building and infrastructure for ECM and Community Support services. Entities, such as providers, CBOs, county agencies, hospitals, tribes, and other, that are contracted or plan to contract with a managed care plan can apply to receive funding for specific capacity needs to support the transition, expansion, and development of these specific services.

Justice-Involved (JI) Capacity Building Program

PATH funding supports the implementation of statewide CalAIM justice-involved initiatives. This includes support for implementation of pre-release Medi-Cal applications, enrollment, and suspension processes, as well as the delivery of Medi-Cal services in the 90 days prior to release. This goal will be achieved through two parts:

- Collaborative planning: Support for correctional agencies, county social services departments, county behavioral health agencies, managed care plans, and others so they can jointly design, modify, and launch new processes aimed at increasing enrollment in Medi-Cal and continuous access to care for justice-involved youths and adults.
- Capacity and Infrastructure: Support for correctional agencies, institutions, and other justice-involved stakeholders as they implement pre-release Medi-Cal enrollment and suspension processes.

Overall Program

Effective July 1, 2022, the Department has contracted with a Third-Party Administrator (TPA) to support the implementation of the PATH initiatives and serve as a fiscal administrator for all PATH initiatives except for the Whole Person Care (WPC) Mitigation initiative.

Reason for Change:

The change from the prior estimate, for FY 2024-25, is an increase due to funding shifting from FY 2023-24 into FY 2024-25 for payment. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due to anticipating more payments in FY 2024-25.

Methodology:

1. PCG has been contracted to provide Fiscal Intermediary and Third-Party Administrative services for the CalAIM PATH initiatives from July 1, 2022, through June 30, 2027.

2. Assume all payments will be made through a passthrough invoice process with PCG. All PATH Initiative participants will submit payment requests to PCG, and PCG will invoice the Department for the approved invoice amount and provide applicable documentation. The Department will process the passthrough invoice and make payment to PCG. PCG will have up to three business days to make that payment to the PATH grantee once funds are received from the Department.

3. Assume TA Marketplace Vendors are paid based on completion of deliverables in their approved budgets and scope of work.

4. Assume the Collaborative Planning and Implementation Initiative facilitators are paid quarterly based on payment terms outline in their contract.

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5. Assume approved applicants for the CITED Initiative are paid based on completing milestones and quarterly reporting.

6. Assume approved JI applicants are paid based on completing milestones and required reporting.

7. As a result of AB 128, the Department received an appropriation for $100,000,000 General Fund ($100,000,000 Federal Fund) for Justice-Involved initiatives within the Medi-Cal PATH program and was available for expenditure or encumbrance by June 30, 2024. The table below displays the estimated spending and remaining funds by Appropriation Years:

(Dollars in Thousands)

Appropriation Year 2021-22	TF	GF	FF*
Prior Years	$200,000	$100,000	$100,000
Estimated in FY 2024-25	$0	$0	$0
Estimated in FY 2025-26	$0	$0	$0
Total Estimated Remaining	$0	$0	$0

*Federal funds authority is newly requested for the fiscal year in which funds are anticipated to be expended. Totals may differ due to rounding.

8. On a cash basis, all PATH Program costs are estimated to be:

(Dollars in Thousands)

Fiscal Years	TF	GF	GF Reimb.	FF
FY 2024-25	**$561,551**	**$236,184**	**$17,830**	**$307,537**
FY 2025-26	**$475,992**	**$194,122**	**$43,874**	**$237,996**

*Totals may differ due to rounding.

CALAIM - PATH

OTHER ADMIN. POLICY CHANGE NUMBER: 1

Funding:

(Dollars in Thousands)

FY 2024-25	TF	GF	GF Reimb.	FF
100% Title XIX FF (4260-101-0890)	$17,830	$0	$0	$17,830
50% Title XIX / 50% GF (4260-101-0890/0001)	$525,891	$236,184	$0	$289,707
Reimbursement GF (4260-601-0995)	$17,830	$0	$17,830	$0
Total	**$561,551**	**$236,184**	**$17,830**	**$307,537**
FY 2025-26	**TF**	**GF**	**GF Reimb.**	**FF**
100% Title XIX FF (4260-101-0890)	$43,874	$0	$0	$43,874
50% Title XIX / 50% GF (4260-101-0890/0001)	$388,244	$194,122	$0	$194,122
Reimbursement GF (4260-601-0995)	$43,874	$0	$43,874	$0
Total	**$475,992**	**$194,122**	**$43,874**	**$237,996**

*Totals may differ due to rounding.

INTERIM AND FINAL COST SETTLEMENTS-SMHS

OTHER ADMIN. POLICY CHANGE NUMBER: 2
IMPLEMENTATION DATE: 7/2016
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1757

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$356,424,000	$180,367,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$356,424,000	$180,367,000

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 & Institutions 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 audit settlements are completed within three years of the last amended cost report the county MHPs submit to the Department.

The reconciliation process for each fiscal year may result in an overpayment or an underpayment to the county and will be handled as follows:

- For counties that have been determined to be overpaid, the Department will recoup any overpayments.
- For counties that have been determined to be underpaid, the Department will reimburse the federal funds.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due an increase in the number of interim and final audit settlements to be processed in FY 2024-25. Additionally, the assumed settlements were updated based on actual settlements processed in FY 2023-24.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due a decrease in the number of interim and final audit settlements that will be completed and processed in FY 2025-26 relative to FY 2024-25. The Department plans to complete and process more interim and final audit settlements in FY 2024-25, than it plans to complete and process in FY 2025-26.

INTERIM AND FINAL COST SETTLEMENTS-SMHS

OTHER ADMIN. POLICY CHANGE NUMBER: 2

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 audit settlements are based on the difference between each county MHP's final audited cost report and the payments they received from the Department.

3. Cost settlements for administration, UR/QA, and MH MAA are each determined separately.

4. To estimate the expected expenditures for FY 2024-25 and FY 2025-26 for interim and final audit settlements not yet received, the following procedures are used:

   - The average expenditure of $1,282,610 per interim settlement is determined by dividing the actual net outflow of $42,326,141 from FY 2023-24 by 33, the number of interim settlement packages processed in FY 2023-24. The average recoupment of $271,600 per final audit settlement is determined by dividing the net inflow, $10,864,010, by 40, the number of final audit settlements processed in FY 2023-24.

   - The average expenditure per settlement is increased by 3% for fiscal years not yet received and is not present in calculating the averages in the prior step.

   - The total number of interim and final audit settlements expected to be processed for each fiscal year is multiplied by the average amount per settlement per fiscal year to determine the total amount to be processed for each fiscal year per settlement type.

   - There are no future payments expected to be made with Title XXI funding.

5. To determine final amounts for interim and final audit settlements for each fiscal year, the following amounts were totaled:
   - The estimated amounts per fund, per settlement type, per fiscal year forecasted for FY 2024-25 and FY 2025-26.

6. The net FF to be reimbursed and/or recouped in FY 2024-25 for interim settlements and final audit settlements is shown below:

(Dollars in Thousands)

Interim Settlements	TF	FF
FY 2016-17	$63,412	$63,412
FY 2017-18	$77,561	$77,561
FY 2018-19	$79,888	$79,888
FY 2019-20	$82,285	$82,285
FY 2020-21	$66,910	$66,910
Subtotal	$370,056	$370,056

INTERIM AND FINAL COST SETTLEMENTS-SMHS
OTHER ADMIN. POLICY CHANGE NUMBER: 2

(Dollars in Thousands)

Final Audit Settlements	TF	FF
FY 2015-16	($1,358)	($1,358)
FY 2016-17	($5,315)	($5,315)
FY 2017-18	($5,475)	($5,475)
FY 2018-19	($1,484)	($1,484)
Subtotal	($13,632)	($13,632)
Total FY 2024-25	**$356,424**	**$356,424**

7. The net FF to be reimbursed and/or recouped in FY 2025-26 for interim settlements and final audit settlements is shown below:

(Dollars in Thousands)

Interim Settlements	TF	FF
FY 2020-21	$17,843	$17,843
FY 2021-22	$87,296	$87,296
FY 2022-23	$89,914	$89,914
Subtotal	$195,053	$195,053

(Dollars in Thousands)

Final Audit Settlements	TF	FF
FY 2018-19	($4,155)	($4,155)
FY 2019-20	($5,808)	($5,808)
FY 2020-21	($4,723)	($4,723)
Subtotal	($14,686)	($14,686)
Total FY 2025-26	**$180,367**	**$180,367**

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

COUNTY SPECIALTY MENTAL HEALTH ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 3
IMPLEMENTATION DATE: 7/2012
ANALYST: Tyler Shimizu
FISCAL REFERENCE NUMBER: 1721

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$272,433,000	$286,048,000
STATE FUNDS	$9,087,000	$9,668,000
FEDERAL FUNDS	$263,346,000	$276,380,000

Purpose:
This policy change estimates the reimbursement for 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 14707.5
Welfare & Institutions Code 14711(c)
California Constitution Article XIII Section 36
CMS Final Rule (CMS-2333-F) (Parity Final Rule)
Title 42, Code of Federal Regulations Part 438

Interdependent Policy Changes:
Not Applicable

Background:
Counties may obtain federal reimbursement for costs associated with administering a county's mental health program. Counties must report their administration costs and direct facility expenditures quarterly. Along with administration costs, counties can claim reimbursement costs for county Utilization Review and Quality Assurance (QAUR), Performance Outcomes System (POS), Managed Care Regulations – Mental Health, and MH Parity Final Rule.

The QAUR and POS 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 funding for the cost increase.

The Centers for Medicare and Medicaid Services (CMS) issued Final Rule CMS-2390-P on May 6, 2016. Final Rule 2390-P changes the Medicaid managed care regulations to reflect changes in the utilization of managed care delivery systems. And on March 30, 2017, CMS issued the Parity Final Rule, to strengthen access to mental health and substance use disorder services for Medicaid members.

As a result of the COVID-19 national public health emergency, increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased FMAP was only available through the end of Calendar Year 2023. However, based on the timing of claims submissions, increased FMAP for this policy change is still allowable.

COUNTY SPECIALTY MENTAL HEALTH ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 3

Reason for Change:
The change for FY 2024-25, from the prior estimate, is an increase is due to using updated forecast including actual claiming in FY 2023-24.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to an expected growth in claiming from year to year.

Methodology:
1. Mental Health administration costs are based on historical claims payment data. Assume 18.33% of each fiscal year claims will be paid in the year the services occur, 74.17% is paid in the following year, and 7.50% in the third year. The estimate costs are:

(Dollars in Thousands)

Fiscal Year	Type	Accrual	FY 2024-25	FY 2025-26
FY 2022-23	Other Admin	$336,293	$25,224	$0
	MCHIP	$18,796	$1,410	$0
	QAUR	$63,745	$4,781	$0
	POS	$3,571	$268	$0
	Parity	$25,987	$1,949	$0
	Managed Care	$11,942	$896	$0
Subtotal		$460,334	$34,528	$0
FY 2023-24	Other Admin	$353,437	$262,139	$26,509
	MCHIP	$19,754	$14,651	$1,482
	QAUR	$66,996	$49,690	$5,025
	POS	$3,753	$2,784	$282
	Parity	$27,313	$20,257	$2,049
	Managed Care	$12,551	$9,309	$941
Subtotal		$483,804	$358,830	$36,288

COUNTY SPECIALTY MENTAL HEALTH ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 3

(Dollars in Thousands)

FY 2024-25	Other Admin	$371,456	$68,092	$275,503
	MCHIP	$20,761	$3,806	$15,398
	QAUR	$70,413	$12,907	$52,224
	POS	$3,945	$723	$2,926
	Parity	$28,705	$5,262	$21,290
	Managed Care	$13,191	$2,418	$9,784
Subtotal		$508,471	$93,208	$377,125
FY 2025-26	Other Admin	$390,393	$0	$71,563
	MCHIP	$21,820	$0	$4,000
	QAUR	$74,004	$0	$13,566
	POS	$4,146	$0	$760
	Parity	$30,169	$0	$5,530
	Managed Care	$13,863	$0	$2,541
Subtotal		$534,395	$0	$97,960
Total		$1,987,004	$486,566	$511,373

2. Mental Health administration costs are shared between federal funds (FF) and county funds (CF). MC claims are eligible for 50% federal reimbursement. CHIP claims are eligible for 65% federal enhanced reimbursement.

3. QAUR expenditures are shared between FF and CF. Pursuant to Proposition 30, GF funding is provided for levels of service that are provided above those levels mandated by the 2011 Realignment. Skilled professional medical personnel (SPMP) are eligible for enhanced federal reimbursement of 75%. All other personnel are eligible for 50% federal reimbursement.

4. POS expenditures are eligible for reimbursement at 50%, and costs for clinical staffing is eligible for enhanced FF at 75%.

5. Managed Care Parity related to pre-authorizations of outpatient services and concurrent reviews of SMHS inpatient admissions, must be conducted by a licensed mental health professional, which assumes a 75% / 25% Federal Medical Assistance Percentage (FMAP). The non-federal share is assumed to be funded with 50% CF and 50% General Funds (GF) pursuant to the California Constitution, Article 13, Section 36(c)(5)(A).

6. For the Managed Care Regulations Final Rule claims, the non-federal share is funded with CF and GF, consistent with the California Constitution, Article 13, Section 36 (c)(5)(A).

COUNTY SPECIALTY MENTAL HEALTH ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 3

(Dollars in Thousands)

Claim Type	FY 2024-25				
	TF	FF	GF	CF	COVID-19 FF
Other Admin	$355,454	$177,727	$0	$177,727	$0
MCHIP	$19,867	$12,913	$0	$3,793	$161
QAUR Reg	$21,128	$10,564	$0	$10,564	$0
QAUR SPMP	$46,251	$34,688	$0	$11,563	$0
POS	$3,775	$2,174	$1,601	$0	$0
Parity	$27,468	$16,470	$5,378	$5,378	$242
Managed Care Regulations	$12,623	$8,407	$2,108	$2,108	$0
Total	$486,566	**$262,943**	**$9,087**	$214,133	**$403**

(Dollars in Thousands)

Claim Type	FY 2025-26				
	TF	FF	GF	CF	COVID-19 FF
Other Admin	$373,576	$186,788	$0	$186,788	$0
MCHIP	$20,880	$13,572	$0	$7,298	$10
QAUR Reg	$22,205	$11,103	$0	$11,102	$0
QAUR SPMP	$48,610	$36,458	$0	$12,152	$0
POS	$3,967	$2,284	$1,683	$0	$0
Parity	$28,869	$17,310	$5,770	$5,770	$19
Managed Care Regulations	$13,266	$8,836	$2,215	$2,215	$0
Total	$511,373	**$276,351**	**$9,668**	$225,325	**$29**

Funding:
100% Title XIX FFP (4260-101-0890)
100% Title XXI FFP (4260-101-0890)
100% Title XIX GF (4260-101-0001)
COVID-19 Title XXI Increased FFP (4260-101-0890)

CYBHI - BH SERVICES AND SUPPORTS PLATFORM

OTHER ADMIN. POLICY CHANGE NUMBER: 4
IMPLEMENTATION DATE: 1/2022
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2289

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$254,120,000	$181,164,000
STATE FUNDS	$254,120,000	$181,164,000
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the cost for procuring a business services vendors to implement a statewide, app-based behavioral health (BH) virtual services platforms that will provide children and youth 25 and younger, and their families access to services and supports. This policy changes also estimates costs for integrating a statewide e-consult service and providing related provider training.

Authority:
AB 133 (Chapter 143, Statutes of 2021)
W&I Code 5961.1
Agreement number 22-20555
Agreement number 23-30175

Interdependent Policy Changes:
Not Applicable

Background:
Established as part of the Budget Act of 2021, the Children and Youth Behavioral Health Initiative (CYBHI) is a multiyear package of investments. The CYBHI intends to transform California's BH system for children and youth aged 0-25 into a world-class, innovative, up-stream focused, ecosystem where all children and young adults are routinely screened, supported, and served for emerging behavioral health needs.

The Department has procured business services vendors to deliver and monitor BH wellness services and treatments so the most effective, least resource-intensive services and treatments are available to children and youth 25 years of age and younger who may not need individual counseling, but need help managing stress and building resilience, through a direct service, virtual platform.

These direct services and supports platforms support regular automated age appropriate assessments/screenings and self-monitoring tools, and develops tools to help families navigate how to access help, regardless of payer source. The direct services and supports platform provides age appropriate and culturally competent support and resources, such as interactive education, self-monitoring tools, app-based games, videos, book suggestions, automated cognitive behavioral therapy and mindfulness exercises, all designed to build skills and enhance well-being. Children and youth 25 years of age and younger with more significant needs would be guided to peers or coaches. Those whose interactions with the platform show they may need clinical services for mental health conditions and/or substance use disorders will be guided to

CYBHI - BH SERVICES AND SUPPORTS PLATFORM
OTHER ADMIN. POLICY CHANGE NUMBER: 4

their health plan to set up assessment visits, allowing ongoing, continuous relationships with licensed clinicians through telehealth or in-person. The direct service platform also builds in coverage by licensed behavioral health providers, so assessments can be performed to determine which children and youth need ongoing clinical services, and which have needs that can be met by peers or coaches. The direct services and supports platform also includes e-consult and e-referrals, to ensure primary care providers can coordinate care with mental health and substance use disorder specialists (e.g., psychiatrists) and clients may have seamless referrals, when needed. In addition, training for pediatric and other primary care providers is offered to support use of the platform in care of their patients.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a decrease due to contract negotiations, changes in expected timing of payments to vendors, and anticipated utilization. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due to contract negotiations, changes in expected timing of payments to vendors, and anticipated utilization.

Methodology:
1. The Budget Act for FY 2022-23 provided $230 million GF, available for expenditure through June 30, 2025. An additional $124.9 million GF is available for FY 2023-24. An additional $140 million GF is proposed for FY 2024-25. The table below displays the estimated spending and remaining funds by Appropriation Year:

	TF	GF	FF
Appropriation Year 2022-23			
Prior Years	$98,516,000	$98,516,000	$0
Estimated in FY 2024-25	$131,484,000	$131,484,000	$0
Total Estimated Remaining	$0	$0	$0
Appropriation Year 2023-24			
Prior Years	$0	$0	$0
Estimated in FY 2024-25	$122,636,000	$122,636,000	$0
Estimated in FY 2025-26	$2,264,000	$2,264,000	$0
Total Estimated Remaining	$0	$0	$0
Appropriation Year 2025-26			
Prior Years	$0	$0	$0
Estimated in FY 2025-26	$178,900,000	$178,900,000	$0
Total Estimated Remaining	$0	$0	$0

2. Total costs are estimated to be:

Fiscal Year	TF	GF	FF
FY 2024-25	**$254,120,000**	**$254,120,000**	**$0**
FY 2025-26	**$181,164,000**	**$181,164,000**	**$0**

CYBHI - BH SERVICES AND SUPPORTS PLATFORM

OTHER ADMIN. POLICY CHANGE NUMBER: 4

Funding:
100% General Fund (4260-101-0001)

CCS CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 5
IMPLEMENTATION DATE: 7/1999
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 230

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$196,060,000	$195,882,000
STATE FUNDS	$69,557,150	$69,471,900
FEDERAL FUNDS	$126,502,850	$126,410,100

Purpose:
This policy change estimates the California Children's Services (CCS) case management cost.

Authority:
Health & Safety Code, sections 123800-123995
AB 2724 (Chapter 73, Statutes of 2022)
AB 133 (Chapter 143, Statutes of 2022)
AB 118 (Chapter 42, Statutes of 2023)
SB 108 (Budget Act of 2024)

Interdependent Policy Changes:
Not Applicable

Background:
The CCS program provides medical case management to all CCS clients. In counties with a population greater than 200,000 (independent counties), county staff determine program financial, residential, and medical eligibility including the evaluation and adjudication of service authorization requests (SARs). For counties with a population under 200,000 (dependent counties), the state shares case management activities. Dependent counties are responsible for the financial and residential verification and the Department's CCS clinical staff are responsible for medical eligibility determinations and SARs adjudications. The Children's Medical Services Network (CMS Net) case management database is utilized by CCS counties and the Department.

On July 1, 2018, the Department transitioned some of the case management administrative functions from the county to the County Organized Health Systems (COHS) health plans under the Whole Child Model (WCM). The WCM transition was completed on July 1, 2019.

AB 2724 authorizes the Department to contract with Kaiser Permanente as an alternative healthcare service plan in select WCM counties. On January 1, 2024, the Department implemented Kaiser Permanente in the following eight WCM counties: Marin, Napa, Orange, San Mateo, Santa Cruz, Solano, Sonoma, and Yolo.

Starting January 1, 2025, as authorized by AB 118, the Department will begin transitioning some of the case management administrative functions from the county to the COHS health plans under the WCM in the following 12 counties: Butte, Colusa, Glenn, Mariposa, Nevada, Placer, Plumas, San Benito, Sierra, Sutter, Tehama, and Yuba. Some case management

CCS CASE MANAGEMENT
OTHER ADMIN. POLICY CHANGE NUMBER: 5

administrative functions will also transition to Kaiser Permanente which will operate as an alternate healthcare service plan in Mariposa, Placer, Sutter, and Yuba counties.

SB 184 sunsets the Child Health and Disability Prevention (CHDP) program on June 30, 2024. Effective July 1, 2024, the Department redirected portions of the CHDP county budget allocation to fund the administrative costs of the Health Care Program for Children in Foster Care (HCPCFC), making HCPCFC a standalone program. The remaining portions of the CHDP county budget allocation were redirected to the CCS program to fund new county workload created due to the July 1, 2025, implementation of CCS Compliance Monitoring and Oversight (M&O).

SB 108 (The Budget Act of 2024) was amended to include provision 21 which extends flexibility to the counties regarding appropriate staffing necessary to implement and operationalize the HCPCFC program manual requirements and readiness activities for the California CCS Compliance M&O Program.

Reason for Change:
The change for FY 2024-25, from the prior estimate, is an increase due to reflecting updated caseload and per member, per month (PMPM) data.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is a slight decrease due to revised WCM and CMS Net expenditure projections for FY 2025-26.

Methodology:
1. Starting in November 2024, the county administrative estimate is updated to reflect recent caseload and PMPM data.

2. The CCS case management costs for FY 2024-25 are $178,846,000 and $178,846,000 for FY 2025-26.

3. Assume administrative costs of $1,057,000 in both FY 2024-25 and FY 2025-26 for the Medi-Cal expansion of undocumented children which are funded at 100% GF.

4. County data processing costs associated with CMS Net for CCS Medi-Cal are estimated to be $3,874,000 in FY 2024-25 and $3,873,000 in FY 2025-26.

5. Medi-Cal Optional Targeted Low Income Children Program (OTLICP) costs are separate from other Medi-Cal costs. Total Medi-Cal OTLICP costs listed below do not include county share of cost:

	FY 2024-25	FY 2025-26
County Administration:	$32,553,000	$32,553,000
County share of cost:	($2,638,000)	($2,638,000)
Total Medi-Cal OTLICP:	$29,916,000	$29,916,000

6. County data processing costs associated with CMS Net for OTLICP are estimated to be $491,000 in FY 2024-25 and $491,000 in FY 2025-26.

CCS CASE MANAGEMENT
OTHER ADMIN. POLICY CHANGE NUMBER: 5

7. Payments to the COHS under the WCM are applied against CCS Case Management. The expenditures using a cash basis accounting are estimated to be $25,625,000 in FY 2024-25. The additional $1,625,000 in FY 2024-25 relates to the impacts of transitioning 12 additional counties to WCM beginning on January 1, 2025. The WCM estimates for FY 2025-26 $25,802,000.

8. Enhanced, Title XIX (75% FFP), funding is available for Skilled Professional Medical Personnel for the Medi-Cal and OTLICP populations in FY 2024-25 and FY 2025-26.

9. To support increased county administrative workload associated with new reporting requirements as specified by AB 133, the Department will proportionately reallocate the CHDP funding to counties utilizing a stratified methodology based on county specific CCS beneficiary caseload. The CCS Compliance M&O cost is estimated at $10,138,000.

FY 2024-25				
CCS Medi-Cal/OTLICP	**TF***	**GF**	**FF**	**CF****
CCS Case Management	$27,278,000	$6,349,000	$20,929,000	$2,638,000
CMS Net	$491,000	$172,000	$319,000	$0
Subtotal	$27,769,000	$6,521,000	$21,248,000	$2,638,000
CCS Medi-Cal				
CCS Case Management	$178,846,000	$67,237,000	$111,609,000	$0
Medi-Cal Expansion	$1,057,000	$1,057,000	$0	$0
CMS Net	$3,874,000	$1,937,000	$1,937,000	$0
Subtotal	$183,777,000	$70,231,000	$113,546,000	$0
WCM Implementation	($25,625,000)	($12,264,000)	($13,361,000)	$0
CCS Compliance M&O	$10,138,000	$5,069,000	$5,069,000	$0
Total	**$196,060,000**	**$69,557,000**	**$126,503,000**	$2,638,000

CCS CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 5

FY 2025-26				
CCS Medi-Cal/OTLICP	**TF***	**GF**	**FF**	**CF****
CCS Case Management	$27,278,000	$6,349,000	$20,929,000	$2,638,000
CMS Net	$491,000	$172,000	$319,000	$0
Subtotal	$27,769,000	$6,521,000	$21,248,000	$2,638,000
CCS Medi-Cal				
CCS Case Management	$178,846,000	$67,237,000	$111,609,000	$0
Medi-Cal Expansion	$1,057,000	$1,057,000	$0	$0
CMS Net	$3,873,000	$1,937,000	$1,936,000	$0
Subtotal	$183,776,000	$70,231,000	$113,545,000	$0
WCM Implementation	($25,802,000)	($12,349,000)	($13,453,000)	$0
CCS Compliance M&O	$10,138,000	$5,069,000	$5,069,000	$0
Total	**$195,882,000**	**$69,472,000**	**$126,410,000**	$2,638,000

* Totals may differ due to rounding

** County Funds are not included in the Total Fund

CCS CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 5

Funding:

FY 2024-25	TF*	GF	FF	CF**
50% FF Title XIX/50% GF (4260-101-0890/0001)	$82,147,000	$41,074,000	$41,073,000	$0
100% FF Title XXI (4260-101-0890)	$9,797,000	$0	$9,797,000	$0
100% GF Title XXI (4260-101-0001)	$2,638,000	$2,638,000	$0	$2,638,000
75% FF Title XIX/25% GF (4260-101-0890/0001)	$103,587,000	$25,897,000	$77,690,000	$0
100% GF Title XIX (4260-101-0001)	$1,057,000	$1,057,000	$0	$0
65% FF Title XXI/35% GF (4260-101-0890/0001)	($3,166,000)	($1,108,000)	($2,058,000)	$0
Total	**$196,060,000**	**$69,558,000**	**$126,502,000**	$2,638,000

FY 2025-26	TF*	GF	FF	CF**
50% FF Title XIX/50% GF (4260-101-0890/0001)	$81,994,000	$40,997,000	$40,997,000	$0
100% FF Title XXI (4260-101-0890)	$9,797,000	$0	$9,797,000	$0
100% GF Title XXI (4260-101-0001)	$2,638,000	$2,638,000	$0	$2,638,000
75% FF Title XIX/25% GF (4260-101-0890/0001)	$103,587,000	$25,897,000	$77,690,000	$0
100% GF Title XIX (4260-101-0001)	$1,057,000	$1,057,000	$0	$0
65% FF Title XXI/35% GF (4260-101-0890/0001)	($3,191,000)	($1,117,000)	($2,074,000)	$0
Total	**$195,882,000**	**$69,472,000**	**$126,410,000**	$2,638,000

* Totals differ due to rounding.

** County Funds are not included in the Total Fund

MEDI-CAL RX - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 6
IMPLEMENTATION DATE: 7/2020
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 2167

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$172,650,000	$120,934,000
STATE FUNDS	$44,183,100	$31,003,850
FEDERAL FUNDS	$128,466,900	$89,930,150

Purpose:
This policy change estimates the net impact of the cost of the Medi-Cal Rx administrative services contract and the prior Fee-for-Service (FFS) pharmacy claims administrator.

Authority:
Executive Order N-01-19

Interdependent Policy Changes:
Not Applicable

Background:
Executive Order N-01-19 required the Department to transition Medi-Cal pharmacy services into a FFS benefit. With this change, Medi-Cal pharmacy benefits are provided and managed through Medi-Cal Rx. To facilitate and support the managed care carve-out and ongoing management of the Medi-Cal pharmacy benefit, the Department procured, Magellan Medicaid Administration, Inc., to provide administrative services for Medi-Cal Rx. Medi-Cal Rx Assumption of Operations (AOO) began January 1, 2022. The initial contract was through September 2024 with five additional optional years. The Department has exercised the first optional year, October 2024 – September 2025.

Medi-Cal Rx provides modern pharmacy support systems, including:

- claims administration and utilization management services,
- pharmacy drug rebate administration, and
- provider and beneficiary support.

Effective July 1, 2020, a consulting and project management contractor was put in place to support the takeover of operations from the current Medi-Cal Fiscal Intermediary (FI) and managed care (MC) plans related to Medi-Cal Rx. The consultant contractor work efforts are expected to continue through FY 2025-26. An additional consultant will provide contract evaluation services.

The federal certification of the claims operation occurred in August 2023 and was retroactive to January 2022. This allowed the retroactive claiming of the claims services and the supporting contractor services to receive Title XIX 75% FF / 25% GF.

MEDI-CAL RX - ADMINISTRATIVE COSTS
OTHER ADMIN. POLICY CHANGE NUMBER: 6

Reason for Change:
The change in FY 2024-25, from the prior estimate is due to:

- Estimated payments have been shifted from FY 2023-24 to FY 2024-25,
- An increase in estimated contractor costs, and
- The FFS related administrative cost savings have been recognized and are no longer included in this policy change.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to FY 2024-25 includes payments shifted from FY 2023-24.

Methodology:

1. Contractor costs are included in FY 2024-25 and FY 2025-26.

2. A portion of the Contractor costs estimated to occur in FY 2023-24 have been shifted to FY 2024-25.

3. The federal certification of the claims operation occurred in August 2023 and is retroactive to January 2022. This allows the retroactive claiming of the claims services and the supporting contractor services to receive Title XIX 75% FF / 25% GF. The majority of this retroactive claiming for the initial claiming of Title XIX 50% FF / 50% GF occurred in FY 2023-24 and the remainder will occur in FY 2024-25.

4. The estimated cost for FY 2024-25 and FY 2025-26 is:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
New Pharmacy Related Administrative Costs	$172,650	$44,183	$128,467
Total	**$172,650**	**$44,183**	**$128,467**

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
New Pharmacy Related Administrative Costs	$120,934	$31,004	$89,930
Total	**$120,934**	**$31,004**	**$89,930**

MEDI-CAL RX - ADMINISTRATIVE COSTS
OTHER ADMIN. POLICY CHANGE NUMBER: 6

Funding:
(Dollars in Thousands)

FY 2024-25	TF	GF	FF
FI 90% Title XIX / 10% GF	$1,791	$179	$1,612
FI 75% Title XIX / 25% GF	$151,583	$37,896	$113,687
Certification -FI 50/50	($3,506)	($1,753)	($1,753)
Certification +FI 75/25	$3,506	$876	$2,630
FI T21 65/35	$14,999	$5,250	$9,749
FI 100% GF	$830	$830	$0
75% Title XIX / 25% GF	$3,124	$781	$2,343
65% Title XXI / 35% GF	$306	$107	$199
100% GF	$17	$17	$0
Total	**$172,650**	**$44,183**	**$128,467**

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
FI 90% Title XIX / 10% GF	$4,976	$498	$4,478
FI 75% Title XIX / 25% GF	$101,521	$25,380	$76,141
FI T21 65/35	$10,414	$3,645	$6,769
FI 100% GF	$576	$576	$0
75% Title XIX / 25% GF	$3,124	$781	$2,343
65% Title XXI / 35% GF	$306	$107	$199
100% GF	$17	$17	$0
Total	**$120,934**	**$31,004**	**$89,930**

COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 7
IMPLEMENTATION DATE: 7/1992
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 1963

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$114,671,000	$113,194,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$114,671,000	$113,194,000

Purpose:
This policy change budgets the federal financial participation (FFP) for claims submitted on behalf of local government agencies (LGAs) including Native American Indian tribes for Medicaid administrative activities.

Authority:
Welfare & Institutions Code (WIC) 14132.47

Interdependent Policy Changes:
Not Applicable

Background:
WIC 14132.47 authorizes the State to administer the County-based Medi-Cal Administrative Activities (CMAA) and Tribal Medi-Cal Administrative Activities (TMAA) claiming processes. CMAA and TMAA are voluntary programs that allow LGAs to receive federal reimbursement for allowable administrative activities upon entering into a contract with the Department. The Department submits claims on behalf of the LGAs, which includes counties and chartered cities, and Native American Indian tribes and tribal organizations to obtain FFP for certified public expenditures incurred through performing CMAA and TMAA. These activities assist Medi-Cal eligible persons to learn about, enroll in, and access services of the Medi-Cal program.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is a net increase due to:

- An increase in the actual claims received for FY 2022-23 as compared to the previously estimated amounts, resulting in a projected increase in claims for FY 2022-23 to be paid during FY 2024-25. Consequently, the estimated claims for FY 2023-24 Q1 will be higher than previously anticipated based on this increase.
- For TMAA, the quarters claimed in FY 2024-25 were updated. FY 2022-23 Q2 shifted from FY 2023-24 and FY 2023-24 Q2 shifted to FY 2025-26.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to:

- A projected decrease of billings for FY 2025-26 as compared to FY 2024-25 due to invoice submission deadline extensions that were granted to stakeholders during FY 2023-24 in order to accommodate timelines for system updates, resulting in additional payments rolling over to FY 2024-25 from FY 2023-24. Billings are expected to resume to standard processing timelines in FY 2025-26.

COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 7

Methodology:

County Medi-Cal Administrative Activities

1. The CMAA FY 2024-25 estimate includes the remaining actuals from FY 2022-23 Q2 to Q4 claims and estimated FY 2023-24 Q1 claims. The FY 2022-23 Q2 to Q4 claims are based on actual claims received for Q1. The estimated base payments for FY 2023-24 claims assume a 1% growth factor from FY 2022-23, based on growth in CMAA claims from FY 2017-18 through FY 2021-22.

CMAA FY 2024-25 Estimated Payments	
FY 2022-23 Q2 to Q4	$86,004,000
FY 2023-24 Q1	$28,083,000
Total	**$114,087,000**

2. The CMAA FY 2025-26 estimate includes estimated claims for FY 2023-24 Q2 to Q4 and FY 2024-25 Q1. The estimated base payments for FY 2023-24 and FY 2024-25 claims assume a 1% growth factor from FY 2022-23, based on growth in CMAA claims from FY 2017-18 through FY 2021-22.

CMAA FY 2025-26 Estimated Payments	
FY 2023-24 Q2 to Q4	$84,249,000
FY 2024-25 Q1	$28,364,000
Total	**$112,613,000**

Tribal Medi-Cal Administrative Activities

1. The TMAA FY 2024-25 estimate includes actual FY 2022-23 Q2 invoices and estimated claims for FY 2022-23 Q3 to Q4 and FY 2023-24 Q1 invoices. The FY 2022-23 Q3 to Q4 claims are based on actual claims received for Q1. The estimated base payments for FY 2023-24 invoices assume a 1% growth factor from FY 2022-23, based on growth in TMAA claims from FY 2017-18 through FY 2021-22.

TMAA FY 2024-25 Estimated Payments	
FY 2022-23 Q2 to Q4	$439,000
FY 2023-24 Q1	$145,000
Total	**$584,000**

COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES
OTHER ADMIN. POLICY CHANGE NUMBER: 7

2. The TMAA FY 2025-26 estimate includes estimated claims for FY 2023-24 Q2 to Q4 claims, and FY 2024-25 Q1 claims. The estimated base payments for FY 2023-24 and FY 2024-25 claims assume a 1% growth factor from FY 2022-23, based on growth in TMAA claims from FY 2017-18 through FY 2021-22.

TMAA FY 2025-26 Estimated Payments	
FY 2023-24 Q2 to Q4	$435,000
FY 2024-25 Q1	$146,000
Total	**$581,000**

3. Total CMAA and TMAA reimbursements for FY 2024-25 and FY 2025-26 on a cash basis are:

FY 2024-25	**TF**	**FF**
County MAA	$114,087,000	$114,087,000
Tribal MAA	$584,000	$584,000
Total	**$114,671,000**	**$114,671,000**

FY 2025-26	**TF**	**FF**
County MAA	$112,613,000	$112,613,000
Tribal MAA	$581,000	$581,000
Total	**$113,194,000**	**$113,194,000**

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

SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 8
IMPLEMENTATION DATE: 7/1992
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 235

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$110,049,000	$112,880,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$110,049,000	$112,880,000

Purpose:
This policy change budgets the federal financial participation (FFP) for claims submitted on behalf of Local Governmental Agencies (LGAs), Local Educational Consortia (LECs) and Local Educational Agencies (LEAs) for costs incurred through performing Medicaid administrative activities.

Authority:
AB 2377 (Chapter 147, Statutes of 1994)
AB 2780 (Chapter 310, Statutes of 1998)
Welfare and Institutions (W&I) Code 14132.47

Interdependent Policy Changes:
Not Applicable

Background:
AB 2377 authorized the State to implement the Medi-Cal Administrative Activities (MAA) claiming process. The Department submits claims on behalf of LGAs, which include counties and chartered cities, to obtain FFP for certified public expenditures incurred through performing Medicaid administrative activities. These activities assist Medi-Cal eligible persons to learn about, enroll in, and access services of the Medi-Cal program. AB 2780 allowed LEAs (including school districts and County Offices of Education) the option of claiming MAA through either their LECs (one of the State's eleven administrative districts) or through their LGAs.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to:

- Actual invoice claims received for FY 2021-22 Q4 are lower than previously estimated.
- The estimated amount for FY 2021-22 Q4 included a decrease due to the Medi-Cal Eligibility Rate (MER) following adjustments for the Unsatisfactory Immigration Status (UIS). The FY 2021-22 Q4 estimation served as the base quarter to estimate for FY 2022-23 Q4. For that reason, the estimate for FY 2024-25 is decreased.
- The Sonoma and Los Angeles Unified School District (LAUSD) FY 2022-23 Q1 claims were previously estimated to be paid in FY 2023-24 but now will be paid in FY 2024-25.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to:

- There is an increase in the estimate for FY 2025-26 due to increasing the prior year quarterly projections by a 4.76% Employment Cost Index (ECI) adjustment factor.

SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 8

Methodology:

The FY 2024-25 estimate includes:

1. The FY 2022-23 Q1 LAUSD estimated amount is based on the FY 2021-22 Q1 LAUSD invoice claims, plus a 4.76 percent ECI adjustment factor.
2. The FY 2022-23 Q1 Sonoma LEC is the actual invoice claims received. The ECI factor is not added to actual claim amounts.
3. The estimated amount for the invoices associated with FY 2022-23 Q2-Q4, which is to be paid in FY 2024-25, is based on the actual invoice claims from FY 2021-22 Q2-Q4, plus a 4.76 percent ECI adjustment factor.
4. The FY 2023-24 Q1 amount is based on estimated invoice claims from FY 2022-23 Q1, plus a 4.76 percent ECI adjustment factor.

The FY 2025-26 estimate includes:

1. The FY 2023-24 Q2-Q4 and FY 2024-25 Q1 amounts that are based on the estimated invoice claims for FY 2022-23 Q2-Q4 and FY 2023-24 Q1, plus a 4.76 percent ECI adjustment factor.

FY 2024-25	TF	FF
FY 2022-23 Q1 LAUSD and Sonoma LEC	$2,301,000	$2,301,000
FY 2022-23 Q2, Q3, Q4	$84,470,000	$84,470,000
FY 2023-24 Q1	$23,278,000	$23,278,000
Total	**$110,049,000**	**$110,049,000**

FY 2025-26	TF	FF
FY 2023-24 Q2, Q3, Q4	$88,493,000	$88,493,000
FY 2024-25 Q1	$24,387,000	$24,387,000
Total	**$112,880,000**	**$112,880,000**

Funding:

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

BH TRANSFORMATION FUNDING FOR COUNTY BH DEPTS.

OTHER ADMIN. POLICY CHANGE NUMBER: 9
IMPLEMENTATION DATE: 5/2025
ANALYST: Tyler Shimizu
FISCAL REFERENCE NUMBER: 2491

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$85,000,000	$93,508,000
STATE FUNDS	$50,000,000	$55,000,000
FEDERAL FUNDS	$35,000,000	$38,508,000

Purpose:
This policy change estimates funding to counties to begin administering the Behavioral Health Services Act (SB 326, Chapter 790, Statutes of 2023).

Authority:
SB 326 (Chapter 790, Statutes of 2023)
Budget Act of 2024 [SB 108 (Chapter 35, Statutes of 2024)]

Interdependent Policy Changes:
Not Applicable

Background:
The Behavioral Health Services Act (BHSA) revises and recasts the Mental Health Services Act (MHSA) as the BHSA. Voters approved amendments to the MHSA at the March 5, 2024, statewide primary election. The BHSA clarifies that county behavioral health programs are permitted to use BHSA funds to treat primary substance use disorder conditions and makes conforming changes throughout the BHSA. This BHSA restructures current MHSA funding buckets; enhances the current process for local planning of various services funded by the BHSA; and for oversight, accountability, and reporting of BHSA funds.

In addition, the BHSA requires counties to prepare and submit a three-year Integrated Plan for Behavioral Health Services and Outcomes (Integrated Plan) and annual updates; and to prepare and submit to the State the annual Behavioral Health Outcomes and Accountability Transparency Report (Transparency Report). Counties will be required to implement new processes to prepare and submit the Integrated Plan and Transparency Report.

Reason for Change:
There is no change, from the prior estimate, for FY 2024-25.

The change in the current estimate, from FY 2024-25 to FY 2025-26 represents continued costs to implement behavioral health reform in FY 2025-26.

Methodology:
1. The following are the estimated costs in FY 2024-25 and FY 2025-26, on a cash basis:

BH TRANSFORMATION FUNDING FOR COUNTY BH DEPTS.

OTHER ADMIN. POLICY CHANGE NUMBER: 9

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2024-25	$85,000	$50,000	$35,000
FY 2025-26	$93,508	$55,000	$38,508

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
100% General Fund (4260-101-0001)

COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE

OTHER ADMIN. POLICY CHANGE NUMBER: 10
IMPLEMENTATION DATE: 10/2024
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2334

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$82,745,000	$21,062,000
STATE FUNDS	$33,001,000	$8,400,000
FEDERAL FUNDS	$49,744,000	$12,662,000

Purpose:
This policy change estimates the costs for funding counties to implement changes to stay in compliance with the federal data exchange standards and regulations of the Interoperability Final Rule.

Authority:
Interoperability Final Rule (CMS-9115-F)
Behavioral Health Information Notice (BHIN): 22-068

Interdependent Policy Changes:
Not Applicable

Background:
On May 1, 2020, the Centers for Medicare and Medicaid Services (CMS) published the "Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, and Health Care Providers," (referred to as "CMS Interoperability and Patient Access final rule") to further advance interoperability for Medicaid and CHIP providers and improve members access to their data. State Medicaid agencies, Medicaid managed care plans, CHIP agencies, and CHIP managed care entities must implement this final rule in a manner consistent with existing guidance and the recently published "21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program" final rule (referred to as the ONC 21st Century Cures Act final rule), by the Office of the National Coordinator for Health Information Technology, published in the Federal Register on May 1, 2020.

The CMS Interoperability Rule requires Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) counties, hereafter referred to as Behavioral Health Plans (BHPs), to implement and maintain a secure, standards-based Patient Access Application Programming Interface (API) and a publicly accessible, standards-based Provider Directory API that can connect to mobile applications and be available through a public-facing digital endpoint on each BHP's website. BHPs must also comply with 42 Code of Federal Regulations (CFR) 438.242, 45 CFR 170.215, the provider directory information requirements specified in 42 CFR 438.10, and the public reporting and information blocking components of the CMS Interoperability Rule 45 CFR Part 171.

COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE

OTHER ADMIN. POLICY CHANGE NUMBER: 10

The CMS Interoperability and Patient Access final rule requires Medicaid managed care plans and CHIP managed care entities to comply with a members request to have their health data transferred from payer to payer by January 1, 2022. Given the federal mandate, this proposal results in a Proposition 30 impact where the non-federal share of costs for counties to come into compliance is split between counties and the state. Federal law already requires Medicaid managed care plans to comply with the data exchange standards and regulations, which includes various Medi-Cal programs including the Medi-Cal BHPs. The Department began verifying compliance for these requirements starting July 1, 2023.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase due to a shift in the start of payments from April 2024 to October 2024. Claims from FY 2023-24 are now expected to be paid in FY 2024-25 due to delays in county submissions.

The change in the current estimate, from FY 2024-25 to FY 2025-26, is due to FY 2024-25 including more prior year claims.

Methodology:
1. Assume reimbursements to counties for incurred expenses will begin in October 2024.

2. Total estimated costs, over several years, to implement interoperability final rule is estimated to be $151,523,000 TF ($43,202,000 GF).

3. The estimated payments in FY 2024-25 and FY 2025-26, on a cash basis, is as follows:

(Dollars in Thousands)

Interoperability Final Rule	TF	GF	FF	CF
FY 2024-25	$115,746	**$33,001**	**$49,744**	$33,001
FY 2025-26	$29,462	**$8,400**	**$12,662**	$8,400

Funding:
100% Title XIX FF (4260-101-0890)
100% General Fund (4260-101-0001)

CALAIM - POPULATION HEALTH MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 11
IMPLEMENTATION DATE: 7/2022
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 2288

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$77,831,000	$61,148,000
STATE FUNDS	$7,783,100	$6,114,800
FEDERAL FUNDS	$70,047,900	$55,033,200

Purpose:
This policy change estimates the cost for creating the Population Health Management (PHM) service under the California Advancing and Innovating Medi-Cal (CalAIM) policy.

Authority:
SB 129 (Chapter 69, Statutes of 2021)
AB 107 (Chapter 22, Statutes of 2024)

Interdependent Policy Changes:
Not applicable

Background:
In alignment with the CalAIM Population Health Management strategy, the Department implemented a Medi-Cal Population Health Management service that utilizes Medi-Cal administrative and clinical data and information for the Department, Managed Care Plans, counties, providers, members, and other Department partners to use in support of the delivery of care for all of Medi-Cal members. Information is available from many Medi-Cal delivery systems and programs, including but not limited to managed care, fee-for-service, specialty mental health, substance use disorder, dental services, long term services & supports, developmental disability services, in-home supportive services (IHSS), 1915c Waivers, Supplemental Nutrition Assistance Program (SNAP), Women, Infants, and Children (WIC), In Lieu of Services (ILOS), and Lab links. This service provides the Department and others with access to identifications of potential gaps in care, provider/care manager information, information on social determinates of health, population health analytics, health education, and tips for members. Additionally, the service provides Medi-Cal members with access to their administrative and clinical information, as appropriate. Clinical data will phase in over time.

Throughout the Medi-Cal program many of the services provided are provided and maintained through individual administrative functions and there is not currently a single process to bring these services together and provide a holistic approach to delivering Medi-Cal to Californians.

Population Health Management provides a service to access necessary information for many different parties and utilizing standard policies. The service will limit the burden on Medi-Cal members when receiving services and support many programs in Medi-Cal through a standardized approach. Additionally, this service with allow the Department to have an elevated view of the care provided to Medi-Cal members.

Reason for Change:

CALAIM - POPULATION HEALTH MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 11

The change from the prior estimate, for FY 2024-25, is an increase due to a modified payment schedule. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due to the projected deliverables and activities associated with the contract.

Methodology:

1. The Budget Act for 2021-22 provided $30 million from the General Fund and $270 million in federal funds for this service, available to be spent through June 30, 2024. AB 107 reappropriated $19 million for expenditure through June 30, 2025. The Department is requesting an extension for expenditure through June 30, 2026. The table below displays the estimated spending and remaining funds by Appropriation Year:

	TF	GF	FF
Appropriation Year 2021-22			
Estimated in FY 2023-24	$52,670,000	$5,267,000	$47,403,000
Estimated in FY 2024-25	$77,831,000	$7,783,000	$70,048,000
Estimated in FY 2025-26	$61,148,000	$6,115,000	$55,033,000
Total Estimated Remaining	**$108,350,000**	**$10,835,000**	**$97,515,000**

2. On a cash basis, costs for the procurement of this service and initial implementation cost assumed for the vendor are estimated to be:

Fiscal Year	TF	GF	FF
FY 2024-25	**$77,831,000**	**$7,783,000**	**$70,048,000**
FY 2025-26	**$61,148,000**	**$6,115,000**	**$55,033,000**

Funding:

90% Title XIX / 10% GF (4260-101-0001/0890)

OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 12
IMPLEMENTATION DATE: 1/2013
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 1748

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$63,066,000	$58,784,000
STATE FUNDS	$31,571,600	$29,398,600
FEDERAL FUNDS	$31,494,400	$29,385,400

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), Medi-Cal special populations, and Hearing Aid Coverage for Children Program (HACCP).

Authority:
AB 1494 (Chapter 28, Statutes of 2012)
AB 89 (Chapter 7, Statutes of 2020)
AB 179 (Chapter 249, Statutes of 2022)
Health Services Advisory Group, Inc. Contract 20-10359
Maximus Contract 12-89315 A12
SB 1019 (Chapter 879, Statues of 2022)

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2013, the Managed Risk Medical Insurance Board (MRMIB) contracted with MAXIMUS for Single Point of Entry (SPE) application services and other administrative vendor services for the Healthy Families Program (HFP), Access for Infants and Mothers (AIM), and Child Health and Disability Prevention (CHDP) Gateway.

HFP subscribers began transitioning into Medi-Cal as OTLICP starting January 1, 2013. Completed applications were sent to the SPE for screening and forwarded to the county welfare departments (CWD) for a Medi-Cal eligibility determination for the children's percent programs or to the new OTLICP.

The AIM infants above 250% of the federal poverty level began transitioning into Medi-Cal Access Infants Program beginning November 1, 2013, through February 1, 2014. The AIM Program was transitioned from MRMIB to the Department as of July 1, 2014, and renamed MCAP.

The Department instructed MAXIMUS to close out SPE for HFP and CHDP Gateway effective January 1, 2014, and to refer applicants to the application portal and toll-free line to Covered California. MAXIMUS completed the shutdown process in FY 2013-14.

OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 12

Effective July 1, 2014, all MRMIB programs, including the MAXIMUS contract, transitioned to the Department. Since the transition, MAXIMUS has provided administrative vendor services for MCAP and OTLICP. Due to application availability in the community, MAXIMUS forwards any HFP applications it receives to the appropriate CWDs for a determination without the benefit of screening for accelerated enrollment.

The Department transitioned the HFP and Children's Health Insurance Program (CHIP) into the Medi-Cal program in September 2013. The Title XXI CHIP program requires the State to contract with an External Quality Review Organization (EQRO) to validate performance measures, evaluate performance improvement projects, conduct focus studies, monitor encounter data activities, conduct an annual survey, and perform other EQRO activities for the duration of the contract. In July 2014, the Department became responsible for having the EQRO conduct the annual survey and other EQRO activities under the terms of the contract. Effective January 1, 2024, the EQRO contract was updated to account for additional projects and activities.

Administrative vendor services include costs for the following services: application processing, call center rate per minute, transaction forwarding fee, processing letters and notices, printing and courier fees, and implementation costs. Effective January 2017, administrative costs include publication costs for Medi-Cal special populations. Publication costs include developing, editing, updating, and performing readability evaluation of member materials as well as translation, printing, mailing, shipping, and focus group testing services that were previously budgeted in the HCO Cost Reimbursement policy change. Per AB 128 (Chapter 21, Statutes of 2021), the Department will look to include contract support to conduct field testing of Medi-Cal materials into other threshold languages for cultural accuracy and appropriateness.

Effective October 1, 2019, the Department transitioned the administrative functions for the County Children Health Initiative Program (CCHIP) to the state's administrative vendor, MAXIMUS. These administrative functions include case management and premium collection for CCHIP. The additional costs for the increased scope of work are budgeted through the current MAXIMUS contract through this policy change.

Effective July 1, 2021, AB 89 (Chapter 7, Statutes of 2020) authorized the HACCP. This new state-only program serves California children who are not eligible for Medi-Cal and/or hearing-related coverage through California Children's Services Program (CCS) and live in a household with income up to 600% of the federal poverty level. HACCP was initially available to children under 18 without insurance or whose insurance does not cover hearing aids and related services. Effective January 1, 2023, AB 179 (Chapter 249, Statutes of 2022) expanded the age criteria for HACCP to children under the age of 21, and broadened coverage to children who had other insurance with coverage of $1,500 or less for hearing aids. Effective July 1, 2021, the Department awarded a Non-Competitive Bid to the existing vendor to administer this program.

The MAXIMUS contract was amended to remove premium collection services due to SB 184 (Omnibus Health Bill 2022), which authorized the Department to reduce premiums for Medi-Cal programs to zero.

Effective January 1, 2024, the Department transitioned to an updated Managed Care Plan landscape, impacting External Quality Review projects and activities due to changes in the reporting unit structure. This transition supports the CMS Protocol 4: Network Adequacy Validation across all plans, and incorporates SB 1019 requirements, which are aimed at addressing the historically low utilization of Medi-Cal Non-Specialty Mental Health Services.

OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 12

Reason for Change:
The change in FY 2024-25, from the prior estimate, is an increase due to higher contract costs associated with public health emergency (PHE) continuous coverage unwinding efforts. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due to a projected reduction in contract costs for FY 2025-26 as PHE continuous coverage unwinding efforts taper off.

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 65/35 FMAP, and Title XIX 50/50 FMAP. The EQRO contract cost is eligible for Title XIX 50/50 FMAP only. The HACCP costs are eligible for 100% GF.

2. Administrative vendor services costs are eligible for Title XIX 50/50 FMAP.

3. Contract costs and administrative vendor service costs by program are as follows:

(Dollars in Thousands)

Program	FY 2024-25	FY 2025-26
OTLICP	$24,959	$23,262
MCAP	$5,367	$5,138
CCHIP	$4,418	$4,241
HACCP	$3,406	$3,144

4. Contract costs and administrative vendor service costs by cost category are as follows:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
Applications Processing, Printing and Courier Services, Letters and Notices, Transaction Forwarding Fee	$14,223	$7,112	$7,111
Call Minute Rate per Minute	$2,995	$1,497	$1,498
Contract Costs	$15,526	$6,099	$9,427
Hearing Aid Coverage for Children Program	$3,406	$3,406	$0
Implementation Costs	$2,000	$1,000	$1,000
Medi-Cal Publications	$24,916	$12,458	$12,458
Total	**$63,066**	**$31,572**	**$31,494**

OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 12

FY 2025-26	TF	GF	FF
Applications Processing, Printing and Courier Services, Letters and Notices, Transaction Forwarding Fee	$13,011	$6,505	$6,506
Call Minute Rate per Minute	$2,764	$1,382	$1,382
Contract Costs	$14,866	$5,867	$8,999
Hearing Aid Coverage for Children Program	$3,144	$3,144	$0
Implementation Costs	$2,000	$1,000	$1,000
Medi-Cal Publications	$22,999	$11,500	$11,499
Total	**$58,784**	**$29,398**	**$29,386**

* Totals may differ due to rounding.

Funding:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890/0001)	$48,564	$24,282	$24,282
65% Title XXI / 35% GF (4260-101-0890/0001)	$11,096	$3,884	$7,212
100% GF (4260-101-0001)	$3,406	$3,406	$0
Total	**$63,066**	**$31,572**	**$31,494**

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890/0001)	$45,204	$22,602	$22,602
65% Title XXI / 35% GF (4260-101-0890/0001)	$10,436	$3,653	$6,783
100% GF (4260-101-0001)	$3,144	$3,144	$0
Total	**$58,784**	**$29,398**	**$29,386**

* Totals may differ due to rounding.

SMH MAA

OTHER ADMIN. POLICY CHANGE NUMBER: 13
IMPLEMENTATION DATE: 7/2012
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1722

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$60,944,000	$53,425,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$60,944,000	$53,425,000

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 MAA 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 in FY 2024-25, from the prior estimate, is due to an update in the forecast for future claims. FY 2022-23 had lower amounts in claiming which leads to a decrease in projections.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to an increase based on projected increases in claiming in FY 2025-26.

Methodology:
1. County MHPs submit claims for reimbursement on a quarterly basis. In line with Short Doyle claiming deadlines, SMH MAA claims may be submitted up to one year after the close of a quarter.

2. Estimates for SMH MAA is based on nine years of actual claims data (from FY 2014-15 to FY 2022-23) and then projected out to future fiscal years using Excel's forecast model, which uses exponential smoothing.

3. Based on data, the expected reduction in claiming for Unsatisfactory Immigration Status (UIS) population members is now part of the forecast model in the estimate.

SMH MAA
OTHER ADMIN. POLICY CHANGE NUMBER: 13

4. This policy change will continue to use the current Certified Public Expenditure methodology and will not be included in the Intergovernmental Transfer methodology being implemented for the California Advancing and Innovating Medi-Cal (CalAIM).

5. Based on the updated claims deadlines, beginning for FY 2023-24 claims, assume 25% of claims will be paid in the year services occur (year one), 50% are paid in the following year (year two), and 25% are paid in the following year after that (year 3).

(Dollars in Thousands)

Fiscal Years	Accrual	FY 2024-25	FY 2025-26
2022-23	$81,745	$40,938	$0
2023-24	$90,780	$45,390	$22,695
2024-25	$96,918	$24,230	$48,459
2025-26	$103,056	$0	$25,764
Total	$372,499	$110,558	$96,918

*Totals may differ due to rounding

6. The 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 2021-22 and FY 2022-23, assume 20.50% of costs are eligible for 75% reimbursement and the remaining 79.50% are eligible for 50% reimbursement. SMH MAA total expenditures are shared between federal funds (FF) and county funds (CF).

(Dollars in Thousands)

	FY 2024-25			FY 2025-26		
Expenditures	**TF**	**FF**	**CF**	**TF**	**FF**	**CF**
SPMP (75/25)	$22,660	$16,995	$5,665	$19,864	$14,898	$4,966
Other (50/50)	$87,898	$43,949	$43,949	$77,054	$38,527	$38,527
Total	$110,558	**$60,944**	$49,614	$96,918	**$53,425**	$43,493

*Totals may differ due to rounding

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

DRUG MEDI-CAL COUNTY ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER: 14
IMPLEMENTATION DATE: 7/2014
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 1813

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$57,794,000	$65,734,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$57,794,000	$65,734,000

Purpose:
This policy change estimates the administrative costs reimbursements for counties who provide Drug Medi-Cal (DMC) services, and 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)
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.

On August 13, 2015, the Department received approval from the Centers for Medicare and Medicaid Services (CMS) to implement the DMC-ODS waiver.

DMC County Administrative Costs
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. Costs are limited to a maximum of 15% of services provided. This process is optional for participating counties.

DRUG MEDI-CAL COUNTY ADMINISTRATION
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- 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.

DMC County UR and QA Administrative Costs

DMC-ODS waiver services include the existing treatment modalities (ODF, IOT, NTP, and Perinatal RTS), and the additional new and expanded services. Participation in the waiver is voluntary for counties and implementation is estimated on a phase-in basis beginning February 2017. Counties that opt-in to participate in the DMC-ODS waiver may also opt-in to implement UR and QA activities to safeguard against unnecessary and inappropriate medical care and expenses. Federal funds (FF) reimbursement for these costs is available at 75% for skilled professional medical personnel (SPMP) and 50% for all other personnel.

Reason for Change:

The change in FY 2024-25, from the prior estimate, is a net decrease due to the following:

- Updated annual projections for DMC county administration and UR and QA claims based on actual data through FY 2021-22;
- FY 2015-16 and FY 2016-17 annual settlement claims, originally forecasted to be paid in FY 2023-24, shifting to FY 2024-25; and
- FY 2019-20 annual settlement claims are now expected to be paid in FY 2025-26.

The change in the current estimate, from FY 2024-25 to FY 2025-26, is an increase due to:

- A higher percentage of county administration and UR and QA claims processed in the second year;
- Including increased FY 2025-26 annual projections for county administration and UR and QA claims; and
- All FY 2019-20 annual settlement claims are estimated to be paid in FY 2025-26.

Methodology:

1. DMC county administration and UR and QA administration expenditures are split between Federal, State and County Funds (CF).

2. UR and QA costs for SPMP will receive enhanced federal reimbursement of 75%. All other personnel will receive 50% federal reimbursement.

3. For counties that submit claims annually, assume claims will be submitted and paid during interim cost settlement.

DRUG MEDI-CAL COUNTY ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER: 14

4. The estimated DMC county administration, annual settlement, and UR and QA administration costs for FY 2024-25 and FY 2025-26 are:

(Dollars in Thousands)

DMC County Admin.	Accrual	FY 2024-25	FY 2025-26
FY 2022-23 Claims	$17,530	$1,753	$0
FY 2023-24 Claims	$18,938	$9,942	$1,894
FY 2024-25 Claims	$20,347	$7,630	$10,682
FY 2025-26 Claims	$22,769	$0	$8,538
Total		$19,325	$21,114

(Dollars in Thousands)

Annual Settlements	Accrual	FY 2024-25	FY 2025-26
FY 2015-16 Claims	$19,393	$11,636	$0
FY 2016-17 Claims	$23,773	$14,264	$0
FY 2017-18 Claims	$17,992	$8,838	$9,154
FY 2018-19 Claims	$27,350	$11,996	$15,354
FY 2019-20 Claims	$28,811	$0	$28,811
Total		$46,734	$53,319

(Dollars in Thousands)

DMC UR and QA Admin.	Accrual	FY 2024-25	FY 2025-26
FY 2022-23 Claims	$26,355	$2,635	$0
FY 2023-24 Claims	$34,966	$18,357	$3,497
FY 2024-25 Claims	$40,075	$15,028	$21,039
FY 2025-26 Claims	$45,185	$0	$16,944
Total		$36,020	$41,480

(Dollars in Thousands)

FY 2024-25	TF	FF	CF
County Administration	$19,325	$9,663	$9,662
UR and QA Administration	$36,020	$24,764	$11,256
Annual Settlements	$46,734	$23,367	$23,367
Total	$102,079	**$57,794**	$44,285

(Dollars in Thousands)

FY 2025-26	TF	FF	CF
County Administration	$21,114	$10,557	$10,557
UR and QA Administration	$41,480	$28,517	$12,963
Annual Settlements	$53,319	$26,660	$26,659
Total	$115,913	**$65,734**	$50,179

DRUG MEDI-CAL COUNTY ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER: 14

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

BHSF - PROVIDER ACES TRAININGS

OTHER ADMIN. POLICY CHANGE NUMBER: 15
IMPLEMENTATION DATE: 9/2022
ANALYST: Whitney Li
FISCAL REFERENCE NUMBER: 2414

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$44,780,000	$5,415,000
STATE FUNDS	$22,390,000	$2,708,000
FEDERAL FUNDS	$22,390,000	$2,707,000

Purpose:
This policy change estimates the cost to train providers on delivering Adverse Childhood Experiences (ACEs) screenings funded with Behavioral Health Services Funds (BHSF).

Authority:
Budget Act of 2022 [AB 178 (Chapter 45, Statutes of 2022)]
Budget Act of 2023 [AB 102 (Chapter 38, Statutes of 2023)]
Budget Act of 2024 [AB 107 (Chapter 22, Statutes of 2024)]

Interdependent Policy Changes:
Not Applicable

Background:
Effective July 1, 2022, the Department was approved to extend funding for provider trainings for ACEs screenings using available BHSF. A total of $135.1 million TF ($67.55 million BHSF) was estimated over a three-year period with $44.1 million TF ($22.05 million BHSF) in FY 2022-23, $45.5 million TF ($22.75 BHSF) in FY 2023-24, and $45.5 million TF ($22.75 million BHSF) in FY 2024-25.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to a decrease in the estimated expenditures from the 2024-25 allocation in FY 2024-25.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to budgeting only the remaining available funds from the 2024-25 allocation in FY 2025-26.

BHSF - PROVIDER ACES TRAININGS

OTHER ADMIN. POLICY CHANGE NUMBER: 15

Methodology:

1. The table below displays the estimated spending and remaining funds by Appropriation Year.

	TF	BHSF	FF*
Appropriation Year 2022-23	$44,100,000	$22,050,000	$22,050,000
Prior Years	$44,100,000	$22,050,000	$22,050,000
Total Estimated Remaining	$0	$0	$0
Appropriation Year 2023-24	$45,500,000	$22,750,000	$22,750,000
Prior Years	$40,805,000	$20,402,000	$20,403,000
Estimated in FY 2024-25	$4,695,000	$2,348,000	$2,347,000
Estimated in FY 2025-26	$0	$0	$0
Total Estimated Remaining	$0	$0	$0
Appropriation Year 2024-25	$45,500,000	$22,750,000	$22,750,000
Estimated in FY 2024-25	$40,085,000	$20,042,000	$20,043,000
Estimated in FY 2025-26	$5,415,000	$2,708,000	$2,707,000
Total Estimated Remaining	$0	$0	$0

2. The provider trainings costs, funded with BHSF, are estimated to be $44,780,000 TF ($22,390,000 SF) in FY 2024-25 and $5,415,000 TF ($2,708,000 SF) in FY 2025-26.

FY 2024-25	TF	BHSF	FF*
Appropriation Year 2023-24	$4,695,000	$2,348,000	$2,347,000
Appropriation Year 2024-25	$40,085,000	$20,042,000	$20,043,000
Total FY 2024-25	**$44,780,000**	**$22,390,000**	**$22,390,000**

*Federal funds authority is newly requested for the fiscal year in which funds are anticipated to be expended.

FY 2025-26	TF	BHSF	FF*
Appropriation Year 2024-25	$5,415,000	$2,708,000	$2,707,000
Total FY 2025-26	**$5,415,000**	**$2,708,000**	**$2,707,000**

Funding:

Behavioral Health Services Fund (4260-101-3085)
100% Title XIX (4260-101-0890)

ENTERPRISE DATA ENVIRONMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 16
IMPLEMENTATION DATE: 7/2002
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 252

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$39,250,000	$37,902,000
STATE FUNDS	$10,498,600	$9,979,700
FEDERAL FUNDS	$28,751,400	$27,922,300

Purpose:
The policy change estimates the contract costs associated with the Enterprise Data Environment (EDE). EDE includes the Management Information System/Decision Support System (MIS/DSS), Management Administration Reporting Subsystem (MARS), Surveillance Utilization Reporting System (SURS), Data Warehouse Maintenance and Operations (M&O), and Data Warehouse Digital Support Services (Data Warehouse DSS).

Authority:
Contract #14-90129 A04
Contract # 21-10284
Centers for Medicare & Medicaid Services (CMS) Transformed Medicaid Statistical Information System (T-MSIS) Requirements

Interdependent Policy Changes:
Not Applicable

Background:
EDE manages the Data Warehouse, which hosts a variety of Medicaid-related data and makes it available for various programmatic uses. MIS/DSS, MARS, and SURS are critical components of gathering the insight necessary to make recommendations, adjust strategic initiatives, and better capture revenue. Data is a critical component of good decision-making, and good decision-making comes from comprehensive reporting, effective analytics, and subsequent implementation.

These systems are used by more than 20 different areas within the Department (i.e., Audits & Investigations, Managed Care Operations, Pharmacy Benefits, Provider Enrollment, Integrated Systems of Care, Third Party Liability and Recovery, and Accounting), several other State departments, such as the California Department of Public Health and the Department of Justice, and other approved entities. The Department uses these systems in various ways, including:

- CMS Reporting
- The Managed Care Quality and Monitoring 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.

ENTERPRISE DATA ENVIRONMENT
OTHER ADMIN. POLICY CHANGE NUMBER: 16

Ongoing M&O are accomplished through a multi-year contract. This contract includes M&O of the data warehouse, help desk support, training, and refreshing of hardware and software to maintain peak performance.

The SURS subsystem was implemented on April 3, 2017, and the MARS subsystem was implemented on February 15, 2019. CMS requires implemented projects to be funded at 50%/ 50% Federal Medical Assistance Percentage until certified. Both systems received certification on August 31, 2020. The systems are now receiving enhanced funding of 75%/25%.

The primary contract with Optum (MIS/DSS, MARS, and SURS) will expire on June 30, 2025. Amendment 4 addresses mandatory mission-critical state and federal requirements that influence the volume and complexity of data to be stored in the warehouse. The increased data will accommodate larger operational data loads, which satisfy T-MSIS requirements now mandated by CMS.

Reason for Change:
The change from the prior estimate, for FY 2024 25, is an increase due to updated actuals, adjusted projection calculations, and the addition of a new Teradata contract. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due to the completion of vendor turnover/takeover activities.

Methodology:
1. Optum contract (MIS/DSS, MARS, and SURS) will end on June 30, 2025.

2. The Department is working to procure a new Data Warehouse M&O contract to take over support of the current data environment and transition the existing workload supported by the expiring contract for EDE. This will result in a seven-month transition takeover period during which both contracts will be in place.

3. The Department is currently working to procure a new Data Warehouse DSS contract to provide product management, technical management, and business management services to EDE in support of the product owners and product managers' responsibilities. There are three one-year optional contract extensions.

4. The Department is currently working to procure hardware, software, licenses, and subscription to support the Data Warehouse. The responsibility of all the hardware and software management for the Data Warehouse will gradually transition by July 2025.

5. The estimated breakdown of the SURS, MARS, MIS/DSS, Data Warehouse M&O, and Data Warehouse DSS costs are:

ENTERPRISE DATA ENVIRONMENT
OTHER ADMIN. POLICY CHANGE NUMBER: 16

Subsystem	FY 2024-25	FY 2025-26
SURS Operational Costs (75%/25%)	$7,653,000	$525,000
MARS Operational Costs (75%/25%)	$2,636,000	$171,000
MIS/DSS Operational Costs (75%/25%)	$16,414,000	$13,563,000
MIS/DSS Operational Costs (50%/50%)	$757,000	$63,000
Data Warehouse Operational Costs (75%/25%)	$9,500,000	$19,000,000
Data Warehouse DSS Operational Costs (75%/25%)	$2,290,000	$4,580,000
Total	**$39,250,000**	**$37,902,000**

6. The estimated breakdown of the SURS, MARS, MIS/DSS, Data Warehouse M&O, and Data Warehouse DSS costs are:

SURS, MARS, MIS/DSS, Data Warehouse M&O, and Data Warehouse DSS	TF	GF	FF
Operational Costs (75%/25%)	$34,875,000	$8,719,000	$26,156,000
Operational Costs (65%/35%)	$3,411,000	$1,194,000	$2,217,000
100% State Fund	$208,000	$208,000	$0
Total FY 2024-25	**$39,250,000**	**$10,499,000**	**$28,751,000**

SURS, MARS, MIS/DSS, Data Warehouse M&O, and Data Warehouse DSS	TF	GF	FF
Operational Costs (75%/25%)	$34,282,000	$8,571,000	$25,711,000
Operational Costs (65%/35%)	$3,352,000	$1,173,000	$2,179,000
Operational Costs (50%/50%)	$64,000	$32,000	$32,000
100% State Fund	$204,000	$204,000	$0
Total FY 2025-26	**$37,902,000**	**$9,980,000**	**$27,922,000**

Funding:
50% Title XIX / 50% GF (4260-101-0890/0001)
75% Title XIX / 25% GF (4260-101-0890/0001)
65% Title XXI / 35% GF (4260-101-0890/0001)
100% GF (4260-101-0001)

POSTAGE & PRINTING

OTHER ADMIN. POLICY CHANGE NUMBER: 17
IMPLEMENTATION DATE: 7/1993
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 231

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$38,763,000	$38,763,000
STATE FUNDS	$19,510,000	$19,510,000
FEDERAL FUNDS	$19,253,000	$19,253,000

Purpose:
This policy change budgets postage and printing costs for items sent to or used by Medi-Cal members.

Authority:
Welfare & Institutions Code 14103.6, 14124.5, and 10725
Title 42, Code of Federal Regulations (CFR), Section 435.905
Title 45, Code of Federal Regulations (CFR), Section 164.520
Title 26, Code of Federal Regulations (CFR), Section 1.6055
California Revenue and Tax Code § 61005

Interdependent Policy Changes:
Not Applicable

Background:
Costs for mailing 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 member household explaining the rights of members 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 members 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, Third Party Liability (TPL) notices, and Public Assistance Reporting Information System are included in this item. IRS Form 1095-B is mailed by the Department to serve as proof of insurance for members enrolled in Medi-Cal and required to report their health insurance coverage to the Internal Revenue Service (IRS) and the Franchise Tax Board (FTB). The NFRA is a letter that the Department sends to members whose record contains inconsistent information that prevents it from being accepted by the IRS. This item also includes additional costs for printing, storage, and mailing of important Department publications and applications to counties and members on request.

POSTAGE & PRINTING
OTHER ADMIN. POLICY CHANGE NUMBER: 17

Medi-Cal members receive health care services from medical or pharmacy providers enrolled in the Medi-Cal program. Providers must receive authorization from Medi-Cal in order to provide and/or be paid for some of these services. The form a provider uses to request authorization is called a Treatment Authorization Request (TAR).

Postage and printing costs for notices and letters for the State-funded component of the BCCTP and the printing of EITC notices are 100% general fund (GF). Costs associated with IRS Form 1095-B are 50% GF and 50% federal fund.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase due to an increase in postage costs for 1095-B mailings. There is no change from FY 2024-25 to FY 2025-26 in the current estimate.

Methodology:
1. Based on actuals, the reported population receiving Form 1095-B mailings for FY 2024-25 and FY 2025-26 is assumed to be 14,510,000.

2. Assume that the cost per mailing is $1.14:

   14,510,000 mailings x $1.14 per mailing = $16,541,000 (rounded)

3. Based on FY 2023-24 actuals, assume that 3% of 1095-B forms are resent due to member request for reprints or for corrected 1095-Bs. The cost to send a reprint/correction is $1.14 per unit.

   3% x 14,510,000 mailings = 435,300 returned mailings

   435,300 returned mailings x $1.14 per unit = $496,000 (rounded)

4. Assume that NFRAs are sent to members for IRS reported errors found on Form 1095-B. The cost to process the Form 1095-B notices is $1.14 per unit. Assume 128,000 mailers will be sent out to members for FY 2024-25 and FY 2025-26.

   128,000 mailings x $1.14 per mailing = $146,000 (rounded)

5. TAR postage costs for Medi-Cal are assumed to be $80,000 for FY 2024-25 and FY 2025-26.

6. Office of State Publishing costs for printing Family Planning, Access, Care, and Treatment program brochures are assumed to be $150,000 in FY 2024-25 and FY 2025-26.

7. The Department estimates the printing and postage costs for FY 2024-25 and FY 2025-26 are:

POSTAGE & PRINTING

OTHER ADMIN. POLICY CHANGE NUMBER: 17

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
Base Mass Mailing	$18,900	$9,579	$9,321
1095B			
1095 Mailings	$16,541	$8,271	$8,270
Reprinted/Corrected Form 1095-B	$496	$248	$248
Notice for Requested Action	$146	$73	$73
1095 B Subtotal	$17,183	$8,592	$8,591
Emergency Mailings	$2,600	$1,300	$1,300
TAR Postage	$80	$40	$40
Total	**$38,763**	**$19,511**	**$19,252**
FY 2025-26	**TF**	**GF**	**FF**
Base Mass Mailing	$18,900	$9,579	$9,321
1095B			
1095 Mailings	$16,541	$8,271	$8,270
Reprinted/Corrected Form 1095-B	$496	$248	$248
Notice for Requested Action	$146	$73	$73
1095 B Subtotal	$17,183	$8,592	$8,591
Emergency Mailings	$2,600	$1,300	$1,300
TAR Postage	$80	$40	$40
Total	**$38,763**	**$19,511**	**$19,252**

*Totals may differ due to rounding.

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

ACTUARIAL COSTS FOR RATE DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 18
IMPLEMENTATION DATE: 8/2015
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1937

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$37,275,000	$41,000,000
STATE FUNDS	$18,637,500	$20,500,000
FEDERAL FUNDS	$18,637,500	$20,500,000

Purpose:
This policy change estimates the costs for contracted actuarial rate development services and actuarial consulting for litigation related services.

Authority:
Welfare & Institutions Code 14301.1
Title 42, Code of Federal Regulations 438.4

Interdependent Policy Changes:
Not Applicable

Background:
Federal requirements for obtaining federal financial participation require that managed care capitation rates be actuarially sound. Actuarially sound capitation rates require:

- Having been developed in accordance with standards specified in Title 42, Code of Federal Regulations (CFR) 438.5, and generally accepted actuarial principles and practices,
- Being appropriate for the populations to be covered and the services to be furnished under the contract, and
- Being certified by an actuary as meeting applicable federal requirements specified in Title 42 CFR 438.4.

The Department entered into a contract with an actuarial services consultant to ensure development of actuarially sound capitation rates.

Due to legislation implementing changes to the Medi-Cal program, the Department continues to experience litigation cases. 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 2024-25. The change from FY 2024-25 to FY 2025-26 in the current estimate, is an increase, due to increased actuarial workload related to the implementation of complex programs and policies necessitating more advanced analysis and additional resources.

ACTUARIAL COSTS FOR RATE DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 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.

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 Hospital Quality Assurance Fee (HQAF) program and Consulting Actuaries costs; however, ongoing actuarial services are needed as these, and other new programs are integrated into the overall managed care delivery system rate setting process.

5. Actuarial costs related to the AB 1705 GEMT Public Provider IGT Program are paid using State GF, but supported by a 10% administrative fee that applies to AB 1705 IGT collections. These amounts are captured in Ongoing Actuarial Services.

6. The FY 2024-25 and FY 2025-26 amounts on an accrual basis are estimated to be:

Policy	FY 2024-25	FY 2025-26
Ongoing Actuarial Services	$35,700,000	$39,700,000
HQAF Program	$300,000	$300,000
Consulting Actuaries	$2,100,000	$2,100,000
Total	**$38,100,000**	**$42,100,000**

The FY 2024-25 and FY 2025-26 amounts on a cash basis are estimated to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	HQAF	FF
FY 2024-25	**$37,275**	**$18,488**	**$150**	**$18,638**
FY 2025-26	**$41,000**	**$20,350**	**$150**	**$20,500**

Funding:

50% Title XIX FF / 50% GF (4260-101-0890/0001)
Hospital Quality Assurance Revenue Fund (4260-611-3158)

MEDI-CAL RECOVERY CONTRACTS

OTHER ADMIN. POLICY CHANGE NUMBER: 19
IMPLEMENTATION DATE: 2/2008
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 1551

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$30,303,000	$32,745,000
STATE FUNDS	$7,575,750	$8,186,250
FEDERAL FUNDS	$22,727,250	$24,558,750

Purpose:
This policy change estimates the cost of third party liability contracts to identify and recover Medi-Cal expenditures from responsible third parties. The policy change also includes contracts for identification of private/group health coverage and the recovery of Medi-Cal expenditures, disability determinations, online database contracts to access public records, and data matches.

Authority:
Contracts:

Dept. of Industrial Relations (DIR) – Electronic Adjudication Management System (EAMS)	22-20079
DIR – Workers' Compensation Information System (WCIS)	19-96030
Department of Social Services (CDSS)	20-10026
Health Management Systems Inc. (HI)	18-95310 A03
RELX Inc.	23-30329

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, unless certain restrictions apply. The above contracts provide:

- Data matches between the Department's Medi-Cal member eligibility file and the carrier's policy holder/subscriber file,
- Identification of private/group health coverage and the recovery of Medi-Cal expenditures when the private/group health coverage is the primary payer,
- Online access to research database services for public records of Medi-Cal members,
- Access to disability determinations for applicants requesting an exemption from estate recovery claims on the basis of a disability, and
- Cost avoidance activities.

For contingency-based contracts, when such insurance is identified, the vendor retroactively bills the third party to recover Medi-Cal paid claims. Payment to the vendor is contingent upon recoveries, and may exceed the vendor's estimated recovery projections. Recoveries due to third party liability vendor activities are incorporated into the Base Recoveries policy change.

The Department awarded the Health Insurance contract (18-95310) to Health Management Systems, Inc. (HMS) with an effective date of December 1, 2018, and an expiration date of November 30, 2023.

MEDI-CAL RECOVERY CONTRACTS
OTHER ADMIN. POLICY CHANGE NUMBER: 19

On April 3, 2023, the Department obtained approval by the Centers for Medicare and Medicaid Services to extend the contract for an additional two years. The amended contract (18-95310 A03) runs through November 30, 2025. The contingency fee remains at 8.5 percent.

The Department has begun an Invitation for Proposal for a new contract term starting November 1, 2025, through November 30, 2030. The contractor and continency fee are unknown at this time; however, for the purposes of projections is assuming a stable contingency fee at 8.5 percent.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is a net increase due to:

- For the HMS – Health Insurance Contract, FY 2024-25 is anticipated to increase due to higher than projected recoveries for dental managed care plans, medical, and pharmacy. Home health recoveries are anticipated to begin in FY 2024-25. The newborn initiative recoveries are now projected to occur in FY 2025-26.
- For Online Database Contracts, the change from the prior estimate is due to an accounting delay of invoice payment for the DIR WCIS and EAMS contracts, which will now be paid in FY 2024-25. Additionally, corrections to CDSS's FY 2023-24 final invoice caused invoices for FY 2023-24 to be paid in FY 2024-25.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is a net increase due to:

- For the HMS – Health Insurance Contract, recoveries for Contract 18-95310 A03 are anticipated to increase as invoicing for closing out of contract 18-95310 A03 will coincide with invoicing for the new contract. This estimate assumes that recoveries and contingency fee will remain stable with a new contract beginning December 1, 2025.
- For Online Database Contracts, the change from FY 2024-25 to FY 2025-26 is due to no anticipated invoice delays in FY 2025-26.

MEDI-CAL RECOVERY CONTRACTS
OTHER ADMIN. POLICY CHANGE NUMBER: 19

Methodology:

1. The amounts paid to the HMS contractor for HI is contingent upon recoveries. Assume the following recoveries for each fiscal year at the contracted contingency fee percentage. The HI recovery contract was recently amended to extend the timeframe an additional two years. The term of this contract is from December 1, 2018, through November 30, 2025. Additional amounts for FY 2025-26 assume that the new HI contract will begin December 1, 2025, maintaining the previous contingency of 8.5%.

   Recoveries x Contingency Fee % = Total Contingency Fee

Contractor	FY 2024-25 Recoveries	FY 2025-26 Recoveries	Contingency Fee %	FY 2024-25 Contingency Fee	FY 2025-26 Contingency Fee
HMS 18A03	$356,000,000	$384,800,000	8.50%	$30,260,000	$32,708,000

2. The amounts paid to the Online Database contractors are either based upon usage or billed at a flat monthly rate:

Online Database Contracts	FY 2024-25	FY 2025-26
Department of Industrial Relations - EAMS	$9,500	$5,000
Department of Industrial Relations - WCIS	$500	$0
Department of Social Services	$5,000	$4,000
RELX Inc.	$28,000	$28,000
Total	$43,000	$37,000

3. The payments shown below include recent recovery activity.

FY 2024-25	TF	GF	FF
Health Insurance	$30,260,000	$7,565,000	$22,695,000
Online Database Contracts	$43,000	$11,000	$32,000
Total	**$30,303,000**	**$7,576,000**	**$22,727,000**

FY 2025-26	TF	GF	FF
Health Insurance	$32,708,000	$8,177,000	$24,531,000
Online Database Contracts	$37,000	$9,000	$28,000
Total	**$32,745,000**	**$8,186,000**	**$24,559,000**

Funding:
75% Title XIX / 25% GF (4260-101-0001/0890)

HCBA WAIVER ADMINISTRATIVE COST

OTHER ADMIN. POLICY CHANGE NUMBER: 20
IMPLEMENTATION DATE: 7/2019
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2152

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$21,612,000	$24,714,000
STATE FUNDS	$10,850,000	$12,407,000
FEDERAL FUNDS	$10,762,000	$12,307,000

Purpose:
This policy change estimates the administrative cost of the Home and Community-Based Alternatives (HCBA) Waiver.

Authority:
Welfare and Institutions Code, Section 14132.991

Interdependent Policy Changes:
Not Applicable

Background:
The HCBA waiver offers services in the home or community to Medi-Cal members 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 member'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.

On February 2, 2023, the Centers for Medicare & Medicaid Services (CMS) approved a HCBA Waiver for a new five-year term, from January 1, 2023, through December 31, 2027. The new waiver term includes phases in additional slots each Calendar Year, beginning on January 1, 2025. However, based on historical enrollment and attrition trends, it was determined that the waiver would reach capacity before the end of 2023. The Department submitted a waiver amendment to begin phasing in new slots on January 1, 2024; CMS approved the waiver amendment on December 11, 2023.

Although administrative payments will increase with higher enrollment into the waiver, the State will ultimately save funding with more members receiving services in a community setting instead of in an institution.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a slight decrease due to updating projections using more recent expenditure data through May 2024. The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to the growth trend in administrative costs.

Methodology:
1. Assume there are 9,046 members in the HCBA Waiver in FY 2023-24.

HCBA WAIVER ADMINISTRATIVE COST
OTHER ADMIN. POLICY CHANGE NUMBER: 20

2. Assume 1,284 new members will be enrolled in FY 2024-25 and in FY 2025-26.

3. Assume 100% of all current and new waiver members will enroll with a Waiver Agency and receive administrative services.

4. Assume the waiver administration costs include Waiver Agency reconciliation payments.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2024-25	$21,612	$10,850	$10,762
FY 2025-26	$24,714	$12,407	$12,307

*Totals may differ due to rounding.

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

EMSA - CALIFORNIA POISON CONTROL SYSTEM SVCS.

OTHER ADMIN. POLICY CHANGE NUMBER: 21
IMPLEMENTATION DATE: 2/2023
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 2402

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$21,573,000	$17,961,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$21,573,000	$17,961,000

Purpose:
This policy change estimates the federal match to the Emergency Medical Services Authority (EMSA) via an Interagency Agreement (IA) for providing services to Medi-Cal members offered by the California Poison Control System (CPCS).

Authority:
Interagency Agreement (IA) 19-96235
IA 24-40021

Interdependent Policy Changes:
Not Applicable

Background:
CPCS is a statewide network of health care professionals that provides free treatment advice and assistance to people over the telephone in case of exposure to poisonous or hazardous substances. CPCS, through a contract between EMSA and the University of California, San Francisco, manages more than 245,000 poison cases each year. CPCS reduces morbidity and mortality associated with harmful exposure and ingestions; it also decreases utilization of Emergency Medical Services (EMS) and emergency department resources. The population served includes everyone with any type of exposure, children and limited-resource populations benefit extensively. CPCS provides poison prevention help and information to the public and health professionals through a toll-free hotline that is accessible 24-hours per day, seven days a week. Calls received by CPCS include ingestion of potentially toxic products, potential allergic reactions to products, and over-the-counter medications.

Uninsured and Medi-Cal population uses constitute 21% and 20%, respectively, of the cases managed by CPCS. The Department and EMSA provides services for Medi-Cal members through utilization of Title XXI Social Security Act reimbursable services offered by the CPCS.

The Department has an IA with EMSA to provide the aforementioned services. The cost for such services may vary year to year. The current IA was executed in May 2021 and is effective from the start of FY 2019-20 through FY 2023-24. The Department is in the process of executing a new IA 24-40021 for FY 2024-25 through FY 2028-29. The Department draws down and passes through the Medicaid federal funds to EMSA. The non-federal share of the reimbursement is paid for by EMSA.

EMSA - CALIFORNIA POISON CONTROL SYSTEM SVCS.

OTHER ADMIN. POLICY CHANGE NUMBER: 21

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to updating the remaining FY 2023-24 payments based on actual invoice amounts and quarters received for FY 2023-24 and updated estimates for FY 2024-25 quarters based on the new contract amounts beginning in FY 2024-25.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to the FY 2025-26 estimates are projections based on the assumed new contract amounts while the FY 2024-25 estimate included amounts from actual invoices.

Methodology:
1. The Department provides Federal Financial Participation (FFP) reimbursements to EMSA based on invoices received in accordance with the signed IA.

2. Contracted annual expenditures are paid on a quarterly basis where three quarters are paid in the same fiscal year and the fourth quarter is paid in the following fiscal year.

3. On September 25, 2024, the Department approved a new contract beginning in FY 2024-25 through FY 2028-29 in the amount of $91.3 million.

4. It is assumed the payments to EMSA will be made as follows on a cash basis:

(Dollars in Thousands)

FY 2024-25	TF	FF
FY 2023-24 Q1-Q4	$8,412	$8,412
FY 2024-25 Q1-Q3	$13,161	$13,161
Total	**$21,573**	**$21,573**

(Dollars in Thousands)

FY 2025-26	TF	FF
FY 2024-25 Q4	$4,387	$4,387
FY 2025-26 Q1-Q3	$13,574	$13,574
Total	**$17,961**	**$17,961**

Funding:
100% Title XXI FF (4260-101-0890)

CAPMAN

OTHER ADMIN. POLICY CHANGE NUMBER: 22
IMPLEMENTATION DATE: 10/2012
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1318

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$20,100,000	$20,819,000
STATE FUNDS	$5,199,200	$5,326,450
FEDERAL FUNDS	$14,900,800	$15,492,550

Purpose:
This policy change estimates the contract costs to make improvements, maintain, and operate the existing Capitation Payment Reporting system (CAPMAN).

Authority:
Affordable Care Act (ACA) of 2010
AB 1602 (Chapter 655, Statutes of 2010)
SB 900 (Chapter 659, Statues of 2010)
CAPMAN Prime Vendor #22-20001
CAPMAN Support Services #23-30073
CAPMAN Discovery & Planning #23-30184

Interdependent Policy Changes:
Not Applicable

Background:
The Health Insurance Portability and Accountability Act (HIPAA) impose transaction requirements, including 5010 and Operating Rules. The CAPMAN system was implemented by the Department in July 2011. The HIPAA-compliant transaction automated and improved the capitation calculation process. CAPMAN allows detailed reporting at the member level while increasing the efficacy of monthly reconciliations and supporting research efforts to perform recoveries. In May 2019, a paperless accounting interface was implemented to interface between the Department's CAPMAN and the State Controller's Office (SCO).

Due to the ACA and the expansion of Medi-Cal Managed Care, the Department implemented additional functionalities in CAPMAN to accommodate the influx of new members. Modifications to the accounting interface were made to enhance the system to incorporate Electronic Funds Transfer (EFT). The paperless accounting interface increases the Department's efficiency. The system will be maintained on an ongoing basis, as new functionality is required.

The Department's administrative activities related to CAPMAN include the following contract and other related costs:

CAPMAN Prime Vendor Contracts
The CAPMAN Prime Vendor Contracts provides services, which include enhancements and maintenance needed to keep up with current technology, new federal and state mandates, and a paperless accounting interface. The contract is effective October 3, 2022, through October 2, 2027.

CAPMAN
OTHER ADMIN. POLICY CHANGE NUMBER: 22

CAPMAN Support Services:
The Support Services contract provides services in product management, infrastructure performance monitoring, and infrastructure services. The contract is effective October 12, 2023, through October 11, 2027.

Hardware/Software
Hardware/Software includes costs for licensed software used by the CAPMAN system and cloud infrastructure.

Discovery & Planning
The CAPMAN system requires planning for continuously increasing healthcare policies and populations to support complex growth. Discovery & Planning contract will provide technical, business, and solution expertise to evaluate the current and future Managed Care Capitation Payment business needs and the support technology system(s). The contract is effective November 4, 2024, through November 5, 2026, and includes one optional extension year.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a net increase due to adjusted projections and Edifecs software cost. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a net increase due to including a full year of contract-related expenditures for Discovery and Planning.

Methodology:
Total costs are estimated to be:

FY 2024-25	TF	GF	FF
CAPMAN Prime Vendor	$12,784,000	$3,361,000	$9,423,000
Support Services	$2,753,000	$724,000	$2,029,000
Hardware/Software	$3,933,000	$1,034,000	$2,899,000
Discovery & Planning	$630,000	$80,000	$550,000
Total	**$20,100,000**	**$5,199,000**	**$14,901,000**

FY 2025-26	TF	GF	FF
CAPMAN Prime Vendor	$12,802,000	$3,366,000	$9,436,000
Support Services	$3,004,000	$790,000	$2,214,000
Hardware/Software	$3,933,000	$1,034,000	$2,899,000
Discovery & Planning	$1,080,000	$137,000	$943,000
Total	**$20,819,000**	**$5,327,000**	**$15,492,000**

Funding:
90% HIPAA FF / 10% HIPAA Fund (4260-117-0001/0890)
75% HIPAA FF / 25% HIPAA Fund (4260-117-0001/0890)
65% Title XXI / 35% GF (4260-101-0001/0890)
100% State GF (4260-101-0001)

PAVE SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 23
IMPLEMENTATION DATE: 4/2016
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1932

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$17,168,000	$17,958,000
STATE FUNDS	$4,704,000	$4,894,600
FEDERAL FUNDS	$12,464,000	$13,063,400

Purpose:
This policy change estimates the costs for the ongoing maintenance and operations (M&O) of the Provider Application and Validation for Enrollment (PAVE) system.

Authority:
Title 42, Code of Federal Regulations 455 Subpart E – Provider Screening and Enrollment
Contract # 15-92256 A04

Interdependent Policy Changes:
Not Applicable

Background:
The Department deployed an enrollment portal and associated business process application to digitize provider management activities to comply with provider integrity mandates under the Affordable Care Act. Some of the requirements are:

- Monthly database checks on enrolled providers and associated entities that manage, own, or have a controlling interest;
- Enroll all ordering, referring, or prescribing providers that bill claims to Medi-Cal;
- Periodic checks of all enrolled providers against various exclusionary databases as well as the Social Security Death Master File; and
- Revalidation of all providers every five years.

PAVE entered the M&O phase in FY 2018-19. Beginning FY 2020-21, the Department requested funding to cover ongoing PAVE M&O costs. PAVE received certification on April 1, 2021, from the Centers for Medicare & Medicaid Services (CMS).

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase due to updated actuals and adjusted projections that include Provider Costs shifting from FY 2023-24 to FY 2024-25. The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to adjusted projection for Provider Costs.

Methodology:
1. The Department continues to add programs and benefits to PAVE on a phase-in basis with costs having begun in FY 2019-20. M&O costs continue to increase due to the inclusion of additional providers, which increases system volume and associated support activities.

PAVE SYSTEM
OTHER ADMIN. POLICY CHANGE NUMBER: 23

2. The Department received CMS certification in April 2021. This allows the M&O Federal Financial Participation (FFP) to be claimed at 75% FF / 25% GF on applicable Provider costs.

3. Funds are based on the monthly service fee associated with using the PAVE system, which is influenced by the number of providers in the system, the number of calls received in the call center, and other key metrics. With these numbers constantly increasing, the monthly rates continuously increase as more providers apply and are enrolled.

4. The FY 2024-25 and FY 2025-26 costs are as follows:

FY 2024-25	TF	GF	FF
Provider Cost	$16,364,000	$4,302,000	$12,062,000
Help Desk Cost	$804,000	$402,000	$402,000
Total	**$17,168,000**	**$4,704,000**	**$12,464,000**

FY 2025-26	TF	GF	FF
Provider Cost	$17,228,000	$4,529,000	$12,699,000
Help Desk Cost	$730,000	$365,000	$365,000
Total	**$17,958,000**	**$4,894,000**	**$13,064,000**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
75% Title XIX / 25% GF (4260-101-0001/0890)
100% GF (4260-101-0001)
100% Title XIX FFP (4260-101-0890)
65% Title XXI / 35% GF (4260-101-0001/0890)

MITA

OTHER ADMIN. POLICY CHANGE NUMBER: 24
IMPLEMENTATION DATE: 1/2011
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1137

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$16,744,000	$34,051,000
STATE FUNDS	$2,126,400	$4,324,950
FEDERAL FUNDS	$14,617,600	$29,726,050

Purpose:
This policy change estimates the costs associated with the Medicaid Information Technology Architecture (MITA) initiative sponsored by Centers for Medicare & Medicaid Services (CMS).

Authority:
42 Code of Federal Regulations 433.112(b) 11
42 Code of Federal Regulations 495.332(a) (2)
45 Code of Federal Regulations 95-626(b)
Interagency Agreement (IA) 23-30074
Contract # 21-10069
Contract # 21-10311
Contract # 21-10331 A1
Contract # 21-10021
Contract #22-20441
Contract #23-30386
Contract #22-20386

Interdependent Policy Changes:
Not Applicable

Background:
CMS requires the Department to create flexible systems, which support interactions between the federal government and their state partners. Through MITA, the Department develops the ability to streamline the process to access information from various systems, which 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 takes steps to achieve the maturity goals of the MITA Framework and focus strategic planning, system changes, and modernization around Department-wide business processes and enterprise organizational change management rather than focusing on separate program needs. These steps prevent the Department from potentially duplicating efforts regarding hardware, software, and resources across the enterprise.

This Enterprise MITA support services 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 also allows the Department to react to federal and state

MITA
OTHER ADMIN. POLICY CHANGE NUMBER: 24

laws more quickly and accurately. Additionally, the Department is 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 required by CMS, which includes a State MITA roadmap. Additionally, CMS requires Medi-Cal Enterprise Systems Certification in order to approve ongoing enhanced funding.

Integral in the Department's MITA governance is the Portfolio Management tool, which houses MITA data/roadmap information, and overall facilitates the Department's project portfolio and governance process.

Pursuant to an IA with the Regents of the University of California, San Diego (UCSD), an analyst and programmer provides support for data management and analytics to assist the Department in reaching MITA maturity.

MITA planning activities to improve provider management information occur and assess efforts necessary for a consolidated provider data repository, improving consumer-facing provider directories, and collecting provider network information from behavioral health and managed care dental plans.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a decrease due to updated actuals and delayed contract start and payment dates. The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to adjusted projections and a full year of expenditures for new MITA contracts.

Methodology:
1. FY 2024-25 and FY 2025-26 contract amounts are associated with the MITA initiative throughout the Department in order to meet federal regulations and guidelines.

2. FY 2024-25 and FY 2025-26 include the cost of the MITA support services and UCSD IA estimates.

3. The projected FY 2024-25 and FY 2025-26 costs are:

FY 2024-25	APD	TF	GF	FF
Enterprise MITA Support Services	MITA	$11,616,000	$1,476,000	$10,140,000
UCSD IA	MITA	$542,000	$69,000	$473,000
Enterprise Certification Support Services	MITA	$4,324,000	$549,000	$3,775,000
Provider Management	PROV.	$262,000	$33,000	$229,000
Total		**$16,744,000**	**$2,127,000**	**$14,617,000**

MITA

OTHER ADMIN. POLICY CHANGE NUMBER: 24

FY 2025-26	APD	TF	GF	FF
Enterprise MITA Support Services	MITA	$28,670,000	$3,642,000	$25,028,000
UCSD IA	MITA	$542,000	$69,000	$473,000
Enterprise Certification Support Services	MITA	$4,577,000	$581,000	$3,996,000
Provider Management	PROV.	$262,000	$33,000	$229,000
Total		**$34,051,000**	**$4,325,000**	**$29,726,000**

Funding:
90% Title XIX / 10% GF (4260-101-0001/0890)
65% Title XXI / 35% GF (4260-101-0001/0890)
100% State GF (4260-101-0001)

CALAIM - JUSTICE INVOLVED MAA

OTHER ADMIN. POLICY CHANGE NUMBER: 25
IMPLEMENTATION DATE: 4/2025
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2447

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$12,000,000	$68,000,000
STATE FUNDS	$6,000,000	$34,000,000
FEDERAL FUNDS	$6,000,000	$34,000,000

Purpose:
This policy change estimates the costs for reimbursing counties and state partners for Medi-Cal Administrative Activities (MAA) claims for MAA provided to the justice-involved population 90 days prior to release.

Authority:
Penal Code Section 4011.11
Welfare & Institutions Code Sections 14011.10, 14132.275, 14184.800, and 14186
AB 133 (Chapter 143, Statutes of 2021)

Interdependent Policy Change:
Not Applicable

Background:
California is requesting federal authority necessary to implement California Advancing & Innovating Medi-Cal (CalAIM), a framework that encompasses broad-based delivery system, program, and payment reform across the Medi-Cal program. CalAIM recognizes the opportunity to move California's whole-person care approach – first authorized by the Medi-Cal 2020 Section 1115 demonstration – to a statewide level, with a clear focus on improving health and reducing health disparities and inequities. Collectively, the Section 1115 CalAIM demonstration and Section 1915(b) waiver, along with related contractual and Medi-Cal State Plan changes, will enable California to fully execute the CalAIM initiative, providing benefits to certain high needs, hard-to-reach populations, with the objective of improving health outcomes for Medi-Cal members and other low-income people in the state.

Inmates leaving correctional facilities are at extremely high risk of poor health outcomes due to high rates of mental illness, substance use disorders, complex medical conditions, and unmet social needs such as housing insecurity, unemployment, and inadequate social connections. CalAIM proposes to improve outcomes for this population by mandating county inmate pre-release application processes, allowing Medi-Cal reimbursement for services in the 90-day time period prior to release, and to ensure a facilitated referral and linkage ("warm hand-off") to behavioral health services, both to providers in managed care networks and to county behavioral health departments.

CALAIM - JUSTICE INVOLVED MAA
OTHER ADMIN. POLICY CHANGE NUMBER: 25

The federal Medicaid 1115 demonstration waiver authorizes one-time funding opportunities to correctional agencies through Providing Access and Transforming Health to build up the capacity and infrastructure of on-the-ground partners to successfully participate in the Medi-Cal delivery system as California widely implements Justice-Involved services under CalAIM. The Department will establish a Justice Involved MAA to ensure county and state participants may have access to an ongoing revenue stream for these activities no later than July 1, 2025, pending the approval of the Centers for Medicare & Medicaid Services (CMS).

CalAIM's justice-involved initiative helps California address poor health outcomes and disproportionate risk of illness and accidental death among justice-involved Medi-Cal eligible adults and youth as they re-enter their communities. To facilitate these activities on an ongoing basis, the Department is proposing to seek federal authority to expand MAA performed by state and county partners for this population. MAA includes activities such as:

- Medi-Cal outreach,
- Facilitating Medi-Cal applications,
- Referrals of Medi-Cal services, and
- Coordination of Medi-Cal services.

Reason for Change:
There is no change from the prior estimate for FY 2024-25. The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase as FY 2025-26 contains a full year of costs due to the program implementing in FY 2024-25.

Methodology:
1. Assume the MAA program for the justice-involved population will be established by FY 2024-25 Quarter 3, subject to the necessary approvals being obtained from CMS.

2. Assume MAA claiming will begin in FY 2024-25 Quarter 3 by 40% of potential claiming units, with the first MAA payments anticipated for payment in Quarter 4 due to a 3-month lag in claims processing.

3. Assume the General Fund will be used for the non-federal share of the MAA claims.

4. Total estimated costs for FY 2024-25 and FY 2025-26 are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2024-25	$12,000	$6,000	$6,000
FY 2025-26	$68,000	$34,000	$34,000

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

HEALTH ENROLLMENT NAVIGATORS

OTHER ADMIN. POLICY CHANGE NUMBER: 26
IMPLEMENTATION DATE: 7/2024
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2144

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$9,362,000	$0
STATE FUNDS	$4,681,000	$0
FEDERAL FUNDS	$4,681,000	$0

Purpose:
This policy change estimates the funding provided to counties and community-based organizations (CBOs) for Medi-Cal outreach, enrollment, and retention activities.

Authority:
SB 154 (Chapter 43, Statutes of 2022)
SB 159 (Chapter 40, statutes of 2024)

Interdependent Policy Changes:
Not Applicable

Background:
CBOs play a vital role in assisting counties to reach out to marginalized populations and help eligible individuals apply and successfully complete the health coverage enrollment process, retain coverage, navigate the health care system, and gain timely access to medical care through community-based care management.

Adequate funding for outreach, enrollment, retention, and community-based assistance with utilization and care management is necessary to ensure all Medi-Cal eligible individuals are enrolled in health care coverage and have access to the care they need.

The Department continued the Health Enrollment Navigators Project starting July 2022, through 2024. Project activities continued with an emphasis on COVID-19 Public Health Emergency-related activities to help members retain Medi-Cal coverage by assisting with annual renewals, reporting updated contact information, and engage in outreach, application assistance, enrollment, and retention of difficult-to-reach target populations and support more focused targeted outreach and enrollment for Medi-Cal program and benefit expansions. The project implementation period was initially set to occur July 1, 2022, through June 30, 2025, while the close-out period was set to occur July 1, 2025, through June 30, 2026.

In FY 2024-25, the remaining funding for Health Enrollment Navigators was decreased. Costs associated with the Health Enrollment Navigators decrease were previously budgeted in the Health Enrollment Navigators Reduction policy change. Those costs are now budgeted in the Health Enrollment Navigators policy change. Additionally, the project implementation period has been changed to end May 21, 2024, with a close-out period occurring from May 22, 2024 – June 30, 2024.

HEALTH ENROLLMENT NAVIGATORS
OTHER ADMIN. POLICY CHANGE NUMBER: 26

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a decrease due to only budgeting the remaining close-out payments in FY 2024-25. There is a decrease from FY 2024-25 to FY 2025-26, in the current estimate, due to the final payments occurring in FY 2024-25.

Methodology:
1. Assume selected counties that partner with local CBOs to conduct outreach, enrollment, and retention activities in their applicable area shall receive supplemental funding for activities conducted from October 2022 through June 2024.

2. Assume costs associated with the Health Enrollment Navigators decrease were previously budgeted in the Health Enrollment Navigators Reduction policy change and are now budgeted in this policy change.

3. The budget agreement for FY 2019-20 (AB 74 with an implementation date of March 1, 2020) provided $60 million TF ($30 million GF) for this item. The FY 2019-20 appropriation has been fully expended. The Budget Act for FY 2022-23 (SB 154 with an implementation date of October 1, 2022) provided an additional $60 million TF ($30 million GF). All SB 154 implementation and close-out activities terminated on June 30, 2024. Due to internal accounting and administrative processes for some contracted entities, all outstanding invoices and deliverables are expected to be supplied by no later than September 30, 2024. The table below displays the actual and estimated spending and remaining funds by Appropriation Years:

Appropriation Year 2022-23	TF	GF	FF*
Prior Years	$20,936,000	$10,468,000	$10,468,000
Estimated in FY 2024-25	$3,064,000	$1,532,000	$1,532,000
Total Estimated Remaining	$0	$0	$0

*Federal funds authority is newly requested for the fiscal year in which funds are anticipated to be expended.

4. The table below estimates the funding for the remaining Health Enrollment Navigator initiatives:

Fiscal Year	TF	GF	FF
FY 2024-25	$6,298,000	$3,149,000	$3,149,000
FY 2025-26	$0	$0	$0

*Totals may differ due to rounding.

5. On a cash basis, all Health Enrollment Navigator costs are estimated to be:

Fiscal Years	TF	GF	FF
FY 2024-25	**$9,362,000**	**$4,681,000**	**$4,681,000**
FY 2025-26	**$0**	**$0**	**$0**

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

PASRR

OTHER ADMIN. POLICY CHANGE NUMBER: 27
IMPLEMENTATION DATE: 7/2013
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1720

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$8,891,000	$8,946,000
STATE FUNDS	$2,222,750	$2,236,500
FEDERAL FUNDS	$6,668,250	$6,709,500

Purpose:
This policy change estimates the contractor costs for the Preadmission Screening and Resident Review (PASRR) Level II evaluations.

Authority:
Title 42, Code of Federal Regulations 483.100-483.136, 483.200-483.206

Interdependent Policy Changes:
Not Applicable

Background:
As mandated by federal regulations, the Department contracts with an independent contractor to complete all Level II PASRR evaluations. Per this PASRR service contract, Evaluators travel to facilities and conduct Level II Evaluations. A Level II Evaluation consists of a face-to-face mental status examination and psychosocial assessment of individuals identified with or suspected to have a mental illness upon admission to a nursing facility. 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 system.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to an increase in the volume of average monthly cases that were completed by the contractor from July 2023 through May 2024.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due the cost for the 10% withholds in FY 2024-25 is based on actual and projected withholds while the FY 2025-26 estimate is based on projected withholds.

Methodology:
1. Expenditures for the PASRR service contract started in July 1, 2023 and will occur through June 30, 2026.

PASRR
OTHER ADMIN. POLICY CHANGE NUMBER: 27

2. The PASRR payments on a cash basis are estimated at:

FY 2024-25	TF	GF	FF
Evaluations	**$8,891,000**	**$2,223,000**	**$6,668,000**

FY 2025-26	TF	GF	FF
Evaluations	**$8,946,000**	**$2,236,000**	**$6,710,000**

Funding:
75% Title XIX / 25% GF (4260-101-0001/0890)

NEWBORN HEARING SCREENING PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 28
IMPLEMENTATION DATE: 7/2014
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1824

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$6,128,000	$6,220,000
STATE FUNDS	$3,064,000	$3,110,000
FEDERAL FUNDS	$3,064,000	$3,110,000

Purpose:
This policy change estimates the Newborn Hearing Screening Program's (NHSP) contract service costs.

Authority:
AB 2780 (Chapter 310, Statutes of 1998)
Health & Safety Code Section 123975 and Sections 124115 - 124120.5
Contract 24-40060

Interdependent Policy Changes:
Not Applicable

Background:
The NHSP contracts with Hearing Coordination Centers (HCC) to provide technical assistance and consultation to hospitals in the implementation and ongoing execution of facility hearing screening programs. The HCCs also track and monitor every infant who refers on their initial hearing screening to assure they receive necessary follow-up services. The HCCs provide a database that assists the NHSP in collection and reporting of infant hearing screening data. The information collected include screening and diagnostic services provided to newborns and infants who are deaf or hard-of-hearing.

- HCC contract #20-40060 began July 1, 2024, and expires June 30, 2027.

Reason for Change:
The decrease for FY 2024-25 from the prior estimate, and the increase from FY 2024-25 to FY 2025-26, in the current estimate, is due to applying terms of the newly awarded NHSP contract.

Methodology:
1. The NHSP contract combines the HCC and Data Management services into one contract. Costs for FY 2024-25 and FY 2025-26 are $6,128,200 and $6,220,123, respectively.

2. The anticipated NCSP costs for FY 2024-25 and FY 2025-26 are as follows:

Fiscal Year	TF	GF	FF
FY 2024-25	**$6,128,000**	**$3,128,000**	**$3,128,000**
FY 2025-26	**$6,220,000**	**$3,110,000**	**$3,110,000**

NEWBORN HEARING SCREENING PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 28

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

MEDCOMPASS SOLUTION

OTHER ADMIN. POLICY CHANGE NUMBER: 29
IMPLEMENTATION DATE: 7/2017
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1982

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$5,288,000	$5,412,000
STATE FUNDS	$1,390,550	$1,422,750
FEDERAL FUNDS	$3,897,450	$3,989,250

Purpose:
This policy change estimates contractor costs to implement the MedCompass system changes and ongoing licensing and operations costs.

Authority:
Title XIX of the Federal Social Security Act 1903(a) (3)
Contract # 16-93448 A03
Contract # 24-40001

Interdependent Policy Changes:
Not Applicable

Background:
The MedCompass is a Software-as-a-Service (SaaS) solution that was implemented for the Integrated Systems of Care Division (ISCD) with a solution provider, AssureCare. MedCompass replaced the Case Management Information System and Microsoft Access Databases that ISCD used to manage cases under the Home and Community-Based Alternatives Waiver, Early Periodic Screening, Diagnostics and Treatment, and Assisted Living Waiver Programs.

MedCompass entered Maintenance and Operations (M&O) on December 18, 2017. The Department obtained Centers for Medicare and Medicaid Services (CMS) certification approval for the MedCompass system on May 14, 2021. The Department submitted a cost recoupment change in MedCompass M&O federal financial participation (FFP) from 50% FF / 50% GF to 75% FF / 25% GF in August 2022. The recoupment request included eligible costs from October 1, 2019, to May 14, 2021. The Department received CMS approval for the cost recoupment change of $626,000 in September 2022; the recoupment was completed in December 2022.

Reason for Change:
There is no change from the prior estimate for FY 2024-25. The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to Licensing Fees and Infrastructure-as-a Service (IaaS) Managed Services M&O costs.

Methodology:
1. The estimated costs are based upon the MedCompass solution provider contract provisions, as amended in July 2021, to exercise the contract's provision for three optional years ending on July 31, 2024.

MEDCOMPASS SOLUTION
OTHER ADMIN. POLICY CHANGE NUMBER: 29

2. From October 1, 2019, to May 14, 2021, all costs reflect payment at 50% FF/ 50% GF. The MedCompass system was certified in May 2021 and currently claims applicable costs at 75% FF/ 25% GF.

3. The NCB contract with AssureCare, LLC began on August 1, 2024, to continue delivering M&O support services. The contract ends on January 31, 2029, and includes four optional two-year terms.

FY 2024-25	TF	GF	FF
Licensing Fees	$3,776,000	$993,000	$2,783,000
SaaS Ongoing Operation Support	$972,000	$255,000	$717,000
IaaS Managed Services M&O	$540,000	$142,000	$398,000
Total	**$5,288,000**	**$1,390,000**	**$3,898,000**

FY 2025-26	TF	GF	FF
Licensing Fees	$3,839,000	$1,009,000	$2,830,000
SaaS Ongoing Operation Support	$853,000	$224,000	$629,000
IaaS Managed Services M&O	$720,000	$189,000	$531,000
Total	**$5,412,000**	**$1,422,000**	**$3,990,000**

*Totals may differ due to rounding

Funding:
75% Title XIX / 25% GF (4260-101-0890/0001)
100% Title XIX FFP (4260-101-0890)
100% GF (4260-101-0001)
65% Title XXI / 35% GF (4260-101-0890/0001)

ELECTRONIC ASSET VERIFICATION PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 30
IMPLEMENTATION DATE: 7/2023
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 2002

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$4,556,000	$4,613,000
STATE FUNDS	$2,278,000	$2,306,500
FEDERAL FUNDS	$2,278,000	$2,306,500

Purpose:
This policy change estimates the administrative costs associated with implementing an electronic asset verification program (AVP) and periodic data matching services (Appriss for Incarceration Verification Program (IVP), Death*, Residency, and Commercial Mail Receiving Agency (CMRA) – inputs/matches) with LexisNexis Risk Solutions (LNRS). The current contract for AVP services with LNRS is required under federal law and includes a 60-month lookback period requirement for Long Term Care (LTC)/Nursing Facility Level of Care (NFLOC) applicants, members, and their responsible relatives.

Authority:
AVP:
Welfare & Institutions Code (W&I), Section 14013.5, 14043.5
Title 42 U.S. Code, Sections 1396w and 1383(e)(1)
California Financial Code, Section 293
Deficit Reduction Act of 2005
State Plan Amendment (SPA) 09-003 and 23-0030
Contract 20-10158 (January 1, 2024, removed Periodic Data Matching)

Periodic Data Matching:
Welfare & Institutions Code (W&I), Section 14005.39, 14043.5
Title 42 U.S. Code, Section 495.368
Payment Integrity Information Act of 2019
Contract 23-30285 (Commenced January 1, 2024)
Contract 20-10158

Interdependent Policy Changes:
Not Applicable

Background:
Section 1940 of the Social Security Act requires that the State implement an asset verification program for use in Non-Modified Adjusted Gross Income (Non-MAGI) eligibility determinations or redeterminations for all Aged, Blind or Disabled (ABD) applicants and members through requests to financial institutions. The law further stipulates that the program be consistent with the approach taken by the Social Security Administration (SSA) under 42 U.S. Code Section 1383(e)(1); this includes the requirement that the program be administered electronically. The SPA 09-003, Asset Verification System, was approved on April 16, 2009, and State legislation (W&I, Section 14013.5 and Financial Code, Section 293) was enacted to implement the federal requirements.

ELECTRONIC ASSET VERIFICATION PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 30

Financial institutions provide data that could indicate assets and property not reported by the applicant or member. If information is obtained indicating unreported assets, the applicant or member must provide additional supporting documentation before an eligibility determination or redetermination is made.

The Department reimburses financial institutions when obtaining asset information for ABD members. The reimbursement rate is based on volume with an average of $4.00 per query.

Program expenditures are reduced when supplemental asset data increases the accuracy of eligibility determinations for the ABD population or detects unreported assets that result in the discontinuance of a member.

The Department conducted a pilot of the asset verification program in order to determine the success of the program in identifying unreported assets and to assist with the development of the program. The pilot concluded in April 2017, and implementation began in December 2017. Due to changes in federal law, and unforeseen delays in internal and external work efforts due to the ongoing COVID-19 public health emergency, the Department's objective is full electronic implementation by the end of 2021.

A first contract amendment was executed on June 14, 2021. This amendment increased the number of annual AVP inputs from 1,000,000 to 1,380,000 to accommodate growth in the ABD renewal population and new at-application request functionality. It also added 240,000 annual Appriss inputs for incarceration verification services since a previous vendor contract expired and those services are available through LNRS.

A second contract amendment was executed on June 28, 2022. This amendment extended the contract by an additional six months from June 2023 to December 31, 2023, for all services stated in the contract. The contract amendment also increases the scope of data matching activities for FY 2022-23 to include Appriss, Death, Residency, and CMRA matching activities. This additional scope of contract work is needed to obtain data matching files that will leverage high value data sources to prevent fraud and abuse by identifying Medi-Cal members who are deceased, residing out-of-state, or have a residential address that is identified as a CMRA.

A third contract amendment was executed on December 14, 2023. The amendment removes the periodic data matching services (Appriss, Death*, Residency, and CMRA matches/inputs) and significantly reduces the volume of AVP inputs purchased from LNRS to align with the elimination of assets for Non-MAGI programs on January 1, 2024. Due to federal asset transfer and Period of Ineligibility (POI) requirements for individuals seeking LTC/NFLOC necessitating a 60-month lookback period, the Department will continue to purchase AVP inputs for LTC applicants, members, and their responsible relatives after January 1, 2024. The Department anticipates this contract will continue until December 31, 2028, or until the remaining POIs expire.

A fourth contract amended was executed on March 4, 2024. This amendment increased the number of AVP inputs for the remainder of FY 2023-24 to 27,000/month, since the Department exceeded its previous allotment of 21,000/inputs designated for January 1, 2024, through June 30, 2024. This amendment ensured the Department would not continue incurring overages charged at $6.99/input, and could continue running asset verification queries on applicants, their responsible relatives, and members seeking LTC/NFLOC to determine whether they made asset transfers for less than fair market value during the 5-year lookback period. The

ELECTRONIC ASSET VERIFICATION PROGRAM
OTHER ADMIN. POLICY CHANGE NUMBER: 30

Department continues to anticipate that this contract will continue until December 31, 2028, or until the remaining POIs expire.

A fifth contract amendment was executed on June 19, 2024. This amendment, which begins in FY 2024-25, purchases an additional 10,500 inputs/month for five fiscal years to continue running asset verification inquiries. The Department anticipates this contract will continue until December 31, 2028, or until the remaining POIs expire.

Appriss, Death*, Residency, and CMRA matches/inputs were separated from the 20-10158 scope of work and shifted to a new contract 23-30285. The new contract for periodic data matching services was executed January 1, 2024, and will continue through December 31, 2026.

*Includes the ten Accurint licenses provided by LNRS.

Reason for Change:
The change from the prior estimate, for FY 2024-25, and the change from FY 2024-25 to FY 2025-26, is an increase due to purchasing additional asset verification inputs/month to reflect request file data trends more accurately.

Methodology:
1. The policy does not apply to applicants or recipients of federal Supplemental Security Income/State Supplementary Payment, whose assets are collected and valued by SSA prior to making an eligibility determination.

2. The Department continues to send AVP requests for LTC applicants, members, and their responsible relatives even after asset elimination on January 1, 2024, due to federal asset transfer and POI requirements for individuals seeking LTC/NFLOC.

3. Based on AVP request file data obtained from Enterprise Technology Services, the estimated number of asset verifications performed will be 42,000 in FY 2024-25. The estimated volume of inputs for Death, Residency, and CMRA is 60,000,000 for fiscal year. This estimation is based on the size and frequency of the input file. The monthly Medi-Cal eligibility file is approximately 15,000,000 records and the match runs quarterly (15,000,000 records x 4 runs/year = 60,000,000 inputs). The estimated volume of inputs for Appriss is 240,000 in FY 2024-25 and based on data obtained from IVP.

4. The combined reimbursement rate for AVP and periodic data matching services, based on estimated query volumes, is estimated to be $100,800 + $281,333 = $382,133/month from July through December 2024, and $100,800 + $276,383 = $377,183/month from January through June 2025.

5. The combined reimbursement rate for AVP and periodic data matching services, based on estimated query volumes, is estimated to be $103,880 + $276,383 = $380,263/month from July through December 2025, and $103,880 + $284,675 = $388,555/month from January through June 2026.

ELECTRONIC ASSET VERIFICATION PROGRAM
OTHER ADMIN. POLICY CHANGE NUMBER: 30

The table below summarizes FY 2024-25 and FY 2025-26 costs:

Time Period	Monthly Rate	Months	Cost
July – December 2024	$382,133	6	$2,292,798
January – June 2025	$377,183	6	$2,263,098
FY 2024-25		12	$4,555,896

Time Period	Monthly Rate	Months	Cost
July – December 2025	$380,263	6	$2,281,578
January – June 2026	$388,555	6	$2,331,330
FY 2025-26		12	$4,612,908

6. The estimated vendor costs are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2024-25	**$4,556**	**$2,278**	**$2,278**
FY 2025-26	**$4,613**	**$2,306**	**$2,307**

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

PUBLIC HEALTH REGISTRIES SUPPORT

OTHER ADMIN. POLICY CHANGE NUMBER: 31
IMPLEMENTATION DATE: 7/2024
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1370

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$4,441,000	$4,441,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$4,441,000	$4,441,000

Purpose:
This policy change estimates the administrative costs for California Department of Public Health (CDPH) programs that the Department is supporting under Medicaid Enterprise Systems (MES) funding.

Authority:
Code of Federal Regulations, Title 42, Part 433
Interagency Agreement CAIR (Pending)
Interagency Agreement CalREDIE (Pending)
Advance Planning Document (CA-2021-01-16-MMIS-IAPD-Public Health Registries APD update forthcoming)

Interdependent Policy Changes:
Not Applicable

Background:
The Department works with the CDPH in support of the California Immunization Registry (CAIR) and California Reportable Disease Information Exchange (CalREDIE) projects. The Centers for Medicare & Medicaid Services (CMS) originally approved federal funding for these projects in the 2021 Public Health Registries Advance Planning Document (APD), which covered the fiscal year (FY) 2021-22. For FY 2022-23, CDPH was able to utilize emergency COVID funding and did not submit an APD. CDPH had also determined no funding was needed for FY 2023-24. However, CDPH will be submitting an APD for FY 2024-25 and FY 2025-26.

The Department is currently working with CDPH to draft Interagency Agreements for administrative costs related to Medicaid share of the projects described below:

- CAIR is the secure, confidential, statewide computerized immunization information system for California residents. Funding allows CAIR to create and maintain a fully-utilized and fully-interactive system to improve immunization coverage to protect Californians from vaccine-preventable diseases.
- CalREDIE is California's secure system for electronic disease reporting and surveillance. Funding allows CalREDIE to improve the efficiency of surveillance activities and the early detection of public health events through complete and timely surveillance of statewide information.

PUBLIC HEALTH REGISTRIES SUPPORT
OTHER ADMIN. POLICY CHANGE NUMBER: 31

Once the APD is submitted and approved, the programs will receive enhanced funding (75% Federal Fund (FF) / 25% General Fund). CDPH plans on submitting and receiving APD approval from CMS during FY 2024-25.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase due to increased contract costs. There is no change from FY 2024-25 to FY 2025-26 in the current estimate.

Methodology:
1. For the CAIR and CalREDIE, the non-federal share is budgeted by CDPH. This policy change budgets the Title XIX FF that will be provided to CDPH per the contracts through an interagency agreement.

2. CAIR and CalREDIE are anticipating the certification by CMS and approval of the APD before the end of FY 2024-25. Once certified, these programs would qualify for 75% Title XIX funding with an approved APD.

FY 2024-25	TF	CDPH GF	FF
CalREDIE (50% FF/50% GF)	$1,864,000	$466,000	$1,398,000
CAIR (50% FF/50% GF)	$4,058,000	$1,015,000	$3,043,000
Total FY 2024-25	$5,922,000	$1,481,000	**$4,441,000**
FY 2025-26	**TF**	**CDPH GF**	**FF**
CalREDIE (75% FF/25% GF)	$1,864,000	$466,000	$1,398,000
CAIR (75% FF/25% GF)	$4,058,000	$1,015,000	$3,043,000
Total FY 2025-26	$5,922,000	$1,481,000	**$4,441,000**

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

DRUG MEDI-CAL PARITY RULE ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER: 32
IMPLEMENTATION DATE: 11/2024
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2206

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$4,407,000	$5,875,000
STATE FUNDS	$1,469,000	$1,958,000
FEDERAL FUNDS	$2,938,000	$3,917,000

Purpose:
This policy change estimates the administration cost related to Parity Rule activities for Drug Medi-Cal (DMC) counties.

Authority:
42 Code of Federal Regulations (CFR) Part 438
Welfare & Institutions (W&I) Code, Section 14197.1

Interdependent Policy Changes:
Not Applicable

Background:
The federal Parity Rule prescribes requirements states must address to ensure Medicaid members are able to access mental health and substance use disorder (SUD) services in the same way they are able to access physical health services.

Specifically, according to Title 42 of the CFR, Part 438.910 and 438.920, parity applies to DMC counties because parity protects the enrollees of medical/surgical Medi-Cal Managed Care Plan, and those Managed Care Plan enrollees could be receiving their substance use disorder services in either a DMC-ODS or DMC county. Furthermore, the W&I Code, Section 14197.1 gives the Department the authority to ensure that all SUD benefits are provided in compliance with the Parity Rule.

Through continued assessment of the Parity Rule, the Department has identified additional requirements that are necessary to align standards for member access to SUD treatment services with standards and requirements for access to medical/surgical health services.

Effective January 1, 2023, the Department standardized and aligned requirements for SUD services with the requirements for medical/surgical health services for the DMC counties, as specified in the DMC county contracts.

Reason for Change:
There change in FY 2024-25, from the prior estimate, is a decrease due to a shift in the start of payments from March 2024 to November 2024, resulting from delayed implementation.

The change in the current estimate, from FY 2024-25 to FY 2025-26, is due to FY 2025-26 including an additional quarter’s cost.

DRUG MEDI-CAL PARITY RULE ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER: 32

Methodology:

1. Payments for the Parity Rule activities will begin in November 2024.

2. Assume claims for the first three quarters (Q1 – Q3) will be paid in the same fiscal year, and claims for the last quarter (Q4) will be paid the following fiscal year.

3. Non-federal share of the costs will be funded through 50% General Fund (GF) and 50% CF for Parity Rule activities.

4. The estimated Parity Rule administrative costs for FY 2024-25 and FY 2025-26 are:

FY 2024-25	TF	GF	FF	CF
DMC Administration - Regular	$5,655,000	$1,414,000	$2,827,000	$1,414,000
DMC Administration - UR & QA	$221,000	$55,000	$111,000	$55,000
Total	$5,876,000	**$1,469,000**	**$2,938,000**	$1,469,000

FY 2025-26	TF	GF	FF	CF
DMC Administration - Regular	$7,539,000	$1,885,000	$3,769,000	$1,885,000
DMC Administration - UR & QA	$294,000	$73,000	$148,000	$73,000
Total	$7,833,000	**$1,958,000**	**$3,917,000**	$1,958,000

Funding:

100% General Fund (4260-101-0001)
100% Title XIX FF (4260-101-0890)

PROTECTION OF PHI DATA

OTHER ADMIN. POLICY CHANGE NUMBER: 33
IMPLEMENTATION DATE: 5/2010
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1452

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$4,148,000	$5,216,000
STATE FUNDS	$2,074,000	$2,608,000
FEDERAL FUNDS	$2,074,000	$2,608,000

Purpose:
This policy change estimates the upgrades to the infrastructure and ongoing costs of maintaining and securing electronic Protected Health Information (PHI).

Authority:
Contract # 23-30336

Interdependent Policy Changes:
Not Applicable

Background:
The Department has implemented security processes, technologies, and backup systems to protect, monitor, and secure electronic PHI data to minimize the amount of encrypted data flowing across the Wide Area Network. These systems contain Medi-Cal member information that is considered confidential and/or PHI by federal and state mandates.

The current protection of these systems will:

- Secure and protect the Department’s electronic data from unauthorized disclosure;
- Protect the privacy of Medi-Cal members;
- Avoid costs to notify millions of people if a large breach does occur; and
- Maintain the Department’s public image and integrity by protecting the confidentiality and privacy of the information that it maintains on its customers.

The Department is continuing its effort in protecting PHI data and will continue to implement and improve security processes and technologies to ensure the Confidentiality, Integrity, and Availability of PHI data and establish accountability for the Department’s administrators and employees with access to PHI data. These ongoing efforts ensure that new and current systems adhere to the Principles of Confidentially, Integrity, and Availability in the most secure manner available. Privileged Access Management (PAM) looks into the entire privileged account lifecycle, starting from granting and revoking permissions of these accounts to having a fail-proof password change cycle.

The Department is also continuing to enhance current security tools and services to reduce its inherent risk pertaining to account compromise, privilege escalation, and lateral movement. These ongoing efforts also will have the residual effect of deterring breaches and cutting off the spread of ransomware before it is allowed to propagate across the organization. In addition, the Department continues to migrate data from on-premises servers to the Department's Amazon Web Services (AWS) cloud in an immutable format that ransomware cannot infect.

PROTECTION OF PHI DATA
OTHER ADMIN. POLICY CHANGE NUMBER: 33

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a decrease due to updated actuals, adjusted projections, and delays in contract start and payment dates. The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to upfront costs for Rubrik's three-year license renewal in FY 2025-26 and not in FY 2024-25 and to a full year of security contract expenditures.

Methodology:
1. The costs include annual licensing, hardware, and software maintenance and support for:
    a. Data Domain is a solution that stores data and includes a software suite that protects data by limiting and monitoring staff access and encrypting data at rest.
    b. Backup and Recovery System is a solution that protects data and prevents data loss by delivering data archival, monitoring, access control, encryption at rest, backup, and point-in-time recovery.
    c. Database Activity Monitoring (DAM) system is a database firewall that has data security profiles designed to protect databases, monitor activities, provide staff access control, and capture security events. The Department is in the process of upgrading systems to provide better safeguards and security.
    d. PAM is a solution that requires privileged users to "check out" their individual privileged account that logs all actions performed by that user in the privileged session. Workforce Password Manager (WPM) is an addition to PAM that covers access to devices, software, and cloud containers.
    e. Browser Isolation is a solution that protects cybersecurity such as personal browsing activities from Department devices to prevent malware, ransomware, and other threats.

2. The annual costs include modifying configurations, implementation, assessments, and contracted personnel to perform the administrative functions of the solution.
    a. Security Enhancement operations functionality requires two or more resources to remediate security findings such as exposure to ransomware, and provide risks assessments to prevent exposure to confidential and sensitive data.
    b. Cybersecurity operations functionality requires two or more resources to review the Department's current threat landscape by enhancing cybersecurity operations to secure and protect data, applications, and resources. This includes establishing standardized and repeatable processes and procedures.

3. The following amounts are based upon the latest projections of cost:

Fiscal Year	TF	GF	FF
FY 2024-25	$4,148,000	$2,074,000	$2,074,000
FY 2025-26	$5,216,000	$2,608,000	$2,608,000

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

PACES

OTHER ADMIN. POLICY CHANGE NUMBER: 34
IMPLEMENTATION DATE: 9/2016
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1972

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$3,618,000	$3,651,000
STATE FUNDS	$951,600	$960,050
FEDERAL FUNDS	$2,666,400	$2,690,950

Purpose:
This policy change estimates the costs to modify the Department's existing Post Adjudicated Claims and Encounters System (PACES) to stay in compliance with federal law.

Authority:
Section 1903(i) (4) of the Social Security Act
Title 42 of the Code of Federal Regulations (CFR), Part 438
Title 22 of the California Code of Regulations, Section 51476
Contract # 22-20002

Interdependent Policy Changes:
Not Applicable

Background:
Federal law mandates the Department to collect and report on Medi-Cal claims and encounters, whether they be submitted as part of a Fee-for-Services or a contracted managed care arrangement. PACES plays a vital role in the collection of encounter and provider network data from Medi-Cal's numerous managed care plans. PACES accepts encounter transactions from both medical and dental managed care plans as well as encounter-related pharmacy transactions. PACES also accepts medical and dental provider network data from Medi-Cal's managed care plans. This data is used to ensure that managed care plans are meeting the department's network adequacy requirements.

PACES Interfaces and New Data Sources
42 CFR 438.10(e) (2) (vi) requires the Department to provide Medi-Cal enrollees with provider directory information for contracted managed care entities on a regular basis. Furthermore, 42 CFR 438.68 requires the Department to enforce network adequacy standards for contracted managed care entities. In order to fulfill these federal regulations, the Department must collect provider network information from participating managed care organizations as well as managed models, such as county behavioral health systems, that are considered managed care for the purpose of regulation.

The Department has completed the analysis to expand the use of the 274 transactions to the county mental health plans and the Drug Medi-Cal Organized Delivery System counties. Extending the 274 processes to behavioral health will allow the Department to monitor the networks within those models.

PACES

OTHER ADMIN. POLICY CHANGE NUMBER: 34

State projects become eligible for increased federal funding for maintenance and operations (M&O) after development meets the Centers for Medicare & Medicaid Service (CMS) System Certification requirements. PACES completed the CMS Final Certification Review on July 12, 2021, and received the Certification Approval Letter dated October 25, 2021.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase due to updated actuals and adjusted projections. The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to adjusted projections.

Methodology:
1. A 5-year contract for M&O services with a vendor began in December 2022 and will continue through December 2027.

2. Include costs for ongoing cloud platforms and services.

3. Total costs are estimated to be:

FY 2024-25	TF	GF	FF
M&O	$3,116,000	$819,000	$2,297,000
Cloud Services	$502,000	$132,000	$370,000
Total	**$3,618,000**	**$951,000**	**$2,667,000**

FY 2025-26	TF	GF	FF
M&O	$3,103,000	$816,000	$2,287,000
Cloud Services	$548,000	$144,000	$404,000
Total	**$3,651,000**	**$960,000**	**$2,691,000**

Funding:
75% Title XIX / 25% GF (4260-117-0001/0890)
65% Title XXI / 35% GF (4260-101-0001/0890)
100% State GF (4260-101-0001)

SDMC SYSTEM M&O SUPPORT

OTHER ADMIN. POLICY CHANGE NUMBER: 35
IMPLEMENTATION DATE: 7/2013
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1732

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$3,574,000	$2,397,000
STATE FUNDS	$1,787,000	$1,198,500
FEDERAL FUNDS	$1,787,000	$1,198,500

Purpose:
This policy change estimates the Behavioral Health administrative costs including 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 #22-20171
Contract #24-40015

Interdependent Policy Changes:
Not Applicable

Background:
Behavioral Health claims for Specialty Mental Health Services (SMHS) and Substance Use Disorder Services (SUDS) are adjudicated for payment in the SDMC system. The Department uses two (2) accounting systems for the payment of claims. Short-Doyle Medi-Cal Application Remediation Technology (SMART) supports the accounting and payment of SUDS and United States Ledger (USL) Financials for SMHS. These accounting systems are used to process the adjudicated claim for payment by the State Controller's Office (SCO), reconciliation, and generation of 835 Remittance Advice. These payments are directed to Mental Health Programs (MHP) in each of the California Counties. Behavioral Health has experienced an increase in the volume of claims which has created a need for system infrastructure upgrades and migration to Amazon Web Services (AWS), including application servers, reporting servers, middleware, database, and storage.

The Department's administrative activities related to Behavioral Health include the following contract and other related costs:

SDMC Prime Vendor Contract
The SDMC Prime Vendor Contract provides services which include enhancements and maintenance needed to keep up with current technology, and new federal and state mandates. The contract is effective July 1, 2022, through June 30, 2027.

USL Financials
The USL Financials contract provides licensing and support for SMHS. This accounting system is used to process the adjudicated claim for payment by SCO, reconciliation, and generation of 835 Remittance Advice. The contract will be effective July 1, 2024, through June 30, 2027.

SDMC SYSTEM M&O SUPPORT
OTHER ADMIN. POLICY CHANGE NUMBER: 35

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase due to delayed payments from the prior fiscal year's activities, updated actuals, and adjusted projection calculations. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due to the absence of delayed payments from previous fiscal years.

Methodology:

FY 2024-25	TF	GF	FF
M&O	$3,574,000	$1,787,000	$1,787,000
Total	**$3,574,000**	**$1,787,000**	**$1,787,000**

FY 2025-26	TF	GF	FF
M&O	$2,397,000	$1,198,000	$1,199,000
Total	**$2,397,000**	**$1,198,000**	**$1,199,000**

*Totals may differ due to rounding

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

CALAIM - INMATE PRE-RELEASE PROGRAM ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 36
IMPLEMENTATION DATE: 1/2023
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2413

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$2,746,000	$2,746,000
STATE FUNDS	$1,373,000	$1,373,000
FEDERAL FUNDS	$1,373,000	$1,373,000

Purpose:
This policy change estimates the cost for county social services agencies to process Medi-Cal applications in support of the Mandatory County Pre-Release mandate, effective January 1, 2023.

Authority:
Penal Code Section 4011.11
Welfare & Institutions Code Sections 14011.10, 14132.275, 14184.800, and 14186
AB 133 (Chapter 143, Statutes of 2021)

Interdependent Policy Change:
Not Applicable

Background:
California is requesting federal authority necessary to implement California Advancing & Innovating Medi-Cal (CalAIM), a framework that encompasses broad-based delivery system, program and payment reform across the Medi-Cal program. CalAIM recognizes the opportunity to move California's whole-person care approach – first authorized by the Medi-Cal 2020 Section 1115 demonstration – to a statewide level, with a clear focus on improving health and reducing health disparities and inequities. Collectively, the Section 1115 CalAIM demonstration and Section 1915(b) waiver, along with related contractual and Medi-Cal State Plan changes, will enable California to fully execute the CalAIM initiative, providing benefits to certain high needs, hard-to-reach populations, with the objective of improving health outcomes for Medi-Cal members and other low-income people in the state.

Inmates leaving correctional facilities are at extremely high risk of poor outcomes due to high rates of mental illness, substance use disorders, complex medical conditions, and unmet social needs such as housing insecurity, unemployment, and inadequate social connections. CalAIM proposes to improve outcomes for this population by mandating county inmate pre-release application processes, allowing Medi-Cal reimbursement for services in the 90 day time period prior to release, and to ensure a facilitated referral and linkage ("warm hand-off") to behavioral health services, both to providers in managed care networks and to county behavioral health departments.

This policy change estimates costs for County Social Services Departments to support the processing of Mandatory County Pre-Release Applications:

CALAIM - INMATE PRE-RELEASE PROGRAM ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 36

- To mandate all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2023, which would include collaboration with county jails, probation offices, and youth correctional facilities.
- To ensure the majority of county inmates/juveniles that are eligible for Medi-Cal and are in need of ongoing physical or behavioral health treatment receive timely access to Medi-Cal services upon release from incarceration.

Reason for Change:
There is no change from the prior estimate for FY 2024-25. There is no change from FY 2024-25 to FY 2025-26 in the current estimate.

Methodology:
1. Assume the Mandatory County Pre-Release Applications implemented on January 1, 2023.

2. Assume funding will also support the new costs to counties to implement the above mentioned initiatives, including developing new services tailored to clients with criminal justice involvement, training for staff and providers, developing new programs and processes to meet the mandate requirements.

3. Total estimated costs for FY 2024-25 and FY 2025-26 are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2024-25	$2,746	$1,373	$1,373
FY 2025-26	$2,746	$1,373	$1,373

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

STATEWIDE VERIFICATION HUB

OTHER ADMIN. POLICY CHANGE NUMBER: 37
IMPLEMENTATION DATE: 7/2024
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 2358

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$2,596,000	$1,018,000
STATE FUNDS	$259,600	$101,800
FEDERAL FUNDS	$2,336,400	$916,200

Purpose:
This policy change estimates the Statewide Verification Hub (SVH) funding for the multi-departmental effort that will see the planning, design, development, and implementation of a data repository service hub to facilitate better data matches and enhance the efficiency of programmatic administration.

Authority:
Welfare & Institutions Code 14005.37 and 14013.3
42 Code of Federal Regulations 435.945, 435.948, 435.949 and 435.952
22 California Code of Regulations 50167, 50167.2 and 50168
Contract #22-20592
Contract #23-061

Interdependent Policy Changes:
Not Applicable

Background:
The SVH is an agency-wide Information Technology (IT) solution that will improve California families' access to services by streamlining the eligibility verification process for many California Health and Human Services Agency (CalHHS) means-tested programs, initially focused on CalFresh, California Work Opportunity and Responsibility to Kids (CalWORKs), Medi-Cal, and childcare program areas. While upholding Californians' privacy and security, the new IT effort developed a modernized and leverageable Hub that connects eligibility case management systems with near real-time data, such as income information, identity validators, non-cash assets, demographics, vital statistics, immigration status, etc. This data is necessary to support eligibility and benefit level determinations for means-tested human services programs, as well as federally mandated Income Eligibility Verification System data matches.

The Office of Technology and Solutions Integration Director is the executive project sponsor for SVH, with formal project sponsorship from the Department and the California Department of Social Services.

The project will work to create a holistic view of the current business process across CalFresh, CalWORKs, Medi-Cal, and childcare programs areas. This includes creating detailed process maps, county and customer worker journey maps, detailed data maps, and existing technical architecture. As a result, the project will be able to identify:

STATEWIDE VERIFICATION HUB
OTHER ADMIN. POLICY CHANGE NUMBER: 37

- Documents to create and guide the need for the future SVH by identifying the to-be functional and service architectures, while developing a robust alternative analysis of proposed solutions for the SVH.
- A recommended solution approach that aligns the needs of county users while prioritizing customer experience.
- Features and functionality that will substantially enhance transparency around eligibility verification and/or determination and benefit and/or aiding-level determinations, while improving the capacity of the State to report upon utilization rates, measures, and outcomes of eligibility verifications for means-tested human services programs.

Pursuant to the Code of Federal Regulations 95.610, the SVH Planning Advance Planning Document (PAPD) was submitted to the Centers for Medicare and Medicaid Services (CMS) to describe the State of California's plan for developing the SVH project. The PAPD describes the planning activities that the SVH project will complete, including business discovery, requirements gathering, market research and developing a proof of concept.

The primary objective and scope of the PAPD is to request enhanced federal financial participation (FFP) to cover staff salary and benefits, and as needed, procure technical consultant assistance to complete the identified work documented in the PAPD. These activities are necessary to fully document the existing business and technical architecture, identify and catalog all business requirements, engage in a robust alternatives' analysis, and prepare to undertake a proof-of-concept approach to development and eventual solution implementation of the SVH. This PAPD requests Eligibility and Enrollment funding in accordance with 42, Code of Federal Regulations 433.112 for planning activities from now until the submission of the Implementation Advance Planning Document.

The initial SVH PAPD was submitted to CMS in October 2021 to request funding from October 1, 2021, through September 30, 2023, which later resulted in DHCS/CDSS SVH Interagency Agreement (IA): DHCS 21-10376. The SVH Project is a muti-year project and as the funding in the previous PAPD ended September 30, 2023, a new SVH PAPD was submitted to CMS to request additional funding to support activities related to planning and development for the SVH project from October 1, 2023, through September 30, 2025. The new PAPD was approved by CMS on November 1, 2023. An IA amendment was initiated due to the latest PAPD approval; however, the SVH IA amendment package was not executed timely and the contract expired June 30, 2024. Therefore, a new IA contract has been initiated.

An As-Needed APD requesting FFP and contract amendment approval for SVH Technical Services contract amendment #22-20592 A1 was submitted to CMS on August 7, 2024, and is currently awaiting approval. The contract includes consulting and professional services with technical support to continue developing SVH. The project management (PM)/SVH Senior PM request for offer #23-061 is also included in this APD, to provide supportive consulting and professional services with project management and technical support to the Department.

Reason for Change:
There is an increase for FY 2024-25 from the prior estimate, due to a contract amendment. There is a decrease from FY 2024-25 to FY 2025-26 in the current estimate, due to SVH PAPD costs ending after September 2025 as well as delayed implementation of the Project Manager contract.

Methodology:
1. Assume the PM contract began in June 2022 and was extended through December 2023.

STATEWIDE VERIFICATION HUB
OTHER ADMIN. POLICY CHANGE NUMBER: 37

2. Assume the technical services contract began in June 2023.

3. The Department estimates SVH costs for FY 2023-24 and FY 2024-25 to be:

Fiscal Years	TF	GF	FF
FY 2024-25	$2,596,000	$260,000	$2,336,000
FY 2025-26	$1,018,000	$102,000	$916,000

Funding:
90% FF/10% GF (4260-101-0001/0890) (Design, Development, and Implementation of Medicaid Management Information System)

MOBILE VISION SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 38
IMPLEMENTATION DATE: 1/2025
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 2467

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$3,936,000	$7,872,000
STATE FUNDS	$1,378,000	$2,755,000
FEDERAL FUNDS	$2,558,000	$5,117,000

Purpose:
This policy change estimates the costs of providing Mobile Vision Services.

Authority:
SB 502 (Chapter 487, Statutes of 2023)
Welfare and Institutions Code section 14132.58 (c) (1)

Interdependent Policy Changes:
Not Applicable

Background:
Mobile vision services will be accessible at school sites statewide through mobile optometric service providers to uninsured children in low-income school districts at no cost to the State General Fund. The Department will contract with a Third-Party Administrator to fund the program through private donations and federal funding.

Reason for Change:
This is a new policy change.

Methodology:
1. For budgeting purposes, assume implementation will begin no later than June 30, 2025.

2. Assume Special Fund (SF) expenditures will flow through the Vision Services Children's Health Insurance Program (CHIP) - Health Services Initiative (HSI) SF.

3. The total estimated expenditures for mobile vision services are:

(Dollars In Thousands)

FY 2024-25	TF	SF	FF
Federal Fund Match	$0	($2,558)	$2,558
Program Expenditures	$3,936	$3,936	$0
Total	**$3,936**	**$1,378**	**$2,558**

MOBILE VISION SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 38

FY 2025-26	TF	SF	FF
Federal Fund Match	$0	($5,117)	$5,117
Program Expenditures	$7,872	$7,872	$0
Total	**$7,872**	**$2,755**	**$5,117**

Funding:
100%Title XXI FFP (4260-101-0890)
Vision Services CHIP HSI Special Fund (4260-101-8140)

HCBS SP - CONTINGENCY MANAGEMENT ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 39
IMPLEMENTATION DATE: 5/2023
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2362

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$2,410,000	$3,937,000
STATE FUNDS	$2,000	$0
FEDERAL FUNDS	$2,408,000	$3,937,000

Purpose:
This policy change estimates the administrative costs of adding Contingency Management (CM) in select Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver counties as an optional evidence-based Medi-Cal benefit under the federally approved CalAIM Section 1115(a) Waiver Program using enhanced federal funding from the American Rescue Plan Act of 2021 (ARP).

Authority:
American Rescue Plan (ARP) Act (2021)
Budget Act of 2021 [SB 129 (Chapter 69, Statutes of 2021)]
Consolidated Appropriations Act of 2023
CalAIM 1115 Demonstration Waiver

Interdependent Policy Changes:
Not Applicable

Background:
The ARP Act of 2021 provides additional Coronavirus Disease 2019 (COVID-19) relief to states. Section 9817 of the ARP provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS). Increased FMAP is available from April 1, 2021, through March 31, 2022. States must use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021, and states must use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. State funds equivalent to the amount of federal funds attributable to the increased FMAP are deposited in the Home and Community-Based Services American Rescue Plan (HCBS ARP) Fund pursuant to Section 11.95 of the 2021 Budget Act. Section 11.95 appropriates this funding to eligible HCBS activities identified in the HCBS Spending Plan.

The Centers for Medicare and Medicaid Services (CMS) approved the addition of CM as an optional benefit in DMC-ODS counties as part of the 1115 Demonstration Waiver renewal, as a pilot, beginning July 1, 2022 through December 31, 2026. CM uses small motivational incentives combined with behavioral health treatment and has been shown in repeated meta-analyses to be the most effective treatment for stimulant use disorder. CM was approved in the 2021 Budget Act, funded from the HCBS ARP Fund.

HCBS SP - CONTINGENCY MANAGEMENT ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 39

This policy change budgets administrative costs for CM services under the CalAIM 1115 Demonstration Waiver. The Department will extend the recovery incentives program as an optional CM benefit for all DMC-ODS counties who opt-in to cover CM as a DMC-ODS service in alignment with the timeline of the CalAIM 1115 Demonstration waiver (through December 31, 2026). Funding for the non-federal share of administrative costs for CM services will continue with HCBS funds through the final claiming date of August 15, 2024. Counties can voluntarily opt-in to this benefit, and those who do, will be responsible for the non-federal share of payments after HCBS funding expires.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is a decrease due to a revised assumption regarding the number of operating sites for CM, resulting in lower estimated administrative costs.

The change in the current estimate, from 2024-25 to FY 2025-26, is an increase due to the anticipated expansion in the number of operating sites serving more beneficiaries in FY 2025-26.

Methodology:
1. CM was added as an optional service to the CalAIM 1115 Waiver Demonstration Waiver effective January 1, 2022, and the services began in April 2023.

2. Reimbursements for the county administrative costs began in May 2023.

3. Assume the HCBS ARP non-federal share of CM services will be available through August 15, 2024 claiming dates. Counties will be responsible for the non-federal share after the HCBS SP expires.

4. Total estimated administrative costs for CM, on a cash basis, is as follows:

Contingency Management Admin	TF	HCBS ARP Fund	FF	CF
FY 2024-25	$4,816,000	**$2,000**	**$2,408,000**	$2,406,000
FY 2025-26	$7,874,000	**$0**	**$3,937,000**	$3,937,000

Funding:
100% Title XIX (4260-101-0890)
Home and Community-Based Services American Rescue Plan Fund (4260-101-8507)

CALIFORNIA HEALTH INTERVIEW SURVEY

OTHER ADMIN. POLICY CHANGE NUMBER: 40
IMPLEMENTATION DATE: 7/2015
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1902

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$2,142,000	$1,785,000
STATE FUNDS	$371,000	$192,500
FEDERAL FUNDS	$1,771,000	$1,592,500

Purpose:
This policy change estimates the California Health Interview Survey (CHIS) contract services costs.

Authority:
Interagency Agreement (IA) 21-10053 A1
IA 22-20502 (Pending)

Interdependent Policy Changes:
Not Applicable

Background:
CHIS is a random-dial telephone survey that asks questions on a wide range of health topics. CHIS is conducted on a continuous basis allowing it to provide a detailed picture of the health and health care needs of California's large and diverse population. The survey provides statewide information on the overall population including many racial and ethnic groups, as well as county-level information for most counties to aid with health planning, priority setting, and to compare health outcomes in numerous ways.

The University of California, Los Angeles (UCLA) Center for Health Policy Research conducts CHIS in collaboration with the California Department of Public Health (CDPH) and the Department. The Department contracts directly with UCLA to utilize the CHIS for program needs and performance. The current contract is funded by federal funds; the non-federal share is paid through certified public expenditures (CPEs). The Department's current contract with UCLA is effective from July 1, 2021, through June 30, 2027, after a three-year extension was exercised in March 2024.

As of January 2023, the Department contracted with UCLA to fund the addition of a Caregiving Module to the CHIS. The contract is funded with 50% federal funds and 50% general fund; the non-federal share is not paid through CPEs.

Reason for Change:
The change from the previous estimate, for FY 2024-25, is an increase due to costs associated with a delay in execution of the IA for the Caregiving Module. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due to the costs associated with the Caregiving Module being lower in FY 2025-26.

CALIFORNIA HEALTH INTERVIEW SURVEY

OTHER ADMIN. POLICY CHANGE NUMBER: 40

Methodology:

1. On an accrual basis, beginning FY 2023-24, the maximum reimbursable amount for CHIS is $1,400,000 FF annually.

2. Beginning January 2023, funding from the Department for the Caregiving Module will be added to the CHIS. This portion of CHIS funding will not be eligible for CPEs.

3. The estimated administrative costs reimbursements for FY 2024-25 and FY 2025-26, on a cash basis, are:

FY 2024-25	TF	GF	FF
FY 2023-24 Claims	$117,000	$0	$117,000
FY 2024-25 Claims	$1,283,000	$0	$1,283,000
FY 2022-23 Caregiving Module	$127,000	$63,000	$64,000
FY 2023-24 Caregiving Module	$251,000	$125,500	$125,500
FY 2024-25 Caregiving Module	$364,000	$182,000	$182,000
Total	**$2,142,000**	**$370,500**	**$1,771,500**

FY 2025-26	TF	GF	FF
FY 2024-25 Claims	$117,000	$0	$117,000
FY 2025-26 Claims	$1,283,000	$0	$1,283,000
FY 2024-25 Caregiving Module	$21,000	$10,000	$11,000
FY 2025-26 Caregiving Module	$364,000	$182,000	$182,000
Total	**$1,785,000**	**$192,000**	**$1,593,000**

*Totals may differ due to rounding.

Funding:

100% Title XIX FF (4260-101-0890)
50% Title XIX FF / 50% GF (4260-101-0890/0001)

MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 41
IMPLEMENTATION DATE: 6/2023
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 2321

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$2,000,000	$2,200,000
STATE FUNDS	$1,000,000	$1,100,000
FEDERAL FUNDS	$1,000,000	$1,100,000

Purpose:
This policy change estimates the cost of the Department's contract with public or private entities for the purpose of assisting dual eligible members with enrollment, benefit, and access questions for Medicare and Medi-Cal managed care plans.

Authority:
AB 133 (Budget Act of FY 2021-22)
Contract 22-20371

Interdependent Policy Changes:
Not Applicable

Background:
The Health Omnibus within the 2021 Budget Act requires that the Department contract with public or private entities to assist dual eligible members understand their health care coverage options, overcome barriers in their access to care, and address eligibility and enrollment barriers. The ombudsperson service is performed by an independent, third-party firm, allowing for more objective analysis and observation, and is designed to:

- Assist potential enrollees,
- Assist enrollees filing appeals and complaints when needed, and
- Investigate, negotiate, and resolve enrollee problems/complaints with Medicare Advantage plans and Dual Eligible Special Needs Plans.

The Budget Act of FY 2021-22 requires the Department to oversee a contract that will continue this independent ombudsperson program to provide these services to dual eligible members statewide in 2023 and ongoing. This contract is intended to enable the continuation and expansion of the CalMediConnect (CMC) Independent Ombudsman, which offered ombudsperson services to CMC members. An amendment to this contract is expected to be made to extend vendor services beyond the December 31, 2025, contract end date.

Reason for Change:
There is no change from the prior estimate for FY 2024-25. The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to the anticipated expansion of Medicare – Medi-Cal Plans (MMP) in 2026 and its associated enrollment. This expansion is expected to bring an increase in call/case volume demand related to MMP workload.

Methodology:
1. Annual contract costs are $2,000,000 TF in FY 2024-25 and $2,200,000 TF in FY 2025-26.

MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 41

2. The contract began in January 2023.

3. The anticipated costs for FY 2024-25 and FY 2025-26 of this contract are:

Fiscal Year	TF	GF	FF
FY 2024-25	$2,000,000	$1,000,000	$1,000,000
FY 2025-26	$2,200,000	$1,100,000	$1,100,000

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

OUTREACH & ENROLLMENT ASSIST. FOR DUAL MEMBERS

OTHER ADMIN. POLICY CHANGE NUMBER: 42
IMPLEMENTATION DATE: 7/2024
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 2405

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$2,000,000	$0
STATE FUNDS	$1,000,000	$0
FEDERAL FUNDS	$1,000,000	$0

Purpose:
This policy change estimates the costs for Medi-Cal eligibility outreach and enrollment for members dually eligible for Medicare and Medi-Cal.

Authority:
SB 129 (Chapter 69, Statute of 2021)
Contract: 21-10405

Interdependent Policy Changes:
Not Applicable

Background:
Per SB 129 (Chapter 69, Statutes of 2021), the Department is contracting with a nonprofit agency for Medi-Cal eligibility outreach and enrollment of $24 million total funds ($12 million general funds from multi-year authority and $12 million federal funds requested as needed in each Budget Act) for encumbrance or expenditure until June 30, 2024. The population of focus for this contract is low-income older adults. The outreach and enrollment is conducted in coordination with the California Department of Aging and the Health Insurance Counseling and Advocacy Program.

Reason for Change:
There is no change from the prior estimate for 2024-25. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due to the last payment for this program being made in FY 2024-25.

Methodology:
1. This policy change budgets for a Department contract for Medi-Cal outreach and enrollment assistance for dually eligible members.

OUTREACH & ENROLLMENT ASSIST. FOR DUAL MEMBERS

OTHER ADMIN. POLICY CHANGE NUMBER: 42

2. The table below displays the estimated spending and remaining funds by Appropriation Years:

(Dollars in Thousands)

	TF	GF	FF*
Appropriation Year 2021-22	$24,000	$12,000	$12,000
Prior Years	$13,400	$6,700	$6,700
Estimated in FY 2023-24	$8,600	$4,300	$4,300
Estimated in FY 2024-25	$2,000	$1,000	$1,000
Total Estimated Remaining	$0	$0	$0

*Federal funds authority is newly requested for the fiscal year in which funds are anticipated to be expended.

3. The estimated costs in FY 2024-25 are as follows:

(Dollars in Thousands)

FY 2024-25	**TF**	**GF**	**FF***
Appropriation Year 2021-22	$2,000	$1,000	$1,000
Total FY 2024-25	**$2,000**	**$1,000**	**$1,000**

*Federal funds authority is newly requested for the fiscal year in which funds are anticipated to be expended.

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

T-MSIS

OTHER ADMIN. POLICY CHANGE NUMBER: 43
IMPLEMENTATION DATE: 9/2013
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1768

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$1,913,000	$1,800,000
STATE FUNDS	$282,600	$270,300
FEDERAL FUNDS	$1,630,400	$1,529,700

Purpose:
This policy change estimates the cost for the maintenance and operations (M&O) of the Extract, Transform, and Load (ETL) data solution used to transmit data to the Transformed Medicaid Statistical Information System (T-MSIS). It estimates the cost for design, development, and implementation (DDI) for the planning, analysis, and testing to achieve technical compliance with the Centers for Medicare & Medicaid Services (CMS) standard operating procedure guidelines for production implementations that impact T-MSIS reporting.

Authority:
Affordable Care Act (ACA)
Medicaid Managed Care Final Rule
42 Code of Federal Regulations 433.120
CMS Informational Bulletin: T-MSIS State Compliance
Contract #22-20364 A01

Interdependent Policy Changes:
Not Applicable

Background:
The CMS requires data in a standardized format from the states to review system projects related to the ACA. The Department implemented an enterprise-wide ETL data solution to modernize and streamline the data transmission processes from the Department to the CMS T-MSIS. The project provides modern capabilities to improve business processes by collecting comprehensive data regarding the cost, quantity, and quality of health care provided for Medi-Cal members. Data transferred to the T-MSIS includes claims, eligibility, third-party liability, managed care, and provider information.

In November 2017, CMS approved an Implementation Advance Planning Document Update (IAPDU), providing enhanced funding for software support as well as ETL system and training costs through Federal Fiscal Year (FFY) 2021. On August 10, 2018, CMS issued a State Health Official (SHO) letter (#18-008) providing guidance to states regarding expectations for Medicaid and Children's Health Insurance Program data and ongoing T-MSIS implementation, and access to enhanced funding for future costs to California's Medicaid Enterprise System (MES). Enhanced funding for additional system enhancement and operational costs associated with MES is contingent upon the Department's continued ability to meet T-MSIS requirements of complete, accurate, and timely data reporting. Specifically, CMS expects that:

- T-MSIS data quality should be a permanent and ongoing process of state operations;

T-MSIS
OTHER ADMIN. POLICY CHANGE NUMBER: 43

- States commit the necessary resources to make steady progress in improving their data quality;
- States resolve data quality issues for the 12 Top Priority Items no later than six months after the release of SHO letter #18-008.

CMS approved the T-MSIS IAPD for FFY 2024-25 on April 10, 2024.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is an increase due to updated actuals, adjusted projections, and the extension of the Standard Operation Procedures (SOP) testing contract. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due to the completion of the SOP testing contract.

Methodology:
1. The approved FFY 2024-25 IAPD includes funding for ongoing M&O (75% Title XIX / 25% GF) activities, which include the annual renewal of software licenses for T-MSIS ETL data solutions and staff training costs.

2. The SOP testing contract began on April 3, 2023, and will end on April 2, 2026. This is for DDI (90% Title XIX/10% GF) activities.

FY 2024-25	TF	GF	FF
M&O	$293,000	$77,000	$216,000
DD&I	$1,620,000	$206,000	$1,414,000
Total	**$1,913,000**	**$283,000**	**$1,630,000**

FY 2025-26	TF	GF	FF
M&O	$305,000	$80,000	$225,000
DD&I	$1,495,000	$190,000	$1,305,000
Total	**$1,800,000**	**$270,000**	**$1,530,000**

Funding:
75% Title XIX / 25% GF (4260-101-0890/0001)
90% Title XIX / 10% GF (4260-101-0890/0001)
65% Title XXI / 35% GF (4260-101-0890/0001)
100% State GF (4260-101-0001)

MFP/CCT SUPPLEMENTAL FUNDING

OTHER ADMIN. POLICY CHANGE NUMBER: 44
IMPLEMENTATION DATE: 10/2022
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2392

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$1,773,000	$5,319,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,773,000	$5,319,000

Purpose:
This policy change budgets supplemental funding in Money Follows the Person (MFP) that the Centers for Medicare and Medicaid Services (CMS) made available to state MFP grantees to support planning and capacity building activities.

Authority:
Federal Deficit Reduction Act (DRA) of 2005 (P.L. 109-171), Section 6071
Affordable Care Act (ACA) (P.L. 111-148), Section 2403
Medicaid Extenders Act of 2019 (P.L. 116-3), Section 2
Medicaid Services Investment and Accountability Act of 2019 (P.L. 116-16), Section 5
Sustaining Excellence in Medicaid Act of 2019 (P.L. 116-39), Section 4
Further Consolidated Appropriations Act, 2020 (P.L. 116-94), Section 205
Coronavirus Aid, Relief, and Economic Security (CARES) Act, 2020 (P.L. 116-136) Section 3811
Consolidated Appropriations Act, 2021 (P.L. 108-361) Section 204
Contract #22-20091-A2

Interdependent Policy Changes:
Not Applicable

Background:
On September 23, 2020, CMS notified MFP state grantees of a supplemental funding opportunity for those that operate MFP Demonstration programs. The Department developed a proposal to submit to CMS to receive up to $5 million in supplemental funding for planning and capacity building activities to accelerate long-term care system transformation design and implementation, and to expand home and community-based services capacity. The Department submitted their proposal for supplemental funding to CMS on June 30, 2021.

On July 27, 2021, CMS approved the Department's MFP Supplemental Funding application. CMS approved the Department's request for $5 million in supplemental funding to conduct a statewide Gap Analysis and Multiyear Roadmap of its Home and Community-Based Services (HCBS) and Managed Medi-Cal Long-Term Supports and Services (LTSS) programs and networks. The Department's project narrative identified how the funding will be utilized for planning and capacity building activities to accelerate long-term care system transformation design and implementation, and to expand HCBS capacity.

In July 2022, the Department selected Mathematica to conduct the MFP Supplemental Funding – Gap Analysis and Multiyear Roadmap. The contract between Mathematica and the

MFP/CCT SUPPLEMENTAL FUNDING
OTHER ADMIN. POLICY CHANGE NUMBER: 44

Department was fully executed on October 6, 2022, retroactive to September 1, 2022, through June 30, 2025. The Department intends to roll over unspent funds from the first year of the contract to the outyears through a contract amendment; those funds will be used to assist Mathematica with implementing the Multi-Year Roadmap.

In May 2024, CMS released the Access Rule and Quality Measures requirements for states implementing HCBS. Due to the size of California's expansive HCBS population, complexities around the different Waiver/State Plan authorities, and the current lack of infrastructure, the Department requires additional support to implement the large-scale statewide effort to ensure compliance with the requirements. To establish compliance, CMS has permitted states to request additional MFP Supplemental Funding. The Department used the additional supplemental funding to amend the Mathematica and Assurecare contracts as follows:

- The Mathematica contract was amended to conduct additional qualitative data collection and provide the Department with technical assistance to build its capacity to report HCBS access and quality measures, as required by CMS' Ensuring Access to Medicaid Services final rule; and
- The Assurecare contract was amended to allow updates to the existing CCT database, MedCompass, to include the new CMS access rule requirements.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is a decrease based on updating payment timing for invoicing. The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to additional funds awarded to implement the new CMS Access Rule requirements.

Methodology:
1. Assume MFP supplemental funding can be spent in the year it was awarded and for four years after, as long as grant funding remains available.

2. Assume the Department received a one-time MFP supplemental funding up to $5,000,000 TF through FY 2024-25 for Gap Analysis and Multiyear Roadmap.

3. Assume the Department was awarded $4,193,000 for the amended Mathematica contract and $975,000 for the amended Assurecare contract to implement the new CMS Access Rule requirements.

4. Assume the Department spent $1,035,000 TF in FY 2022-23 and $2,041,000 TF in FY 2023-24. The Department will spend $1,773,000 TF in FY 2024-25 and $5,319,000 TF in FY 2025-26.

FY 2024-25	TF
Gap Analysis Funding	$1,773,000
FY 2024-25 Total	**$1,773,000**

FY 2025-26	TF
Gap Analysis Funding	$151,000
CMS Access Rule	$5,168,000
FY 2025-26 Total	**$5,319,000**

MFP/CCT SUPPLEMENTAL FUNDING
OTHER ADMIN. POLICY CHANGE NUMBER: 44

Funding:
MFP Federal Grant (4260-106-0890)

SSA COSTS FOR HEALTH COVERAGE INFO.

OTHER ADMIN. POLICY CHANGE NUMBER: 45
IMPLEMENTATION DATE: 1/1989
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 237

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$1,480,000	$1,559,000
STATE FUNDS	$740,000	$779,500
FEDERAL FUNDS	$740,000	$779,500

Purpose:
This policy change estimates the cost of obtaining Supplemental Security Income/State Supplementary Payment (SSI/SSP) recipient information from the Social Security Administration (SSA).

Authority:
Social Security Act 1634(a)

Interdependent Policy Changes:
Not Applicable

Background:
The Department uses SSI/SSP information from the SSA to defer medical costs to other payers. The SSA administers the SSI/SSP programs. The SSI program is a federally funded program, which provides income support for persons aged 65 or older and qualified blind or disabled individuals. The SSP is a state program which augments SSI. The Department receives SSI/SSP information about health coverage and assignment of rights to medical coverage from SSA. The SSA bills the Department quarterly for this activity.

Reason for Change:
The change in the FY 2024-25, from the prior estimate, is an increase based on an average projection using the actual billed amount from the SSA in FY 2021-22, FY 2022-23, and FY 2023-24.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase based upon the most current actual billings from the SSA for FY 2022-23, FY 2023-24, and the projected billings for FY 2024-25.

Methodology:
1. The following projections are averaged based upon the most current actual billings from SSA.

Fiscal Year	TF	GF	FF
FY 2024-25	$1,480,000	$740,000	$740,000
FY 2025-26	$1,559,000	$780,000	$779,000

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

MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)

OTHER ADMIN. POLICY CHANGE NUMBER: 46
IMPLEMENTATION DATE: 7/2009
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1441

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$1,199,000	$1,199,000
STATE FUNDS	$415,250	$415,250
FEDERAL FUNDS	$783,750	$783,750

Purpose:
This policy change estimates the maintenance and operations (M&O) expenses resulting from legislative mandates, federal and/or state directives, and Medi-Cal program policy changes, which impact the Medi-Cal Eligibility Data System (MEDS).

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
The MEDS is a statewide database containing eligibility information for public assistance programs administered by the Department and other departments. MEDS provides users with the ability to perform multi-program application searches, verify program eligibility status, enroll members in multiple programs, and validate information on application status. Funding is required for the following M&O functions:

- MEDS Master Client Index maintenance;
- Data matches from various federal and state agencies;
- Supplemental Security Income termination process support;
- Medi-Cal application alerts;
- Medicare Modernization Act Part D buy-in process improvements;
- Eligibility renewal process;
- Reconciling county eligibility data used to support the counties in Medi-Cal eligibility determination;
- Supporting eligibility and enrollment functions; and
- Enabling counties to perform online statistical analysis and MEDS-alert reporting as well as allowing them to track and report county workers' MEDS transactions.

MEDS generates Client Index Numbers (CIN) to uniquely identify Medi-Cal members. CINs can be used to identify members for public assistance programs, including Temporary Assistance for Needy Families, In-Home Support Services, and other Health and Human Services programs such as Covered California's Advance Premium Tax Credit.

The Department implements MEDS functionality to support the Medi-Cal program related to member eligibility and interfacing with the county consortia and state and county business

MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)
OTHER ADMIN. POLICY CHANGE NUMBER: 46

partners. The California Department of Technology (CDT) houses MEDS and charges the Department for all associated data storage, processing, networking, data archiving, and backup costs. CDT invoices the Department on a monthly basis for the services provided. CDT data center charges change based on the volume of members enrolled within the MEDS system.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a decrease due to lower costs for system tracking and M&O functions. There is no change from FY 2024-25 to FY 2025-26 in the current estimate.

Methodology:
1. Reporting and tracking costs include non-production support costs consisting of CDT data center charges for development, testing, quality assurance, and not all system-related charges related to essential M&O functions.

2. M&O costs include, but are not limited to, the MEDS Reconciliation Process for both the counties and the State, Third Party Liability file matches related to recipients that may have other health coverage, and Medicaid-related system and production support costs to cover the M&O functions described in the background section.

3. M&O and Reporting and Tracking costs include quarterly reconciliation for OTECH services incorrectly billed, resulting in retro-corrections of expenses.

4. The projected costs for FY 2024-25 and FY 2025-26 are:

FY 2024-25	TF	GF	FF
Reporting and Tracking (50% FF / 50% GF)	$462,000	$231,000	$231,000
Maintenance & Operations (75% FF / 25% GF)	$737,000	$184,000	$553,000
Total	**$1,199,000**	**$415,000**	**$784,000**

FY 2025-26	TF	GF	FF
Reporting and Tracking (50% FF / 50% GF)	$462,000	$231,000	$231,000
Maintenance & Operations (75% FF / 25% GF)	$737,000	$184,000	$553,000
Total	**$1,199,000**	**$415,000**	**$784,000**

Funding:
50% Title XIX / 50% GF (4260-101-0890/0001)
75% Title XIX / 25% GF (4260-101-0890/0001)

FAMILY PACT PROGRAM ADMIN.

OTHER ADMIN. POLICY CHANGE NUMBER: 47
IMPLEMENTATION DATE: 7/2012
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 1675

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$1,006,000	$1,006,000
STATE FUNDS	$100,600	$100,600
FEDERAL FUNDS	$905,400	$905,400

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 19-96361 A1
AB 1464 (Chapter 21, Statutes of 2012)

Interdependent Policy Changes:
Not Applicable

Background:
The Family PACT program has two main objectives, to increase (1) access to services for low-income women and men, including adolescents; and (2) the number of providers who serve these clients. Education and support services are provided to the Family PACT providers and potential providers, as well as clients and potential clients. Services include, but are not limited to:

- Public education, awareness, and direct client outreach;
- Provider enrollment, recruitment, and training;
- Training and technical assistance for medical and non-medical staff;
- Education and counseling services;
- Preventive clinical services;
- Sexually transmitted infection/human immunodeficiency virus training and technical assistance services; and
- Toll-free referral number.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is an increase due to updated contract costs. There is no change from FY 2024-25 to FY 2025-26 in the current estimate.

FAMILY PACT PROGRAM ADMIN.

OTHER ADMIN. POLICY CHANGE NUMBER: 47

Methodology:

1. The administrative costs for the Family PACT program are estimated in the table below:

Fiscal Years	TF	GF	FF
FY 2024-25	$1,006,000	$101,000	$905,000
FY 2025-26	$1,006,000	$101,000	$905,000

Funding:

90% Family Planning / 10% GF (4260-101-0890/0001)

CALAIM - BH - CONNECT DEMONSTRATION ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 48
IMPLEMENTATION DATE: 1/2025
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2398

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$946,000	$416,556,000
STATE FUNDS	$172,000	$208,278,000
FEDERAL FUNDS	$774,000	$208,278,000

Purpose:
This policy change estimates the administrative costs of the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration which will expand access to and strengthen the continuum of mental health services for Medi-Cal members living with significant behavioral health needs.

Authority:
Medicaid Section 1115 Demonstration Waiver
Welfare & Institutions Code 14184.400(c)

Interdependent Policy Changes:
Not Applicable

Background:
California is facing a growing mental health crisis exacerbated by the COVID-19 pandemic. As a result, the Department has made strengthening California's behavioral health system a top priority and is already making many investments in expanding behavioral health services. The BH-CONNECT Demonstration was designed to expand on these investments, complement existing major behavioral health initiatives, and strengthen the continuum of care for Medi-Cal members.

The Department applied for a new Medicaid Section 1115 demonstration in October 2023, titled the BH-CONNECT Demonstration, to expand access to and strengthen the continuum of behavioral health services for Medi-Cal members living with significant behavioral health needs. The disparities addressed in the demonstration are based largely off California's 2022 Assessment, titled Assessing the Continuum of Care for Behavioral Health Services in California.

The proposed BH-CONNECT Demonstration approach included five key components:

- Strengthening the statewide continuum of community-based services and evidence-based practices available through Medi-Cal for individuals living with significant behavioral health needs.
- Supporting statewide practice transformations and improvements in the county-administered behavioral health system.
- Improving statewide county accountability for meeting service improvement requirements and implementing new benefits through incentives, robust technical assistance, and oversight.
- Establishing a county option to provide enhanced community-based services.

CALAIM - BH - CONNECT DEMONSTRATION ADMIN
OTHER ADMIN. POLICY CHANGE NUMBER: 48

- Establishing a county option to receive Federal Funds Participation (FFP) for services provided during short-term stays in IMDs, contingent on counties meeting robust accountability requirements.

This policy change budgets administrative costs for the BH-CONNECT Demonstration. In December 2024, the Centers for Medicare and Medicaid Services (CMS) approved a modified version of the BH-CONNECT Demonstration proposal. For budgeting purposes, this policy change displays estimated amounts for the BH-CONNECT Demonstration as proposed. Adjustments to the Estimate will be made to reflect the final approved BH-CONNECT Demonstration as part of the May Revision.

Reason for Change:
There is no change from the prior estimate for FY 2024-25.

The change in the current estimate, from FY 2024-25 to FY 2025-26, is due FY 2025-26 reflecting a full year's cost and the ramp-up of additional proposed features for the BH-CONNECT Demonstration.

Methodology:
1. Assume the BH-CONNECT demonstration will be implemented through a staged approach over multiple years, beginning January 1, 2025.

2. Total estimated administrative costs for the BH-CONNECT Demonstration, on a cash basis, is as follows:

FY 2024-25	TF	GF	FFP	IGT*
SMHS - Statewide	$858,000	$38,000	$730,000	$90,000
SMHS -Opt-in	$88,000	$0	$44,000	$44,000
Total	**$946,000**	**$38,000**	**$774,000**	**$134,000**

FY 2025-26	TF	GF	FFP	IGT*	BHSF
SMHS - Statewide	$232,158,000	$9,034,000	$116,079,000	$94,545,000	$12,500,000
SMHS -Opt-in	$184,398,000	$0	$92,199,000	$92,199,000	$0
Total	**$416,556,000**	**$9,034,000**	**$208,278,000**	**$186,744,000**	**$12,500,000**

Funding:
100% GF (4260-101-0001)
Title XIX FF (4260-101-0890)
Medi-Cal County Behavioral Health Fund (4260-601-3420)*
Behavioral Health Services Fund (4260-101-3085)

MMA - DSH ANNUAL INDEPENDENT AUDIT

OTHER ADMIN. POLICY CHANGE NUMBER: 49
IMPLEMENTATION DATE: 7/2009
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 266

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$769,000	$800,000
STATE FUNDS	$384,500	$400,000
FEDERAL FUNDS	$384,500	$400,000

Purpose:
This policy change estimates the administrative costs of contracting for the annual independent audit of the Disproportionate Share Hospital (DSH) program.

Authority:
Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)
Title 42, Code of Federal Regulations, Section 455.300 et. seq.

Interdependent Policy Changes:
Not Applicable

Background:
The MMA requires an annual independent certified audit that primarily certifies:

1. The extent to which DSH hospitals have reduced their uncompensated care costs to reflect the total amount of claimed expenditures made under section 1923 of the MMA.

2. That DSH payment calculations of hospital-specific limits include all payments to DSH hospitals, including supplemental payments.

DSH-eligible Designated Public Hospitals participating in the Global Payment Program are not subject to the DSH audit.

The audits are funded with 50% Federal Financial Participation and 50% General Fund (GF). The Centers for Medicare and Medicaid Services (CMS) released the final regulation and criteria for the annual certified audit in 2008. Each fiscal year's annual audit and report is due to CMS by December 31st.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to a lower actual invoice amount for May 2024 than previously estimated.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to higher estimated payments in FY 2025-26, which are based on an estimated monthly average of the full contracted amount and FY 2024-25 includes one actual invoice that was for an amount less than the estimated monthly projection.

MMA - DSH ANNUAL INDEPENDENT AUDIT

OTHER ADMIN. POLICY CHANGE NUMBER: 49

Methodology:

1. The initial contract period began on January 1, 2020, and was valid through June 30, 2022, for a total amount of $2,000,000. The Department has exercised an extension through December 31, 2024, for an additional $2,000,000.

2. The Department is procuring a new DSH Audit contract beginning on January 1, 2025, and valid through June 30, 2029. The initial contract period is 30-months, or $2 million with additional two Department-option 12-month $800,000 extensions for a total contract cost of $3.6 million. The invitation for bid (IFB) was released on July 30, 2024.

3. In FY 2024-25, the Department will make payments for the FY 2020-21 and FY 2021-22 audit invoices.

4. In FY 2025-26, the Department will make payments for the FY 2021-22 and FY 2022-23 audit invoices.

Fiscal Year	TF	GF	FF
FY 2024-25	$769,000	$384,000	$385,000
FY 2025-26	$800,000	$400,000	$400,000

Funding:

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

HEALTH INFORMATION EXCHANGE INTEROPERABILITY

OTHER ADMIN. POLICY CHANGE NUMBER: 50
IMPLEMENTATION DATE: 7/2023
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2159

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$500,000	$500,000
STATE FUNDS	$50,000	$50,000
FEDERAL FUNDS	$450,000	$450,000

Purpose:
This policy change estimates the cost to administer data exchange activities to support care for Medi-Cal members. The policy change also estimates the cost to deploy and operate the Department's health information exchange (HIE) activities.

Authority:
21st Century Cures Act of 2016
Title 42, Code of Federal Regulations, Section 431.60
Title 42, Code of Federal Regulations, Section 457.730
Title 45, Code of Federal Regulations, Section 170.213
Title 22, California Code of Regulations, Section 51476
CMS Interoperability and Patient Access Final Rule (CMS-9115-F)

Interdependent Policy Changes:
Not Applicable

Background:
The California Health Information Exchanges (HIE) Onboarding Program (Cal-HOP), approved by Centers for Medicare and Medicaid Services (CMS) in February 2020, was constructed based on the CMS guidance and supported Health Information Organizations (HIO) onboarding and technical assistance as well as establish interfaces between HIOs and Controlled Substance Utilization Review and Evaluation System (CURES).

The Cal-HOP, which used state and federal funds, ended in September 2021. The state funds were originally appropriated as part of a stakeholder proposal to support data exchange in Medi-Cal. The Department received budget authority to spend the unused general funds share of the Cal-HOP funding to support other interoperability and data exchange efforts during FY 2021-22, which was extended in the May 2022 Appropriations Budget until the end of FY 2022-23.

In FY 2022-23, the Department utilized the unused Cal-HOP funding for two main initiatives. One of these, the Authorization to Share Confidential Medi-Cal Information (ASCMI) Form and consent management service pilot, ended June 30, 2023, though invoices were paid in FY 2023-24. The second initiative was a contract to build an HIE Roadmap focused on California Advancing and Innovating Medi-Cal (CalAIM), which included recommendations on how HIE should be utilized to achieve Departmental goals, and develop a communications plan to reach key stakeholders about fulfilling the goals identified for the Department and partner HIEs. Invoices for the HIE Roadmap were paid in FY 2023-24.

HEALTH INFORMATION EXCHANGE INTEROPERABILITY

OTHER ADMIN. POLICY CHANGE NUMBER: 50

To continue building on the efforts of Cal-HOP, ASCMI, and the HIE Roadmap, to implement the requirements under the federal Interoperability rules, and to facilitate the improved care coordination desired by CalAIM initiatives, the Department needs to plan for consent management and associated identity management services.

The Interoperability and Patient Access Rule, finalized by the CMS in 2020, requires Medicaid organizations and other entities to implement a Patient Access Application Programming Interface (API) through which members can access their health information through a third-party vendor of their choosing. In order to share information through the third-party vendor, the Department must collect consent from the member to share their information with the third-party vendor. The Interoperability rule also requires Medicaid organizations and other entities to implement a Payer to Payer API, which supports care continuity by enabling data to follow an individual as they move to different health plans. For Medi-Cal to exchange a member's data with another payer, consent is required from the member for some components of the data such as that governed by 42 CFR Part 2.

Many CalAIM initiatives are focused on improving care coordination for members for which consent to share data essential. Through CalAIM, the Department is partnering with entities in disparate sectors, including housing and homeless programs, the justice system, education, foster youth programs, and other social services organizations. Such organizations may or may not be covered by the Health Insurance Portability and Accountability Act (HIPAA) and may have different data privacy and data sharing rules than Medi-Cal and other health care providers. Furthermore, data elements used to capture an individual's identity may also be disparate across these organizations. As such, consent and associated identity management services are essential to confirm data shared with these new partners has been consented to by the correct individual.

The funds requested will support planning for the consent management services. The Department will be requesting 90% funding from CMS by updating the Interoperability Advance Planning Document (APD).

Reason for Change:
The change for FY 2024-25, from the prior estimate, is an increase due to the need for additional funds to plan consent management and identity management services. There is no change from FY 2024-25 to FY 2025-26 in the current estimate.

Methodology:

FY 2024-25	TF	GF	FF
Consent Management Services	$500,000	$50,000	$450,000
Total	**$500,000**	**$50,000**	**$450,000**

FY 2025-26	TF	GF	FF
Consent Management Services	$500,000	$50,000	$450,000
Total	**$500,000**	**$50,000**	**$450,000**

HEALTH INFORMATION EXCHANGE INTEROPERABILITY

OTHER ADMIN. POLICY CHANGE NUMBER: 50

Funding:
100% State GF (4260-101-0001)
100% Title XIX (4260-101-0890)

CCT OUTREACH - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 51
IMPLEMENTATION DATE: 4/2011
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 1556

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$340,000	$340,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$340,000	$340,000

Purpose:
This policy change budgets the federal funding to cover California Community Transitions (CCT) administrative costs to increase the community-based network of service providers that serve the CCT-eligible population.

Authority:
Federal Deficit Reduction Act (DRA) of 2005 (P.L. 109-171), Section 6071
Affordable Care Act (ACA) (P.L. 111-148), Section 2403
Medicaid Extenders Act of 2019 (P.L. 116-3), Section 2
Consolidated Appropriations Act, 2021 (P.L. 108-361) Section 204
California Department of Aging (ADRC) 21-10023

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 members who are interested in returning to the community. The Department is collaborating with the Aging and Disability Resources Connection (ADRC) programs, CCT lead organizations, and other community-based providers to increase the community-based network of service providers that serve the CCT-eligible population. This supplemental grant funding does not require matching funds. The costs were 100% federally funded.

Beginning January 1, 2016, the Department will allocate MFP grant funding to continue efforts that were initiated under the supplemental grant to increase community-based network of service providers that serve the CCT-eligible population. These activities qualify as administrative marketing and outreach activities, which are 100% federally funded through the MFP grant.

On January 24, 2019, the federal Medicaid Extenders Act of 2019 was passed into law and authorized MFP state grantees to continue to transition members to through December 31, 2019, using available MFP funding. The Extenders Act provided CMS with authority to allocate new funding to state grantees for FY 2019-20, to allow funding appropriated through the Extenders Act to be spent through 2023.

CCT OUTREACH - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 51

On December 27, 2020, the President signed the Consolidated Appropriations Act, 2021 into law, which included an extension of the MFP grant through FFY 2023 and appropriated funding through FFY 2023. Under the Act, the CCT Program received grant funding to continue to transition eligible members through September 2023 and up to four years after, as long as grant funding remains available.

On December 29, 2022, the President signed the Consolidated Appropriations Act of 2023 into law, which appropriates additional funding for each fiscal year 2024 through 2027. Unexpended grant funds awarded for any fiscal year can continue to be spent for up to four additional years, through September 30, 2031.

Reason for Change:
There is no change from the prior estimate, for FY 2024-25. There is no change, in the current estimate, from FY 2024-25 to FY 2025-26.

Methodology:
1. Assume $340,000 from the MFP grant administrative funding is expected to be paid in FY 2024-25 and FY 2025-26.

2. An amended contract was executed in January 2024.

3. Estimated costs are based on the approved contract budget which includes proposed expenditures for the following activities:

    - ADRC planning and implementation,
    - ADRC/MFP collaborative strategic planning,
    - MDS 3.0 Section Q referrals policy development,
    - MDS/Options counseling training sessions, and
    - ARDC Workgroup.

CCT OUTREACH - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 51

FY 2024-25	TF	GF	FF
CCT Costs PC:			
Regular CCT Population	$49,778,000	$21,059,000	$28,719,000
State-Funded CCT Population	$118,000	$10,229,000	($10,111,000)
ALW Transition Costs	$52,095,000	$10,473,000	$41,622,000
Total Costs	$101,991,000	$41,761,000	$60,230,000
CCT Savings:			
Total GF savings and Total FFP	($115,724,000)	($69,434,000)	($46,290,000)
CCT Fund Transfer to CDSS PC:	$65,000	$0	$65,000
CCT Outreach - Admin costs PC:	**$340,000**	**$0**	**$340,000**
Total of CCT PCs including savings	($13,328,000)	($27,673,000)	$14,345,000

*The savings are included in the total, however, they are fully reflected in the base estimates.

FY 2025-26	TF	GF	FF
CCT Costs PC:			
Regular CCT Population	$49,779,000	$10,008,000	$39,771,000
State-Funded CCT Population	$118,000	$11,147,000	($11,029,000)
ALW Transition Costs	$61,277,000	$12,319,000	$48,957,000
Total Cost	$111,174,000	$33,474,000	$77,699,000
CCT Savings:			
Total GF savings and Total FFP	($40,806,000)	($24,484,000)	($16,322,000)
CCT Fund Transfer to CDSS PC:	$65,000	$0	$65,000
CCT Outreach - Admin costs PC:	**$340,000**	**$0**	**$340,000**
Total of CCT PCs including savings	$70,773,000	$8,990,000	$61,782,000

*The savings are included in the total, however, they are fully reflected in the base estimates.

Funding:
MFP Federal Grant (4260-106-0890)

HEALTH PLAN OF SAN MATEO DENTAL INTEGRATION EVAL

OTHER ADMIN. POLICY CHANGE NUMBER: 52
IMPLEMENTATION DATE: 7/2023
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 2438

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$162,000	$186,000
STATE FUNDS	$81,000	$93,000
FEDERAL FUNDS	$81,000	$93,000

Purpose:
This policy change estimates costs for the statutorily mandated external program evaluation of the Health Plan of San Mateo (HPSM) Dental Integration.

Authority:
SB 849 (Chapter 47, Statutes of 2018)

Interdependent Policy Changes:
Not Applicable

Background:
Chapter 47, Statutes of 2018 authorizes HPSM to evaluate the integration of dental benefits into the Medi-Cal Managed Care Plan in San Mateo County. The HPSM Dental Integration began January 1, 2022. In accordance with the Welfare & Institutions Code Section 14184.90(f), the Department is required to contract with an external entity to conduct, complete, and publish an evaluation of HPSM Dental Integration no later than December 31, 2026. State funds for the evaluation will be provided by HPSM to the Department, and the Department will request federal matching funding through the Cost Allocation Plan. In total, $500,000 will be available for this evaluation over the course of the contract.

The Department executed the contract on April 3, 2024, effective February 1, 2024, through December 31, 2026,with the evaluation produced during the final year.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a decrease due to contract start and payment delays and adjusted projections. The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to adjusted projections.

Methodology:
Total costs are estimated to be:

Fiscal Year	TF	GF Reimb.	FF
FY 2024-25	$162,000	$81,000	$81,000
FY 2025-26	$186,000	$93,000	$93,000

HEALTH PLAN OF SAN MATEO DENTAL INTEGRATION EVAL

OTHER ADMIN. POLICY CHANGE NUMBER: 52

Funding:

FY 2024-25	TF	GF Reimb.	FF
100% Title XIX FF (4260-101-0890)	$81,000	$0	$81,000
Reimbursement GF (4260-601-0995)	$81,000	$81,000	$0
Total	**$162,000**	**$81,000**	**$81,000**

FY 2025-26	TF	GF Reimb.	FF
100% Title XIX FF (4260-101-0890)	$93,000	$0	$93,000
Reimbursement GF (4260-601-0995)	$93,000	$93,000	$0
Total	**$186,000**	**$93,000**	**$93,000**

ELECTRONIC VISIT VERIFICATION M&O COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 53
IMPLEMENTATION DATE: 7/2025
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2505

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$0	$26,299,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$26,299,000

Purpose:
This policy change estimates the Electronic Visit Verification (EVV) Maintenance and Operations (M&O) contract costs for the California Department of Social Service (CDSS), California Department of Aging (CDA), California Department of Public Health (CDPH), and California Department of Developmental Services (CDDS).

Authority:
Interagency Agreements (IA):
CDSS IA 18-85714
CDA IA 25-50009
CDPH IA 25-50008
CDDS IA 25-50007

Interdependent Policy Changes:
Not Applicable

Background:
EVV is a telephone and computer-based method that electronically verifies in home service visits. EVV solutions must verify type of service performed, individual receiving the service, date of the service, location of service delivery, individual providing the service, and time the service begins and ends. Pursuant to Subsection I of Section 1903 of the Social Security Act (SSA)(42 U.S.C. 1396b), all states must implement EVV for Medicaid-funded Personal Care Services (PCS) and Home Health Care Services (HHCS) that require an in-home visit by a provider. This applies to PCS provided under SSA sections 1905(a)(24), 1915(c), 1915(i), 1915(j), 1915(k), or a waiver under section 1115; and HHCS provided under section 1905(a)(7) of the SSA or a waiver of the State Plan.

In California, EVV impacts all PCS and HHCS provided under the Medi-Cal state plan and under several Medicaid waiver programs. These services are provided in California through programs managed by multiple state departments which the Department currently has contracts with: CDSS, CDA, CDPH, and CDDS.

EVV is now shifting from the Design, Development, and Implementation phase to the M&O phase during the contract renewal process. The CDSS contract costs were previously budgeted in the Personal Care Services and Department of Social Services Admin Cost policy changes, and the CDA contract costs were previously budgeted in the Department of Aging Administrative Costs policy change. The M&O costs for CDSS and CDA are now budgeted in this this policy change.

ELECTRONIC VISIT VERIFICATION M&O COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 53

Reason for Change:
This is a new policy change.

Methodology:
1. Assume the total M&O costs for CDSS, CDA, CDPH, and CDDS are as follows:

FY 2025-26	TF	GF	FF
CDSS	$22,687,000	$0	$22,687,000
CDA	$186,000	$0	$186,000
CDPH	$98,000	$0	$98,000
CDDS	$3,328,000	$0	$3,328,000
Total	**$26,299,000**	**$0**	**$26,299,000**

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

DESIGNATED STATE HEALTH PROGRAMS

OTHER ADMIN. POLICY CHANGE NUMBER: 55
IMPLEMENTATION DATE: 9/2024
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 2459

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$0	$0
STATE FUNDS	-$323,213,000	-$178,255,000
FEDERAL FUNDS	$323,213,000	$178,255,000

Purpose:
This policy change estimates the net impact for additional federal financial participation (FFP) received for Certified Public Expenditures (CPEs) from certain Designated State Health Programs (DSHPs) and the savings to the General Fund (GF) from the reduction in state spending.

Authority:
California Advancing and Innovating Medi-Cal (CalAIM) Section 1115(a) Medicaid Demonstration
California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115 Demonstration

Interdependent Policy Changes:
CalAIM PATH
CalAIM - BH-CONNECT Workforce Initiative

Background:
Pursuant to the CalAIM Section 1115 Demonstration renewal request submitted to the Centers for Medicare and Medicaid Services (CMS) on June 30, 2021, the DSHP is effective January 1, 2023, to December 31, 2026. In 2023, DHCS applied for a new Medicaid Section 1115 Demonstration, BH-CONNECT, to increase access to and improve behavioral health services for Medi-Cal members statewide. The BH-CONNECT Demonstration includes a workforce initiative component effective July 1, 2025. The Department will utilize additional FFP received through DSHP to support the CalAIM Providing Access and Transforming Health (PATH) Supports and BH-CONNECT Workforce Initiative. The PATH program will support services and capacity building, including payments for supports, infrastructure, interventions, and services to complement the array of care authorized in the consolidated waiver request. The BH-CONNECT Workforce Initiative will support workforce recruitment and retention of behavioral health care practitioners serving Medi-Cal.

DSHPs are funded by state funds (GF). Those expenditures are used to draw FFP, which is then used to credit the GF. The CalAIM waiver authorizes the Department to claim up to a total of $646.425 million in FFP over a four-year period using the CPEs of the approved DSHPs listed below. The BH-CONNECT waiver will allow the Department to claim up to a total of $807.5 million FFP over a five-year period using the CPEs of the approved DSHPs.

DESIGNATED STATE HEALTH PROGRAMS

OTHER ADMIN. POLICY CHANGE NUMBER: 55

State Only Medical Programs
California Children Services (CCS)
Genetically Handicapped Persons Program (GHPP)
Medically Indigent Adult Long Term Care (MIA-LTC)
Department of Developmental Services (DDS)
Prostate Cancer Treatment Program (PCTP)
Workforce Development Programs
Department of Health Care Access and Information (HCAI) • Song-Brown Health Care Workforce Training • Steven M. Thompson Physician Corp Loan Repayment Program (STLRP)

The DSHP proposal within the CalAIM Section 1115 Demonstration renewal was approved by CMS on January 26, 2023.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to:

- Shifting four quarters of DSHP CalAIM claiming from FY 2023-24 to FY 2024-25, and
- The implementation date of the proposed California's Reproductive Health Access Demonstration (CalRHAD) has shifted to January 1, 2026. DSHP CalRHAD claiming was removed from the Estimate as the claiming will not start until after FY 2025-26.

The change in FY 2024-25 to FY 2025-26 in the current estimate is due to:

- The DSHP CalAIM claiming includes four quarters in FY 2025-26 compared to eight quarters in FY 2024-25, and
- Estimating DSHP BH-CONNECT claiming will begin in FY 2025-26.

Methodology:

1. DSHP CalAIM claiming is effective January 1, 2023, and claiming will commence in FY 2024-25.

2. DSHP BH-CONNECT claiming is effective July 1, 2025, and claiming will commence in FY 2025-26.

3. The estimated total net impact on a cash basis is:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
DSHP CalAIM	$0	($323,213)	$323,213
Total DSHP	**$0**	**($323,213)**	**$323,213**

DESIGNATED STATE HEALTH PROGRAMS

OTHER ADMIN. POLICY CHANGE NUMBER: 55

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
DSHP CalAIM	$0	($161,606)	$161,606
DSHP BH-CONNECT	$0	($16,649)	$16,649
Total DSHP	**$0**	**($178,255)**	**$178,255**

Funding:
100% GF (4260-101-0001)
100% Health Care Support Fund (4260-601-7503)

MEDICAL FI BO & IT COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 56
IMPLEMENTATION DATE: 11/2019
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2115

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$55,485,000	$55,435,000
STATE FUNDS	$15,416,850	$15,497,450
FEDERAL FUNDS	$40,068,150	$39,937,550

Purpose:
This policy change estimates the total cost reimbursement of the Gainwell Medical Fiscal Intermediary (FI) contracts.

Authority:
Gainwell Contract # 18-95357
IBM Contract # 18-95302

Interdependent Policy Changes:
Not Applicable

Background:
The FI contracts require the FIs to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal members. The Assumption of Operations for the Business Operations and Information Technology Maintenance and Operations (IT M&O) contracts started in October 2019. The FI Business Operations contract term is five years with two one-year optional extensions. The IT M&O contract term is five years with five (5) one-year optional extensions.

Various costs incurred by the contractor while performing responsibilities under the contract are reimbursed by the Department using a cost reimbursement, or direct cost, pricing methodology. These costs are not a part of the bid price of the contract and are paid dollar for dollar, with no overhead or profit included. Any of the following costs may be cost reimbursed under the contract:

- Postage
    - Postal rates utilized to mail documents to providers, members, 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, members, and state or federal offices.

MEDICAL FI BO & IT COST REIMBURSEMENT
OTHER ADMIN. POLICY CHANGE NUMBER: 56

- Equipment and Services (personal computers, monitors, printers, related equipment, and software)
    - Installation and monthly charges for data lines;
    - Purchase, lease, installation, and maintenance of desktops for State staff at Field Offices and Contractor facilities; and
    - Point-of-Sale (POS) devices.

- Facilities Lease, Improvement, Modifications
    - The direct costs for the Medi-Cal Operations Center (MOC) as well as any required modifications and improvements.

- Consultant Contracts
    - Consultant contracts utilized for operational project oversight that are paid through Cost Reimbursement.

- Telecommunications and Data Center
    - Telephone Toll Charges – Actual telecommunication charges paid for by the contractor for maintaining toll-free lines available to providers and members, 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 member or provider use lines. Excludes all other direct or indirect costs associated with telephone toll charges.

    - Data Center Access – Actual charges incurred by the contractor for access to records contained in the Medi-Cal Eligibility Data System and the utilization of the telecommunications network, as charged by the Department of Technology Services Data Center.

- Other Cost Reimbursable Items
    - Equipment and furniture for the Field Office Automation Group (FOAG).

    - The Department has established a rate policy which applies to the contract and defines lodging, mileage, and meal expense reimbursement for travel expenses.

    - Drug Use Review (DUR) work performed on behalf of the Department to provide DUR research, articles for DUR publication, attend conferences, and submit monthly/quarterly reports.

    - Special Training which falls outside the required training scope, as defined by the contract, and directly relates to California Medicaid Management Information System (CA-MMIS) support activities.

    - The demand for the Telehealth Nurse Advice Line (COVID-19 consultations) will continue beyond the planned expiration date of April 30, 2022. There will be $250,000 increase to the cost estimate.

MEDICAL FI BO & IT COST REIMBURSEMENT
OTHER ADMIN. POLICY CHANGE NUMBER: 56

- 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.

- Audits and Research
  - Annual audits for the Electronic Data Processing Application System shall be cost reimbursed for the direct cost of the audit as paid to the independent auditor by the contractor, excluding procurement costs or effort expended by the contractor.

- Change Order and/or Amendments
  - Certain costs associated with Contract Change Orders/ Amendments can be paid through Cost Reimbursement.

Costs under these categories consist of direct costs, or subsets thereof, which can be specifically identified with the particular cost objective.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to various minor adjustments to cost reimbursement line items.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is a net decrease due to anticipated reductions in facility costs and adjustments to other cost reimbursement line items.

Methodology:
1. Contract costs are shared between Federal Funds (FF) and General Funds (GF).

2. Beginning contract year 3 and each year thereafter through the end of the Gainwell contract, CPI adjustments are applied annually to the contract cost.

FY 2024-25	TF	GF	FF
Postage	$1,939,000	$949,000	$990,000
Parcel Services & Common Carriers	$423,000	$207,000	$216,000
Equipment & Services	$4,502,000	$1,183,000	$3,319,000
Facilities Improvement & Modification	$11,356,000	$2,985,000	$8,371,000
Consultant Contracts	$32,451,000	$8,530,000	$23,921,000
Telecommunications & Data Center	$2,598,000	$707,000	$1,891,000
Other Cost Reimbursable Items	$2,216,000	$856,000	$1,360,000
Total	**$55,485,000**	**$15,417,000**	**$40,068,000**

MEDICAL FI BO & IT COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 56

FY 2025-26	TF	GF	FF
Postage	$2,036,000	$996,000	$1,040,000
Parcel Services & Common Carriers	$444,000	$217,000	$227,000
Equipment & Services	$4,253,000	$1,118,000	$3,135,000
Facilities Improvement & Modification	$10,242,000	$2,692,000	$7,550,000
Consultant Contracts	$33,559,000	$8,821,000	$24,738,000
Telecommunications & Data Center	$2,597,000	$706,000	$1,891,000
Other Cost Reimbursable Items	$2,304,000	$947,000	$1,357,000
Total	**$55,435,000**	**$15,497,000**	**$39,938,000**

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)
FI 65% Title XXI / 35% GF (4260-101-0001/0890)
FI 75% HIPAA FF / 25% GF (4260-117-0001/0890)

MEDICAL FI BO & IT CHANGE ORDERS

OTHER ADMIN. POLICY CHANGE NUMBER: 57
IMPLEMENTATION DATE: 11/2019
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2117

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$52,893,000	$39,146,000
STATE FUNDS	$13,902,450	$10,289,700
FEDERAL FUNDS	$38,990,550	$28,856,300

Purpose:
This policy change estimates the cost of the Gainwell Medical Fiscal Intermediary (FI) contract Change Orders (i.e. Change Requests).

Authority:
Gainwell Contract # 18-95357
IBM Contract # 18-95302
SB 853 (Chapter 717, Statutes of 2010)
Welfare & Institutions Code Section 14105.05
Budget Act of 2024 [Assembly Bill (AB) 107 (Chapter 2, Statutes of 2024)]

Interdependent Policy Changes:
Not Applicable

Background:
The Gainwell FI contracts require the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal members. The Assumption of Operations for the Business Operations (BO) and Information Technology Maintenance and Operations (IT M&O) FI contracts started in October 2019. The Gainwell BO FI contract term is five years with five (5) one-year optional extensions. The IT M&O contract term is five years with two one-year optional extensions.

Modifications resulting in changes to contractor responsibilities are initiated by Change Orders (CO) and billed separately from contract operations. A CO is a documentable increase of effort identified as having a direct relation to the administration of the contract that is above the volume of the required work within the scope and above the normal costs of the contract. Either or both of the FI contractors may be required to engage in a CO project and their respective scope is determined at the initiation phase. IT infrastructure services estimated in this policy change are comprised of work that is outside the scope of work that is estimated in the Medical Infrastructure and Data Management Services policy change.

MEDICAL FI BO & IT CHANGE ORDERS
OTHER ADMIN. POLICY CHANGE NUMBER: 57

At the time the contract was procured it is unknown how many COs are needed as it may require increased level of work and effort. The Department has agreed to reimburse the FI for all documentable expenses that are a direct result of CO efforts. The BO FI costs are determined during the analysis phase of a CO. The IT Infrastructure, Development, and Operations costs are estimated based on the preliminary pricing bids that have been submitted by the IT M&O contractor.

While COs are generally not known at the time the contract was executed, in this case, the COs were identified and known but detailed scope and line item costs were not finalized. The items were termed “unanticipated tasks” by the Department of General Services when they approved the contract.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is mainly due to unanticipated new change orders for SURGE Phase 2-SoftSole, MF to Cloud, and CO-19 Facilities.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is mainly due to a lower projection of future change order costs in FY 2025-26.

Methodology:
1. Certain costs, such as software and travel expenses, can be paid through cost reimbursement. These costs are budgeted in the Medical FI BO & IT Cost Reimbursement policy change.

2. The contract allows for overhead and profit to be included in CO expenses (not to exceed thirty-percent). The FI itemizes the actual costs, overhead, and profit on the invoices submitted to the Department.

3. Contract costs are shared between Federal Funds (FF) and General Funds (GF).

MEDICAL FI BO & IT CHANGE ORDERS

OTHER ADMIN. POLICY CHANGE NUMBER: 57

4. Beginning contract year 3 and each year thereafter through the end of the Gainwell contract, Consumer Price Index (CPI) adjustments are applied annually to the contract cost.

FY 2024-25	TF	GF	FF
Alternative Format C0-16 (Conlon & Braille)	$657,000	$173,000	$484,000
CO-16 Alternative Format (Threshold Language)	$500,000	$131,000	$369,000
CO-17 Conlon Interim Claim Packet Processing	$30,000	$8,000	$22,000
Contract Innovations	$178,000	$47,000	$131,000
CO-19 Facilities	$246,000	$65,000	$181,000
Stabilization	$20,000,000	$5,257,000	$14,743,000
Level 1 Help Desk	$1,040,000	$273,000	$767,000
COGNOS	$272,000	$71,000	$201,000
File Maintenance	$4,341,000	$1,141,000	$3,200,000
Security Services	$4,423,000	$1,163,000	$3,260,000
Testing Services	$5,500,000	$1,446,000	$4,054,000
Formulary Liaison Services	$1,368,000	$360,000	$1,008,000
FOAG	$2,200,000	$578,000	$1,622,000
TPL Liaison	$293,000	$77,000	$216,000
API Connect	$107,000	$28,000	$79,000
RAIS Extension	$1,414,000	$371,000	$1,043,000
SURGE Phase 2 - SoftSole	$7,324,000	$1,925,000	$5,399,000
MF to Cloud	$3,000,000	$788,000	$2,212,000
Total	**$52,893,000**	**$13,902,000**	**$38,991,000**

MEDICAL FI BO & IT CHANGE ORDERS

OTHER ADMIN. POLICY CHANGE NUMBER: 57

FY 2025-26	TF	GF	FF
Alternative Format C0-16 (Conlon & Braille)	$657,000	$173,000	$484,000
CO-16 Alternative Format (Threshold Language)	$500,000	$131,000	$369,000
CO-17 Conlon Interim Claim Packet Processing	$41,000	$11,000	$30,000
Contract Innovations	$137,000	$36,000	$101,000
CO-19 Facilities	$1,186,000	$312,000	$874,000
Stabilization	$6,000,000	$1,577,000	$4,423,000
Level 1 Help Desk	$1,061,000	$279,000	$782,000
COGNOS	$276,000	$73,000	$203,000
File Maintenance	$4,293,000	$1,128,000	$3,165,000
Security Services	$4,470,000	$1,175,000	$3,295,000
Testing Services	$3,821,000	$1,004,000	$2,817,000
Formulary Liaison Services	$1,391,000	$366,000	$1,025,000
FOAG	$2,160,000	$568,000	$1,592,000
TPL Liaison	$297,000	$78,000	$219,000
API Connect	$113,000	$30,000	$83,000
RAIS Extension	$1,104,000	$290,000	$814,000
SURGE Phase 2 - SoftSole	$2,639,000	$693,000	$1,946,000
MF to Cloud	$9,000,000	$2,366,000	$6,634,000
Total	**$39,146,000**	**$10,290,000**	**$28,856,000**

Funding:
FI 75% Title XIX / 25% GF (4260-101-0001/0890)
FI 100% GF (4260-101-0001)
FI 65% Title XXI / 35% GF (4260-101-0001/0890)

MEDICAL INFRASTRUCTURE & DATA MGT SVCS

OTHER ADMIN. POLICY CHANGE NUMBER: 58
IMPLEMENTATION DATE: 11/2019
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2118

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$44,470,000	$44,701,000
STATE FUNDS	$11,688,900	$11,749,500
FEDERAL FUNDS	$32,781,100	$32,951,500

Purpose:
This policy change estimates the cost of data management expenses such as networking, infrastructure costs, as well as the Medical Fiscal Intermediary (FI) Information Technology Maintenance and Operations (IT M&O) contract for infrastructure services.

Authority:
IBM Contract # 18-95302

Interdependent Policy Changes:
Not Applicable

Background:
The FI contracts require the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal members. The Assumption of Operations for the FI IT M&O contract started in October 2019. The FI contract term is five years with two one-year optional extensions. The Department has begun transferring hosting services and data to the cloud in an effort to increase stability and reduce costs. These non-FI Contract costs, as well as IT M&O costs, are captured in this policy change.

IT Infrastructure Services of the Medical Application Hosting and Managed Network Support Services (AH/MNS) include:

- Mainframe Data Center Operations Services
- Midrange Data Center Operations Services
- Midrange Storage Operations Services
- Managed Network Services
- Disaster Recovery
- Service Delivery Management, Asset Management, and Facilities
- Fixed Security Services
- Hardware and Refresh
- Software

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to less than anticipated costs for the Mainframe Data Center.

MEDICAL INFRASTRUCTURE & DATA MGT SVCS

OTHER ADMIN. POLICY CHANGE NUMBER: 58

The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to minor increases in various infrastructure costs.

Methodology:

1. IT M&O costs are paid under an hourly rate or via a fixed price negotiated during the procurement phase of the contract.

2. Contract costs are shared between Federal Funds (FF) and General Funds (GF).

3. Network Management and cloud services are provided through an agreement with the California Department of Technology.

FY 2024-25	TF	GF	FF
Mainframe Data Center Operations Services	$5,424,000	$1,425,000	$3,999,000
Midrange Data Center Operations Services	$3,496,000	$919,000	$2,577,000
Midrange Storage Operations Services	$258,000	$68,000	$190,000
Managed Network Services	$16,457,000	$4,326,000	$12,131,000
Disaster Recovery	$1,788,000	$470,000	$1,318,000
Service Delivery Mgmt, Asset Mgmt, and Facilities	$6,420,000	$1,687,000	$4,733,000
Fixed Security Services	$2,487,000	$654,000	$1,833,000
Hardware and Refresh	$592,000	$156,000	$436,000
Software	$7,548,000	$1,984,000	$5,564,000
Total	**$44,470,000**	**$11,689,000**	**$32,781,000**

FY 2025-26	TF	GF	FF
Mainframe Data Center Operations Services	$5,466,000	$1,437,000	$4,029,000
Midrange Data Center Operations Services	$3,522,000	$926,000	$2,596,000
Midrange Storage Operations Services	$259,000	$68,000	$191,000
Managed Network Services	$16,474,000	$4,330,000	$12,144,000
Disaster Recovery	$1,800,000	$473,000	$1,327,000
Service Delivery Mgmt, Asset Mgmt, and Facilities	$6,470,000	$1,700,000	$4,770,000
Fixed Security Services	$2,500,000	$657,000	$1,843,000
Hardware and Refresh	$600,000	$158,000	$442,000
Software	$7,610,000	$2,000,000	$5,610,000
Total	**$44,701,000**	**$11,749,000**	**$32,952,000**

MEDICAL INFRASTRUCTURE & DATA MGT SVCS

OTHER ADMIN. POLICY CHANGE NUMBER: 58

Funding:
65% Title XXI / 35% GF (4260-101-0001/0890)
75% Title XIX / 25% GF (4260-101-0001/0890)
100% GF (4260-101-0001)
FI 65% Title XXI / 35% GF (4260-101-0001/0890)
FI 75% Title XIX / 25% GF (4260-101-0001/0890)
FI 100% GF (4260-101-0001)

MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 59
IMPLEMENTATION DATE: 11/2019
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2119

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$39,925,000	$40,544,000
STATE FUNDS	$10,495,000	$10,656,850
FEDERAL FUNDS	$29,430,000	$29,887,150

Purpose:
This policy change estimates the cost of the IBM Medical Fiscal Intermediary (FI) contract IT Development and Operations Services.

Authority:
IBM Contract # 18-95302

Interdependent Policy Changes:
Not Applicable

Background:
The IBM FI contracts require the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal members. The Assumption of Operations for the FI IT Maintenance and Operations (IT M&O) contract started in October 2019. The FI contract term is five years with five one-year optional extensions.

IT Development and Operations Services of the Medical FI IT M&O contract are performed and paid under either an hourly rate or a fixed price where the FI provides a set cost per contract year for the services provided under that portion of the contract. IT Development and Operations Services include the following Application Maintenance and Support Services (AMSS):

- Application Development Services
- Application M&O Services
- Project Management Office

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to increases in the System Development Notice (SDN) hours assumed for Application Development Services costs.

The change from 2024-25 to FY 2025-26, in the current estimate, is due to increases in rates used for the FY 2025-26 estimated Application Development Services costs, and increases estimated for the Application M&O Services and Project Management Office in FY 2025-26.

MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 59

Methodology:

1. Costs are paid under an hourly rate or via a fixed price negotiated during the procurement phase of the contract.

FY 2024-25	TF	GF	FF
Application Development Services	$21,524,000	$5,657,000	$15,867,000
Application M&O Services	$10,657,000	$2,802,000	$7,855,000
Project Management Office	$7,744,000	$2,036,000	$5,708,000
Total	**$39,925,000**	**$10,495,000**	**$29,430,000**

FY 2025-26	TF	GF	FF
Application Development Services	$21,840,000	$5,741,000	$ 16,099,000
Application M&O Services	$10,847,000	$2,851,000	$ 7,996,000
Project Management Office	$7,857,000	$2,065,000	$5,792,000
Total	**$40,544,000**	**$10,657,000**	**$29,887,000**

Funding:

FI 75% Title XIX FF / 25% GF (4260-101-0001/0890)
FI 100% GF (4260-101-0001)
FI 65% Title XXI / 35% GF (4260-101-0001/0890)

MEDICAL FI BO OTHER ESTIMATED COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 60
IMPLEMENTATION DATE: 11/2019
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2112

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$25,766,000	$26,545,000
STATE FUNDS	$7,738,500	$7,972,400
FEDERAL FUNDS	$18,027,500	$18,572,600

Purpose:
This policy change estimates the other estimated costs of the Gainwell Medical Fiscal Intermediary (FI) contract.

Authority:
Gainwell Contract # 18-95357

Interdependent Policy Changes:
Not Applicable

Background:
The Gainwell FI contract requires the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal members. The Assumption of Operations for the Business Operations FI contract started in October 2019. The FI contract term is five years with five (5) one-year optional extensions.

Some functions and services of the Gainwell Medical FI contract are performed and paid using a fixed price payment methodology. For fixed price categories, the Contractor is paid a fixed rate for certain annual services.

Costs under this category consist of payment to the contractor for contract services, such as:

- Process Appeals - The Contractor reviews the appeal documents and the claim history, and either rejects the appeal or approves and resubmits the claim for processing. The Contractor regularly provides information to the providers regarding claim appeal status, denial reasons, and estimated payment dates, as appropriate. All appeal information is recorded in the California Medicaid Management Information System (CA-MMIS) Appeals subsystem.

- Support Audits - The Contractor is required to plan, track, and coordinate audit support tasks, gather data or other information requested for the audit, and obtain all information necessary to present a complete and accurate audit response to the Department for review and approval.

- Process Drug Rebates – The Contractor processes drug rebates in order to create invoices submitted to manufacturers which generate revenue received by the Department in excess of $4 billion annually.

MEDICAL FI BO OTHER ESTIMATED COSTS
OTHER ADMIN. POLICY CHANGE NUMBER: 60

- Provide Litigation Support - The Contractor's litigation support includes, but is not limited to, planning, tracking, and coordinating litigation support tasks, developing responses to subpoenas and other legal requests, and providing written and oral testimony on behalf of the Department.

- Service Delivery Support – The Contractor performs broad management, administrative, and supporting services that apply to the delivery of all business, information technology, and facilities services while conforming to standardized process, protocols, templates, and tools as prescribed by the Department.

- Publish Provider Communications – The Contractor assists with the development and distribution of provider communications related to provider billing as well as related processes and procedures. Provider communications take many forms, such as bulletins targeted to the different provider types, forms, public content forums, Provider Manual changes, Medi-Cal website content, provider letters, news articles, system alerts, user guides, technical documents, and education and training opportunities.

- Conduct Provider Outreach and Education – The Contractor conducts centralized and regional provider outreach and education activities, and provides on-site support resources and specialists focused on small providers, and out-of-state providers to address specific provider issues.

- Print and Mail Medi-Cal Information - The Department requires the Contractor to print and mail information of any type, as approved by the Department, to audiences, identified by the Department, on a scheduled and ad hoc basis. The Contractor is also required to create, update, and manage forms, including developing and maintaining a Master Index of Forms. The Contractor prints 1099s, Departmental standard forms, ad hoc forms as requested, and reports monthly regarding these activities.

- Perform Proactive Provider Research - The Contractor conducts research and reviews provider customer services data from multiple sources to identify trends, systemic issues, needs, and concerns. The findings lead to recommendations for development of provider communication materials, provider educational materials, policy changes, and process and procedural improvements for review by the Department. The Contractor prepares position papers, problem statements, and reports for review and approval by the Department prior to taking any action. The Contractor also develops and submits content changes directly to outreach and training teams for inclusion in ongoing services.

Reason for Change:
The change in FY 2024-25 from the prior estimate, is due to updates to various minor anticipated costs.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to the CPI adjustment in FY 2025-26.

MEDICAL FI BO OTHER ESTIMATED COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 60

Methodology:

1. Other estimated costs are paid using fixed pricing methodology. The contract stipulates an annual rate for each of the services defined above.

2. Costs are shared between Federal Funds (FF) and General Funds (GF).

3. Beginning contract year 3 and each year thereafter through the end of the Gainwell contract, CPI adjustments are applied annually to the contract cost.

FY 2024-25	TF	GF	FF
Process Appeals	$909,000	$239,000	$670,000
Support Audits	$194,000	$51,000	$143,000
Process Drug Rebates	$1,378,000	$362,000	$1,016,000
Provide Litigation Support	$199,000	$52,000	$147,000
Service Delivery Support	$11,418,000	$3,001,000	$8,417,000
Publish Provider Communication Materials	$3,712,000	$1,564,000	$2,148,000
Conduct Provider Outreach and Education	$5,371,000	$1,412,000	$3,959,000
Print and Mail Medi-Cal Information	$2,379,000	$1,003,000	$1,376,000
Perform Proactive Provider Research	$206,000	$54,000	$152,000
Total	**$25,766,000**	**$7,738,000**	**$18,028,000**

FY 2025-26	TF	GF	FF
Process Appeals	$937,000	$246,000	$691,000
Support Audits	$200,000	$53,000	$147,000
Process Drug Rebates	$1,419,000	$373,000	$1,046,000
Provide Litigation Support	$205,000	$54,000	$151,000
Service Delivery Support	$11,760,000	$3,091,000	$8,669,000
Publish Provider Communication Materials	$3,824,000	$1,611,000	$2,213,000
Conduct Provider Outreach and Education	$5,536,000	$1,455,000	$4,081,000
Print and Mail Medi-Cal Information	$2,451,000	$1,033,000	$1,418,000
Perform Proactive Provider Research	$213,000	$56,000	$157,000
Total	**$26,545,000**	**$7,972,000**	**$18,573,000**

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)
FI 65% Title XXI / 35% GF (4260-101-0001/0890)

MEDICAL FI BO TELEPHONE SERVICE CENTER

OTHER ADMIN. POLICY CHANGE NUMBER: 61
IMPLEMENTATION DATE: 11/2019
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2116

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$18,805,000	$19,371,000
STATE FUNDS	$5,628,800	$5,798,050
FEDERAL FUNDS	$13,176,200	$13,572,950

Purpose:
This policy change estimates the Telephone Service Center (TSC) costs of the Gainwell Medical Fiscal Intermediary (FI) contract.

Authority:
Gainwell Contract # 18-95357

Interdependent Policy Changes:
Not Applicable

Background:
The FI contracts require an FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal members. The Assumption of Operations for the Business Operations FI contract started in October 2019. The FI contract term is five years with five (5) one-year optional extensions.

The TSC functions and services of the Gainwell Medical FI contract are paid using a fixed price and a variable pricing methodology. For fixed price categories, the Contractor is paid a fixed rate for certain annual services. Variable pricing methodology is based on estimated volume-driven metrics and account for increases in actual volumes. The costs are calculated using a fixed annual rate for transactions up to a State-specified volume and a per-transaction rate for transactions which exceed that volume. Variable pricing is also known as “fixed plus.”

The TSC provides telephone and chat services to providers and members in three areas. Each TSC service area utilizes telecommunications infrastructure, Customer Relationship Management application(s), and the records repository which are implemented and maintained by the contractor.

- Provider Customer Services (variable pricing)
- Member Customer Services (variable pricing)
- Financial Services (fixed price)

MEDICAL FI BO TELEPHONE SERVICE CENTER

OTHER ADMIN. POLICY CHANGE NUMBER: 61

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to various minor decreases in costs.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to a CPI adjustment in FY 2025-26.

Methodology:
1. TSC costs are paid using variable price rates based on volumes within a maximum threshold. The contract stipulates an annual fixed price for services up to a specified volume and a per-transaction price for services which exceed that volume.

2. Costs are shared between Federal Funds (FF) and General Funds (GF).

3. Beginning contract year 3 and each year thereafter through the end of the Gainwell contract, CPI adjustments are applied annually to the cost.

FY 2024-25	TF	GF	FF
TSC – Conduct Provider Customer Services	$10,200,000	$3,053,000	$7,147,000
TSC – Conduct Member Customer Services	$6,680,000	$2,000,000	$4,680,000
TSC – Provide Financial Services	$1,925,000	$576,000	$1,349,000
Total	**$18,805,000**	**$5,629,000**	**$13,176,000**

FY 2025-26	TF	GF	FF
TSC – Conduct Provider Customer Services	$10,506,000	$3,145,000	$7,361,000
TSC – Conduct Member Customer Services	$6,881,000	$2,059,000	$4,822,000
TSC – Provide Financial Services	$1,984,000	$594,000	$1,390,000
Total	**$19,371,000**	**$5,798,000**	**$13,573,000**

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)
FI 65% Title XXI / 35% GF (4260-101-0001/0890)

MEDICAL FI BUSINESS OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER: 62
IMPLEMENTATION DATE: 11/2019
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2111

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$17,141,000	$17,655,000
STATE FUNDS	$4,513,650	$4,649,000
FEDERAL FUNDS	$12,627,350	$13,006,000

Purpose:
This policy change estimates the operational costs of the Gainwell Medical Fiscal Intermediary (FI) contract.

Authority:
Gainwell Contract # 18-95357
DHCS Contract # 22-20044

Interdependent Policy Changes:
Not Applicable

Background:
The FI contracts require an FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal members. The Assumption of Operations for the Gainwell Business Operations FI contract started in October 2019. The Gainwell Business Operations FI contract term is five years with five (5) one-year optional extensions.

The Operations functions and services of the Gainwell Medical FI contract are paid using a variable pricing methodology. The variable pricing methodology is based on estimated volume-driven metrics and account for increases in actual volumes. The costs are calculated using a fixed annual rate for transactions up to a State-specified volume and a per-transaction rate for transactions which exceed that volume. Variable pricing is also known as “fixed plus.”

Operations constitute contractual responsibilities required for the contractor to administer and operate the California Medicaid Management Information System (CA-MMIS). These cost categories consist of:

- Process Paper Claims – The Contractor is responsible for the manual entry of claim data into the CA-MMIS Claims system for adjudication, when those claims are received on paper (mail or fax), rather than electronically.

- Process Suspended Claims - The Contractor uses CA-MMIS subsystems and applications to manually adjudicate suspended claims and address suspended claims issues, in accordance with program policy, system validations, established rates, and state and federal statutes and regulations.

MEDICAL FI BUSINESS OPERATIONS
OTHER ADMIN. POLICY CHANGE NUMBER: 62

- Manage Records - The Contractor is required to provide a comprehensive Manage Records service that results in preservation, protection and maintenance of all official Medi-Cal records according to State, Federal, Contractual, or program requirements. The Contractor acts as “Custodian of Records” for the Medi-Cal program, including certifying record authenticity, managing electronic access to records, performing manual research and record retrieval, and producing “acceptable copies.”

- Process Member Card Request – The Contractor is responsible for the production and distribution of Benefit Identification Cards to Medi-Cal members, and Health Access Program cards to public health providers.

- Process Paper Treatment Authorization Request (TAR) – The Contractor is responsible for the entering of TAR data into the TAR system for review and/or adjudication of TARs and TAR Appeals, including the scanning of paper TARs and attachments so that an official record is stored and made available for further use by TAR adjudicators in the Records Repository.

The FI has provided state-specified volumes for each of the above categories. The Department estimates operations costs by applying the rates established by the contract to the projected volumes for the current and budget year.

During the transition of FI’s on October 2019, from Conduent to DXC, DHCS Contract #22-20044 remains active and services accounted for with the County Medi-Cal Services Program which is paid through GF reimbursements in this policy change. The Department sends the program invoices for services in Provider Master File Transmission, Denial of Misrouted Claims previously known as Adjudicated Claim Lines (ACL), Benefits Identification Cards, (BIC), and Medi-Cal Automated Eligibility Verification System (AEVS).

Reason for Change:
The change in FY 2024-25, in the prior estimate, is due to projected decreases to the various business operations cost line items.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to projected increases to various business operations cost line items.

Methodology:
1. Operation costs are paid using fixed plus pricing methodology with a rate for an annual volume threshold and a rate for each transaction which exceeds that threshold.

2. Projected volumes are established by the Department using trends and counts from previous years and the FI rate established by the contract is applied to the respective volume.

3. Costs are shared between Federal Funds (FF), GF, and GF Reimbursements.

4. Beginning contract year 3 and each year thereafter through the end of the Gainwell contract, CPI adjustments are applied annually to the cost.

MEDICAL FI BUSINESS OPERATIONS
OTHER ADMIN. POLICY CHANGE NUMBER: 62

5. County Medi-Cal Services Program (CMSP) is billed annually for services agreed upon in the Incoming Funds Request (IFR) agreement #22-20044.

- FY 2024-25 cost estimate includes services for FY 2024-25.
- FY 2025-26 cost estimate includes services for FY 2025-26.

FY 2024-25	TF	GF	FF	Reimbursement
Process Paper Claims	$9,441,000	$2,482,000	$6,959,000	$0
Process Suspended Claims	$3,753,000	$986,000	$2,767,000	$0
Manage Records	$1,474,000	$387,000	$1,087,000	$0
Process Member Card Requests	$2,034,000	$535,000	$1,499,000	$0
Process Paper TAR	$428,000	$112,000	$316,000	$0
Contract #22-20044				
FY 2024-25	$11,000	$0	$0	$11,000
Total	**$17,141,000**	**$4,502,000**	**$12,628,000**	**$11,000**

FY 2025-26	TF	GF	FF	Reimbursement
Process Paper Claims	$9,725,000	$2,556,000	$7,169,000	$0
Process Suspended Claims	$3,866,000	$1,016,000	$2,850,000	$0
Manage Records	$1,516,000	$399,000	$1,117,000	$0
Process Member Card Requests	$2,096,000	$551,000	$1,545,000	$0
Process Paper TAR	$441,000	$116,000	$325,000	$0
Contract #22-20044				
FY 2025-26	$11,000	$0	$0	$11,000
Total	**$17,655,000**	**$4,638,000**	**$13,006,000**	**$11,000**

Funding:
FI 75% Title XIX / 25% GF (4260-101-0001/0890)
FI 100% GF (4260-101-0001)
FI 65% Title XXI / 35% GF (4260-101-0001/0890)
FI GF Reimbursement (4260-601-0995)

MEDICAL FI BO HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 63
IMPLEMENTATION DATE: 11/2019
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2113

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$12,397,000	$12,768,000
STATE FUNDS	$3,258,000	$3,356,200
FEDERAL FUNDS	$9,139,000	$9,411,800

Purpose:
This policy change estimates the hourly reimbursement costs of the Gainwell Medical Fiscal Intermediary (FI) contract.

Authority:
Gainwell Contract # 18-95357

Interdependent Policy Changes:
Not Applicable

Background:
The Gainwell FI contracts require the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal members. The Assumption of Operations for the Business Operations FI contract started in October 2019. The FI contract term is five years with five one-year optional extensions.

Under the Gainwell Medical FI contract, certain activities are reimbursed on an hourly basis by the Department. The rate paid to the contractor consists of all direct and indirect costs required to support these activities, plus profit. Hourly reimbursed items under the contract consist of Medical Review Services and Service Changes.

- Medical Review Services - The Contractor provides drug utilization review, Formulary File analysis, medical review consultation, and Treatment Authorization Request (TAR) adjudication. An outcome of the Contractor's Medical Review Services is a reduction in excessive treatment and expense while remaining fully compliant with State and Federal requirements and Medi-Cal policy.

- Service Changes - The collection of activities performed by the Contractor's Business Services staff to ensure any changes to the California Medicaid Management Information System (CA-MMIS) Business Services either improve the efficiency of and/or minimize the disruption to related services.

MEDICAL FI BO HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 63

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to minor reductions to various hourly reimbursement cost line items.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to a CPI adjustment projected for FY 2025-26.

Methodology:
1. Hourly costs are paid using hourly rates which vary depending on the service being performed and the expertise required.

2. Costs are shared between Federal Funds (FF) and General Funds (GF).

3. Beginning contract year 3 and each year thereafter through the end of the Gainwell contract CPI adjustments are applied annually to the contract cost.

FY 2024-25	TF	GF	FF
Perform Medical Review Services	$7,036,000	$1,849,000	$5,187,000
Service Changes (formerly Systems Group)	$5,361,000	$1,409,000	$3,952,000
Total	**$12,397,000**	**$3,258,000**	**$9,139,000**

FY 2025-26	TF	GF	FF
Perform Medical Review Services	$7,246,000	$1,905,000	$5,341,000
Service Changes (formerly Systems Group)	$5,522,000	$1,451,000	$4,071,000
Total	**$12,768,000**	**$3,356,000**	**$9,412,000**

Funding:
FI 75% Title XIX / 25% GF (4260-101-0001/0890)
FI 65% Title XXI / 35% GF (4260-101-0001/0890)
FI 100% GF (4260-101-0001)

MEDICAL FI BO MISCELLANEOUS EXPENSES

OTHER ADMIN. POLICY CHANGE NUMBER: 64
IMPLEMENTATION DATE: 11/2019
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2114

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$328,000	$268,000
STATE FUNDS	$85,650	$70,150
FEDERAL FUNDS	$242,350	$197,850

Purpose:
This policy change estimates the cost of miscellaneous expenses of the Gainwell Medical Fiscal Intermediary (FI) contract.

Authority:
Gainwell Contract # 18-95357
Interagency Agreement (IA) # 20-10163, 21-10145 A01, 21-10005 A02, and 22-20086

Interdependent Policy Changes:
Not Applicable

Background:
The FI contracts require the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal members. The Assumption of Operations for the Business Operations FI contract started in October 2019. The Gainwell FI contract term is five years with five (5) one-year optional extensions.

Under the Medi-Cal FI contract, services classified as miscellaneous expenses are paid using a fixed pricing methodology and include IAs, Optional Contract Services (OCS), and Facilities provisioning.

Pursuant to an IA with the Department, the California State Controller's Office (SCO) issues warrants to Medi-Cal providers and the California State Treasurer's Office (STO) provides funds for warrant redemption.

Pursuant to an IA with the California Department of Consumer Affairs (CDCA), Medical Board of California, the Department purchases licensure data. This data gives the Department the ability to verify prospective providers are currently licensed prior to enrollment in the Medi-Cal program. It also enables the Department to verify the validity of the referring provider license number on Medi-Cal claims.

OCS are contractor-proposed methods of providing services, functions, and procedures above contract requirements to improve the California Medicaid Management Information System (CA-MMIS) performance. Unlike regular operations activities, OCS are not always part of the FI budget. Costs in this category are due to the contractor proposing an OCS and the Department approving the OCS.

MEDICAL FI BO MISCELLANEOUS EXPENSES

OTHER ADMIN. POLICY CHANGE NUMBER: 64

The FI is required to provide and manage the Medi-Cal Operations Center (MOC) where the Department and contractors supporting the Medi-Cal program can be co-located with adequate security to ensure protection of the sensitive information and data consumed and produced by the program.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to a decrease to SCO IA costs due to the elimination of Remittance Advice Detail issuances.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to no longer budgeting the costs for the non-medical transportation contract that ends June 30, 2025.

Methodology:
1. Miscellaneous costs are paid using fixed pricing methodology. The contract stipulates an annual rate for each of the services defined above.

2. Costs are shared between Federal Funds (FF) and General Funds (GF).

FY 2024-25	TF	GF	FF
Interagency Agreements	$328,000	$86,000	$242,000
Total	**$328,000**	**$86,000**	**$242,000**

FY 2025-26	TF	GF	FF
Interagency Agreements	$268,000	$70,000	$198,000
Total	**$268,000**	**$70,000**	**$198,000**

Funding:
FI 75% Title XIX / 25% GF (4260-101-0001/0890)
FI 100% GF (4260-101-0001)
FI 65% Title XXI / 35% GF (4260-101-0001/0890)

HCO OPERATIONS 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 65
IMPLEMENTATION DATE: 11/2018
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 2051

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$44,591,000	$45,204,000
STATE FUNDS	$21,961,150	$22,263,000
FEDERAL FUNDS	$22,629,850	$22,941,000

Purpose:
This policy change estimates the operational costs of the Health Care Options (HCO) program for the #17-94437 contract with Maximus.

Authority:
HCO Contract #17-94437

Interdependent Policy Changes:
Not Applicable

Background:
The enrollment broker contractor for the HCO program is responsible for enrolling Medi-Cal members into managed care health plans within three Medi-Cal managed care health plan models including Two-Plan, Regional, and Geographic Managed Care. The broker also enrolls members with two Dental Managed Care plan models; one in Sacramento County where enrollment is mandatory, and one in Los Angeles County, where enrollment is voluntary. The contractor assumed operations on October 1, 2018. Operations for the contractor are based on a fixed-price bid.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase due to updated actuals. The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to adjusted projection calculations.

Methodology:
1. Operations costs are fixed price rates based on volumes within the minimum and maximum ranges under the HCO contract. These are based on agreed-upon contracted bid rates in the contract.

HCO OPERATIONS 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 65

FY 2024-25	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced Title XXI	Enhanced Title XXI
Transactions	$8,471,000	$4,024,000	$4,024,000	$148,000	$275,000
Packet Mailings	$8,471,000	$4,024,000	$4,024,000	$148,000	$275,000
BDA/Call Center	$27,649,000	$13,133,000	$13,133,000	$484,000	$899,000
Total	**$44,591,000**	**$21,181,000**	**$21,181,000**	**$780,000**	**$1,449,000**

FY 2025-26	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced Title XXI	Enhanced Title XXI
Transactions	$8,589,000	$4,080,000	$4,080,000	$150,000	$279,000
Packet Mailings	$8,589,000	$4,080,000	$4,080,000	$150,000	$279,000
BDA/Call Center	$28,026,000	$13,312,000	$13,312,000	$491,000	$911,000
Total	**$45,204,000**	**$21,472,000**	**$21,472,000**	**$791,000**	**$1,469,000**

Funding:
FI 50%Title XIX / 50% GF (4260-101-0001/0890)
FI 65% Title XXI / 35% GF (4260-101-0001/0890)

HCO COST REIMBURSEMENT 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 66
IMPLEMENTATION DATE: 11/2018
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 2052

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$36,903,000	$29,646,000
STATE FUNDS	$18,174,750	$14,600,700
FEDERAL FUNDS	$18,728,250	$15,045,300

Purpose:
This policy change estimates the total cost reimbursement of the Health Care Options (HCO) program under the #17-94437 contract with Maximus.

Authority:
HCO Contract #17-94437

Interdependent Policy Changes:
Not Applicable

Background:
The enrollment broker contract for the HCO program is responsible for enrolling Medi-Cal members into managed care health plans within three Medi-Cal managed care health plan models including Two-Plan, Regional, and Geographic Managed Care. The broker also enrolls members 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 contractor assumed operations on October 1, 2018. Cost reimbursements are direct costs incurred by the enrollment contractor while performing responsibilities under the contract that are in addition to fixed operations costs.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase due to updated actuals and adjusted projection calculations for additional staff through June 30, 2025, to support various projects including Dental Plan Procurement and CalAIM (California Advancing and Innovating Medi-Cal) Justice Involved (JI). The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due to the completion of several projects.

HCO COST REIMBURSEMENT 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 66

Methodology:

1. Contract costs are shared between GF and FF.

FY 2024-25	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced Title XXI	Enhanced Title XXI
Postage	$18,743,000	$8,903,000	$8,903,000	$328,000	$609,000
Printing	$5,516,000	$2,620,000	$2,620,000	$97,000	$179,000
Materials Maintenance and Development	$4,581,000	$2,176,000	$2,176,000	$80,000	$149,000
Mass Mailings	$1,452,000	$690,000	$690,000	$25,000	$47,000
Other Cost Reimb.	$1,832,000	$870,000	$870,000	$32,000	$60,000
Additional Systems Group Staff	$3,945,000	$1,874,000	$1,874,000	$69,000	$128,000
Miscellaneous	$834,000	$396,000	$396,000	$15,000	$27,000
Total	**$36,903,000**	**$17,529,000**	**$17,529,000**	**$646,000**	**$1,199,000**

FY 2025-26	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced Title XXI	Enhanced Title XXI
Postage	$15,057,000	$7,152,000	$7,152,000	$264,000	$489,000
Printing	$4,432,000	$2,105,000	$2,105,000	$78,000	$144,000
Materials Maintenance and Development	$3,679,000	$1,748,000	$1,748,000	$64,000	$119,000
Mass Mailings	$1,166,000	$554,000	$554,000	$20,000	$38,000
Other Cost Reimb.	$1,472,000	$699,000	$699,000	$26,000	$48,000
Additional Systems Group Staff	$3,170,000	$1,506,000	$1,506,000	$55,000	$103,000
Miscellaneous	$670,000	$318,000	$318,000	$12,000	$22,000
Total	**$29,646,000**	**$14,082,000**	**$14,082,000**	**$519,000**	**$963,000**

Funding:

FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 65% Title XXI / 35% GF (4260-101-0001/0890)

HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 67
IMPLEMENTATION DATE: 11/2018
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 2053

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$15,210,000	$14,975,000
STATE FUNDS	$7,491,000	$7,375,150
FEDERAL FUNDS	$7,719,000	$7,599,850

Purpose:
This policy change estimates the Enrollment Services Representative's (ESRs) hourly reimbursement for the Health Care Options (HCO) program under the #17-94437 contract with Maximus.

Authority:
HCO contract # 17-94437

Interdependent Policy Changes:
Not Applicable

Background:
The enrollment broker contractor for the HCO program is responsible for enrolling Medi-Cal members into managed care health plans within three Medi-Cal managed care health plan models including Two-Plan, Regional, and Geographic Managed Care. The broker also enrolls members into two Dental Managed Care plan models; one in Sacramento County, where enrollment is mandatory, and one in Los Angeles County, where enrollment is voluntary Assumption of operations for the new contractor began October 1, 2018. An important goal of the HCO program is to provide every Medi-Cal applicant/member, 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/members 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:
The change from the prior estimate, for FY 2024-25, is an increase due to updated actuals. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due to the reduction of 17 ESRs.

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 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 67

The estimated costs for FY 2024-25 and FY 2025-26 are based on 234.50 ESRs until May 31, 2024, and 217.5 ESRs thereafter.

FY 2024-25	TF	GF	FF
Title XXI (65% FF / 35% GF)	$14,450,000	$7,225,000	$7,225,000
Title XIX (50% FF / 50% GF)	$760,000	$266,000	$494,000
Total	**$15,210,000**	**$7,491,000**	**$7,719,000**

FY 2025-26	TF	GF	FF
Title XXI (65% FF / 35% GF)	$14,226,000	$7,113,000	$7,113,000
Title XIX (50% FF / 50% GF)	$749,000	$262,000	$487,000
Total	**$14,975,000**	**$7,375,000**	**$7,600,000**

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 65% Title XXI / 35% GF (4260-101-0001/0890)

DENTAL FI-DBO ADMIN 2022 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 68
IMPLEMENTATION DATE: 10/2022
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2380

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$90,286,000	$84,310,000
STATE FUNDS	$23,047,250	$22,453,250
FEDERAL FUNDS	$67,238,750	$61,856,750

Purpose:
This policy change estimates the total administrative cost for operations, cost reimbursable items, and billable labor for the Fiscal Intermediary-Dental Business Operations (FI-DBO) contract. This policy change includes the total cost of Fiscal Intermediary-Dental Business Operations (FI-DBO) contract Takeover, which facilitates the orderly transition of required business services from the dental Administrative Services Organization (ASO) contract 16-93287 and dental Fiscal Intermediary (FI) contract 16-93286 to the FI-DBO contract 22-20181.

Authority:
Contract 22-20181

Interdependent Policy Changes:
Not Applicable

Background:
The Department selected Gainwell Technologies LLC as the FI-DBO vendor, and the resulting Contract Effective Date (CED) was October 1, 2022. FI-DBO Takeover began on CED and continued until the FI-DBO Contractor assumed operations of all required business services from the ASO and FI Contractors, as approved by the Department, with assumption of operations on May 13, 2024.

Takeover constitutes all contractual responsibilities required for the FI-DBO Contractor to assume administrative responsibilities, as defined in Exhibit A, Attachment I – Takeover, as well as any work that occurs during Takeover that is required under Exhibit C – General Terms and Conditions, Exhibit D(F) – Special Terms and Conditions, and Exhibit E – Additional Provisions.

The Department is evaluating Additional Contractual Services (ACS) solicited during the request for proposal, and after CED may direct the FI-DBO to implement one or more ACS items, in accordance with Exhibit A, Attachment V – Additional Contractual Services. ACS are services related to the contract Scope of Work that enhance the support for, or increase the efficiency and effectiveness of, administering the Medi-Cal program.

The FI-DBO is a multi-year contract that provides business operations services for the Medi-Cal Dental Program including, but not limited to, claim and Treatment Authorization Request adjudication, Customer Service Center operations, and member and provider outreach. The administrative cost of the FI-DBO consists of reimbursement for operations, cost reimbursement, and billable labor. The administrative cost will be paid through a combination of payment methods including fixed price, variable price, cost reimbursement, and billable labor.

DENTAL FI-DBO ADMIN 2022 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 68

Operations constitutes all contractual responsibilities required for the contractor to administer and operate the FI-DBO. Operations costs are reimbursed through a combination of fixed price and fixed plus variable price payment methods, across payment categories as defined in Exhibit B, Attachment I, Provision 3. In addition, the FI-DBO will take on an increase of services transferred from FI, which include Printing, Postage, Parcel Services & Common Carrier.

A two percent (2%) withhold will be administered on Member Outreach and Provider Outreach invoices, to account for performance standards evaluating year-over-year increases in volume, in accordance with Exhibit B, Attachment I, Provision 7.A. The 2% withhold will be held from each monthly invoice until the end of each Contract Year, pending contractor substantiation that annual performance outcomes are met. If the FI-DBO does not meet required performance standards, the 2% withhold will not be released.

The Department will reimburse various cost, in arrears, incurred by the FI-DBO in fulfilling its requirements under the contract, referred to as cost reimbursement. These items are in addition to operations and are not part of the contract bid price. The cost reimbursement payment method is limited to direct cost within the following categories, as defined in Exhibit B, Attachment I, Provision 4:

- Postage
- Parcel Services and Common Carriers
- Office Automation
- Printing
- Travel and Special Training Sessions
- Facilities Improvements
- Audits and Research
- Sales/Use Tax
- Change Orders and/or Contract Amendments
- Consultant Contracts
- Services and Subscriptions
- Annual Risk Assessments
- Conventions, Provider Enrollment Workshops, and Health Fairs
- Telephone Toll Charges
- Language Line
- Clinical Screening
- Translation and Alternative Format Services
- Other Cost Reimbursable Items

In addition, certain activities are reimbursed as billable labor by the Department, subject to written pre-approval from the Department. The rate paid to the contractor consists of all direct and indirect costs required to support these activities.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase due the additional postage, printing and parcel services transferred from the FI. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due takeover costs completing in FY 2024-25.

DENTAL FI-DBO ADMIN 2022 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 68

Methodology:

1. Takeover will be paid on a fixed price basis up to a maximum of thirty million dollars ($30,000,000), and subject to validation of submitted documentation by the Department.

2. Eighty percent (80%) of the Takeover bid will be paid in equal monthly installments, as defined by the Department approved Contractor's project schedule. Twenty percent (20%) of the Takeover bid will be paid upon completion of Takeover as approved by the Department Contracting Officer.

3. ACS items approved for implementation by the Department will be paid on a fixed price basis, in addition to the Takeover maximum, and subject to validation of submitted documentation by the Department.

4. Eighty percent (80%) of each ACS bid will be paid in equal monthly installments, as defined by the Department approved Contractor's project schedule. Twenty percent (20%) of each ACS bid will be paid upon completion of the ACS as approved by the Department Contracting Officer.

5. Takeover Costs:

Fiscal Year	TF	GF	FF
FY 2024-25	$6,000,000	$600,000	$5,400,000
FY 2025-26	$0	$0	$0

6. Operations cost are a combination of fixed price and fixed plus variable price for defined payment categories under the FI-DBO contract.

7. A two percent (2%) withhold will be held from monthly Perform Member Outreach and Conduct Provider Outreach invoices, until the end of each Contract Year pending Contractor substantiation that annual performance outcomes are met. The withhold is based on actual invoices received.

8. Operations Costs:

Fiscal Year	TF	GF	FF
FY 2024-25	$75,695,000	$18,924,000	$56,771,000
FY 2025-26	$75,719,000	$18,930,000	$56,789,000

9. Cost Reimbursements:

Fiscal Year	TF	GF	FF
FY 2024-25	$5,803,000	$2,826,000	$2,977,000
FY 2025-26	$5,803,000	$2,826,000	$2,977,000

DENTAL FI-DBO ADMIN 2022 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 68

10. Billable Labor Costs:

Fiscal Year	TF	GF	FF
FY 2024-25	$2,788,000	$697,000	$2,091,000
FY 2025-26	$2,788,000	$697,000	$2,091,000

11. Total Administration Costs:

Fiscal Year	TF	GF	FF
FY 2024-25	$90,286,000	$23,047,000	$67,239,000
FY 2025-26	$84,310,000	$22,453,000	$61,857,000

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)
***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

DENTAL ASO ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 69
IMPLEMENTATION DATE: 3/2018
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2007

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$29,430,000	$0
STATE FUNDS	$9,073,000	$0
FEDERAL FUNDS	$20,357,000	$0

Purpose:
This policy change estimates the total cost for reimbursable items, operations, turnover, and runout for the 2016 Dental Administrative Services Organization (ASO).

Authority:
Contract 16-93287

Interdependent Policy Changes:
Not Applicable

Background:
Delta Dental of California (Delta) was awarded a multi-year ASO contract in 2016. ASO assumption of operations began in February 2018. Delta is responsible for ASO services for the Medi-Cal Dental Program. The administrative costs consist of reimbursement for cost reimbursables, operations, turnover, and runout.

Operations constitute all contractual obligations required for the contractor to administer and operate the ASO. Only direct costs of certain operations are eligible for cost reimbursement. All other costs are to be included in fixed price components. These cost categories consist of:

- Adjudicated Claim Service Lines (ACSL), paid on a per claim line basis and includes claims related to the Dental Transformation Initiative from Federally Qualified Health Centers;
- Treatment Authorization Requests (TAR), paid on a per document basis; and
- Telephone Service Center (TSC), paid on a per minute basis.

A 2% withhold is being administered on operation invoices which are calculated using ACSL and TAR. The 2% withhold will be released if the ASO meets performance requirements set in the ASO contract; if the ASO does not meet performance measures, the 2% withhold will not be released.

Cost reimbursements are direct costs incurred by the enrollment contractor while performing responsibilities under the contract that are in addition to fixed operations costs. Various costs incurred by the contractor while performing responsibilities under the contract will be reimbursed by the Department. These costs are not a part of the bid price of the contract. Any of the following costs may be cost reimbursed under the contract:

DENTAL ASO ADMINISTRATION 2016 CONTRACT
OTHER ADMIN. POLICY CHANGE NUMBER: 69

1. Postage
2. Parcel Services and Common Carriers
3. Printing
4. Telephone Toll Charges
5. Special Training Sessions
6. Conventions, Provider Enrollment Workshops, and Health Fairs
7. Facilities Improvement and Modifications
8. Personal Computers, Monitors, Printers, Related Equipment, and Software
9. Cost Reimbursed Audits and Research
10. Independent Contractor Consideration
11. Annual Risk Assessments
12. Miscellaneous

The ASO has expanded its outreach efforts by securing a subcontractor, RSE, who specializes in marketing and education. RSE began with a member survey at the end of 2017 followed by focused groups in early 2018. This enabled them to identify any gaps or barriers and create marketing strategies that best captured this population's needs, develop innovative marketing approaches, and improve the content of outreach and education materials while containing costs. Outreach and education will help increase member awareness about dental benefits and provide assistance in locating a dentist to schedule an appointment.

With the release of the Notice of Intent to Award for the Fiscal Intermediary – Dental Business Operations (FI-DBO) contract, the Department expects to utilize the one-time period of extended operations to extend ASO operations into FY 2024-25 to allow the ASO to remain in operations during the FI-DBO Takeover phase. The addition of the period of extended operations, the Turnover, and Runout phases under the ASO contract will be pushed back as a result.

The Department selected Gainwell Technologies LLC as the FI-DBO vendor, and the resulting Contract Effective Date (CED) was October 1, 2022. FI-DBO Takeover began on CED and continued until the FI-DBO Contractor assumed operations of all required business services from the ASO and FI Contractors, as approved by the Department, with assumption of operations on May 13, 2024. Liquidated damages will be applied for invoices due to unsatisfactory metrics.

Turnover constitutes all work activities required of the ASO as defined in the contract documents for with Delta. Turnover ensures the orderly transfer of services from the ASO to the successor Fiscal Intermediary-Dental Business Operations (FI-DBO) contract. The schedule of payments for turnover to the ASO is contractually agreed upon. 55% of the turnover bid price is paid in nine equal installments, with nine percent withheld from each installment. One final installment of 45% and withholds is made upon completion of all turnover requirements. These payments started to be paid in September 2023.

Following turnover of the ASO contract is runout. Runout constitutes all work activities required of the ASO during runout, as defined in the contract documents with Delta. Runout ensures the orderly decommissioning of systems and closeout of the ASO contract. The schedule of payments for runout services to the ASO is contractually agreed upon. 55% of the runout bid price is paid in seven equal installments, with seven percent withheld from each installment. One final installment of 45% and withholds is made upon completion of all runout requirements. These payments are expected to be paid starting in November 2024.

DENTAL ASO ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 69

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase due to delayed payment of invoices for several categories of services. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due operations transitioning and runout costs ending in FY 2024-25.

Methodology:

1. Operations costs are fixed price rates based on volumes within minimum and maximum ranges under the ASO contract.

2. ACSL and TAR volumes are based on actual invoices with a caseload growth factor. Provider Enrollment activities account for 15% of the total ACSL/TAR costs.

    a. Provider Enrollment
        i. 58% of costs are funded at 50% FF and 50% GF
        ii. 42% of costs are funded at 75% FF and 25% GF
    b. Remaining costs are funded at 75% FF and 25% GF

3. The 2% withhold is based on actual invoices received. If performance requirements are met for the calendar year, the funds will be released the following September.

4. TSC minutes are based on actual invoices funded at 50% FF and 50% GF.

FY 2024-25	TF	GF	FF
Administration/Operations (75% FF / 25% GF)	$9,801,000	$2,450,000	$7,351,000
Provider Enrollment (50% FF / 50% GF & 75% FF / 25% GF)	$1,729,000	$614,000	$1,115,000
2% Withhold (net of prior year withhold release)	$240,000	$64,000	$176,000
Total ACSL/TAR	$11,771,000	$3,128,000	$8,643,000
TSC – Provider (50% FF / 50% GF)	$912,000	$456,000	$456,000
TSC – Member (50% FF / 50% GF)	$3,176,000	$1,588,000	$1,588,000
Total TSC	$4,088,000	$2,044,000	$2,044,000
Total Operations Costs	**$15,859,000**	**$5,172,000**	**$10,687,000**

5. Cost reimbursements are based on actual invoices with a caseload growth factor.

Cost Reimbursable	TF	GF	FF
FY 2024-25	**$2,219,000**	**$588,000**	**$1,631,000**

6. Turnover and Runout Costs

Fiscal Year	TF	GF	FF
FY 2024-25	**$11,352,000**	**$2,838,000**	**$8,514,000**

DENTAL ASO ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 69

7. Total Administration Cost

Fiscal Year	TF	GF	FF
FY 2024-25	$29,430,000	$8,598,000	$20,832,000

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 FI ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 70
IMPLEMENTATION DATE: 11/2017
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2006

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$20,406,000	$22,038,000
STATE FUNDS	$5,191,000	$5,604,250
FEDERAL FUNDS	$15,215,000	$16,433,750

Purpose:
This policy change estimates the total cost for operations, cost reimbursable items, and hourly reimbursables for the 2016 Dental Fiscal Intermediary (FI).

Authority:
Contract 16-93286

Interdependent Policy Changes:
Not Applicable

Background:
A contract amendment was executed to change the FI contractor's name from DXC Technology Services (DXC) to Gainwell Technologies LLC (Gainwell). Gainwell assumes all contractual responsibilities and obligations under the multi-year FI contract from 2016 for the FI services of the Medi-Cal Dental Program. The administrative costs consist of reimbursement for operations, cost reimbursables, and hourly reimbursable costs.

Operations constitute all contractual responsibilities required for the contractor to administer and operate the FI. Only direct costs of certain operations are eligible for cost reimbursement. All other costs are included in fixed price components. These cost categories consist of a combined document count of claims, including Federally Qualified Health Center (FQHC) claims for the Dental Transformation Initiative program, and Treatment Authorization Requests (TAR), paid on a per document basis.

Cost reimbursements are direct costs incurred by the enrollment contractor while performing responsibilities under the contract that are in addition to fixed operations costs. Various costs incurred by the contractor while performing responsibilities under the contract will be reimbursed by the Department. These costs are not a part of the bid price of the contract. Any of the following costs may be cost reimbursed under the contract:

1. Data Center Access
2. Special Training Sessions
3. Facilities Improvement and Modifications
4. Personal Computers, Monitors, Printers, Related Equipment, and Software
5. Cost Reimbursed Audits and Research
6. Independent Contractor Consideration
7. Annual Risk Assessments
8. Miscellaneous

DENTAL FI ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 70

9. Cost Reimbursement Invoice

Certain activities are reimbursed on an hourly basis by the Department. The rate paid to the contractor consists of all direct and indirect costs required to support these activities. The hourly reimbursed area consists of the Systems Group (SG). A Notice of Change (NOC) was executed June 10, 2024 which will increase usage of SG Hours.

Costs related to Printing, Parcel Service and Common Carriers, and Postage have completely shifting to Fiscal Intermediary – Dental Business Operation (FI-DBO). A portion of the costs for front end services was also moved to the FI-DBO contractor.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a slight decrease due to revised projections for several categories of service. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a net increase due to rate changes for several categories of services.

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. Check write expenditures are associated with the cost of sending payment to providers, based on adjudicated claims from the FI-DBO.

FY 2024-25	TF	GF	FF
Scanned Claims/TAR	$12,443,000	$3,111,000	$9,332,000
Check Write	$272,000	$68,000	$204,000
Change Orders	$336,000	$168,000	$168,000
Total	**$13,051,000**	**$3,347,000**	**$9,704,000**

FY 2025-26	TF	GF	FF
Scanned Claims/TAR	$12,491,000	$3,123,000	$9,368,000
Check Write	$278,000	$70,000	$208,000
Change Orders	$356,000	$178,000	$178,000
Total	**$13,125,000**	**$3,371,000**	**$9,754,000**

4. Cost reimbursements are based on actual invoices.

Fiscal Year	TF	GF	FF
FY 2024-25	**$22,000**	**$11,000**	**$11,000**
FY 2025-26	**$22,000**	**$11,000**	**$11,000**

DENTAL FI ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 70

5. Hourly Reimbursables:

System Group	TF	GF	FF
FY 2024-25	$7,333,000	$1,833,000	$5,500,000
FY 2025-26	$8,891,000	$2,223,000	$6,668,000

6. Total Administration Cost:

Fiscal Year	TF	GF	FF
FY 2024-25	$20,406,000	$5,191,000	$15,215,000
FY 2025-26	$22,038,000	$5,605,000	$16,433,000

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.

PERSONAL CARE SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 71
IMPLEMENTATION DATE: 4/1993
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 236

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$514,725,000	$561,679,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$514,725,000	$561,679,000

Purpose:
This policy change provides Title XIX federal financial participation (FFP) to the California Department of Social Services (CDSS) for the county cost of administering two In-Home Supportive Services (IHSS) programs: the Personal Care Services Program (PCSP) and the IHSS Plus Option (IPO) program. Title XIX FFP is also provided to CDSS for the IHSS Case Management & Information Payrolling System (CMIPS) Legacy and CMIPS II.

Authority:
Interagency Agreement (IA) 03-75676
IA 09-86307 IPO
IA 18-95714

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:
There is an increase from the prior estimate for FY 2024-25, due to updated expenditure data provided by CDSS. There is an increase in the current estimate from FY 2024-25 to FY 2025-26 due to updated expenditure data provided by CDSS.

PERSONAL CARE SERVICES
OTHER ADMIN. POLICY CHANGE NUMBER: 71

Methodology:
1. On an accrual basis, CDSS estimated FY 2024-25 expenditures at $510,787,000 FF and FY 2025-26 expenditures at $523,615,000 FF.

2. On a cash basis, the estimates below were provided by CDSS.

(Dollars in Thousands)

FY 2024-25	TF	DHCS FFP	CDSS GF/ County Match
EW Time & Health Related	$962,146	$481,073	$481,073
CMIPS II	$30,138	$15,069	$15,069
CMIPS II EVV	$37,166	$18,583	$18,583
Total	$1,029,450	**$514,725**	$514,725
FY 2025-26	**TF**	**DHCS FFP**	**CDSS GF/ County Match**
EW Time & Health Related	$1,088,322	$544,161	$544,161
CMIPS II	$35,036	$17,518	$17,518
CMIPS II EVV	$0	$0	$0
Total	$1,123,358	**$561,679**	$561,679

*Totals may differ due to rounding.

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

HEALTH-RELATED ACTIVITIES - CDSS

OTHER ADMIN. POLICY CHANGE NUMBER: 72
IMPLEMENTATION DATE: 7/1992
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 233

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$434,236,000	$496,442,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$434,236,000	$496,442,000

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.

Authority:
CWS Interagency Agreement (IA) 01-15931
CWS/CMS IA 06-55834
CSBG/APS IA 01-15931

Interdependent Policy Changes:
Not Applicable

Background:
The health-related services involve helping Medi-Cal members to access covered medical services or maintain current treatment levels in these program areas: 1) Child Welfare Services (CWS); 2) Child Welfare Services/Case Management System (CWS/CMS); 3) County Services Block Grant (CSBG); 4) Adult Protective Services (APS); and 5) Psychotropic Medications Medical Review.

Reason for Change:
There is an increase from the prior estimate for FY 2024-25, due to updated expenditure data provided by CDSS. There is an increase in the current estimate from FY 2024-25 to FY 2025-26 due to updated expenditure data provided by CDSS.

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

HEALTH-RELATED ACTIVITIES - CDSS

OTHER ADMIN. POLICY CHANGE NUMBER: 72

(Dollars in Thousands)

FY 2024-25	TF	DHCS FFP	CDSS GF/ County Match
CWS	$453,423	$226,711	$226,711
CWS/CMS	$10,210	$5,105	$5,105
CSBG/APS	$404,839	$202,419	$202,419
TOTAL	$868,472	**$434,236**	$434,236
FY 2025-26	**TF**	**DHCS FFP**	**CDSS GF/ County Match**
CWS	$519,538	$259,769	$259,769
CWS/CMS	$11,719	$5,901	$5,818
CSBG/APS	$463,756	$230,772	$232,984
TOTAL	$995,013	**$496,442**	$498,571

*Totals may differ due to rounding.

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

CALHEERS DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 73
IMPLEMENTATION DATE: 6/2012
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1679

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$192,225,000	$168,235,000
STATE FUNDS	$48,882,750	$44,677,100
FEDERAL FUNDS	$143,342,250	$123,557,900

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 to maintain the electronic interface between the Medi-Cal Eligibility Data System (MEDS) and CalHEERS.

Authority:
Affordable Care Act (ACA) of 2010
AB 1602 (Chapter 655, Statutes of 2010)
SB 900 (Chapter 659, Statues of 2010)
SB 644 (Chapter 983, Statues of 2022)
Contract # 21-10137
Contract # 21-10171
Contract # 22-20089

Interdependent Policy Changes:
LGBT Disparities Reduction Act (AB 1163)

Background:
California established Covered California to provide competitive health care coverage for individuals and small employers. CalHEERS determines an applicant's eligibility for subsidized coverage. In creating this one-stop-shop experience, states are required to use a single, streamlined application for the applicants to apply for all applicable health subsidy programs. The application may be filed online, in person at a county social services agency, by mail, or by telephone. To meet this requirement, the Department and Covered California formed a partnership to acquire a Systems Integrator to design and implement the CalHEERS as the business solution that allows the required one-stop shopping, making health insurance eligibility purchasing easier and more understandable.

The Department is responsible for the coordination, clarification, and implementation of Medi-Cal regulations, policies, and procedures to ensure the accurate and timely determination of Medi-Cal eligibility for applicants and members. 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 members in the county eligibility 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

CALHEERS DEVELOPMENT
OTHER ADMIN. POLICY CHANGE NUMBER: 73

and implemented technology solutions for the ongoing maintenance of MEDS and Health Exchange Medi-Cal Interface (HEMI) web services.

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 receives enhanced federal funding for the requirements validation, design, development, testing, and implementation of MEDS-related system changes needed to interface with CalHEERS. The majority of CalHEERS' costs are shared between Covered California and Medi-Cal. For any design, development, and implementation (DD&I) or maintenance and operations (M&O) activities that are not eligible for federal reimbursement, costs are funded 100% by either the Department or Covered California, as applicable.

The Department requested enhanced federal funding for HEMI from the Centers for Medicare & Medicaid Services (CMS). In September 2023, CMS approved the Operational Advanced Planning Document for HEMI which increased funding in FFY 2024 and funding for FFY 2025. The Department submitted an As Needed Advance Planning Document (IAPDU) for CalHEERS to increase funding in FFY 2024 and FFY 2025. CMS approved the IAPDU in August 2023. Under both projects, approval for enhanced federal funding will remain in effect until September 30, 2025. Additionally, the Department submitted an IAPDU in July 2024, requesting additional funding for FFY 2025 and FFY 2026 with a proposed cost share between the Department (86.55%) and Covered CA (13.45%) effective October 1, 2024. The Department submitted an IADPU for the HEMI project in August 2024 to request additional funding for FFY 2025 and FFY 2026.

Reason for Change:
CalHEERS
The change from the prior estimate, for FY 2024-25, is an increase due to annual augmentations to personnel and Office of Technology and Solution Integration (OTSI) indirect costs, SDMO fixed price services, including increased cost to maintain in state and offshore facilities as well as incremental cost increases to support necessary service contracts. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due to the transition of the FPACT project to M&O activities and execution of the Lexis Nexis Provider Directory which will include the elimination of transition resources from the previous provider directory support vendor.

HEMI
The change from the prior estimate, for FY 2024 25, is a decrease due to updated HEMI actuals and adjusted projection calculations. The change from FY 2024-25 to FY 2025-26, in the current estimate is an increase due to the execution of a Web Developer contract and Quality Assurance Tester contract.

The change from the prior estimate, for FY 2024-25, is an overall increase due to contract and administrative costs necessary for M&O for the CalHEERS system. The change from FY 2024-25 to FY 2025-26, in the current estimate, is an overall decrease due to CalHEERS completion of major project implementations including FPACT and the provider directory transition to Lexis Nexus.

Methodology:
CalHEERS' costs are shared between Covered California and Medi-Cal based on the approved Cost Allocation Plan.

CALHEERS DEVELOPMENT
OTHER ADMIN. POLICY CHANGE NUMBER: 73

- Effective FY 2021-22, costs for all Medi-Cal activities that are not eligible for federal reimbursement are identified separately from Title XIX and Title XXI;
- All costs directly attributable to the Department are the responsibility of the Department;
- Effective October 1, 2023, the proposed cost share is 13.46% from Covered California and 86.54% from the Department;
- Effective October 1, 2024, the proposed cost share is 13.45% from Covered California and 86.55% from the Department;
- Effective FY 2023-24, Implementation of Eligibility Functionality for Family PACT Program will follow the reimbursement rates only under Title XIX at 90% and the Department at 100% GF;
- Effective FY 2024-25, ongoing costs for retrieval of CSI data from the CMS Hub will follow the reimbursement rates only under Title XIX at 75% and 100% from the Department.

2. Costs incurred are for CalHEERS' DD&I and M&O activities, which have different FFP reimbursement percentages.
    - The DD&I portion of costs is eligible for:
        i. Title XIX at 90% federal reimbursement;
        ii. Title XXI at 65% federal reimbursement.
    - The M&O portion of costs is eligible for:
        i. Title XIX at 75% federal reimbursement;
        ii. Title XXI at 65% federal reimbursement.

3. The estimates for FY 2024-25 and FY 2025-26 are as follows:

FY 2024-25	TF	GF	FF
Title XIX (90% FF / 10% GF)	$47,722,000	$4,772,000	$42,950,000
Title XIX (75% FF / 25% GF)	$112,184,000	$28,046,000	$84,138,000
Title XXI (65% FF / 35% GF)	$22,546,000	$7,891,000	$14,655,000
100% State GF	$7,602,000	$7,602,000	$0
CalHEERS Subtotal	$190,054,000	$48,311,000	$141,743,000
75% Title XIX FF / 25% GF	$1,884,000	$472,000	$1,412,000
65% Title XXI FF / 35% GF	$287,000	$100,000	$187,000
ETS Subtotal	$2,171,000	$572,000	$1,599,000
Total	**$192,225,000**	**$48,883,000**	**$143,342,000**

CALHEERS DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 73

FY 2025-26	TF	GF	FF
Title XIX (90% FF / 10% GF)	$30,168,000	$3,017,000	$27,151,000
Title XIX (75% FF / 25% GF)	$107,648,000	$26,912,000	$80,736,000
Title XXI (65% FF / 35% GF)	$21,368,000	$7,479,000	$13,889,000
100% State GF	$6,633,000	$6,633,000	$0
CalHEERS Subtotal	$165,817,000	$44,041,000	$121,776,000
75% Title XIX FF / 25% GF	$2,098,000	$524,000	$1,574,000
65% Title XXI FF / 35% GF	$320,000	$112,000	$208,000
ETS Subtotal	$2,418,000	$636,000	$1,782,000
Total	**$168,235,000**	**$44,677,000**	**$123,558,000**

Funding:
90% Title XIX / 10% GF (4260-101-0001/0890)
75% Title XIX / 25% GF (4260-101-0001/0890)
65% Title XXI / 35% GF (4260-101-0001/0890)
100% GF (4260-101-0001)

MATERNAL AND CHILD HEALTH

OTHER ADMIN. POLICY CHANGE NUMBER: 74
IMPLEMENTATION DATE: 7/2022
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 234

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$70,496,000	$87,327,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$70,496,000	$87,327,000

Purpose:
This policy change estimates the federal match provided to the California Department of Public Health (CDPH) for the Maternal, Child, and Adolescent Health (MCAH) programs.

Authority:
Interagency Agreement 07-65592
SB 852 (Chapter 25, Statutes of 2014)

Interdependent Policy Changes:
Not Applicable

Background
The MCAH program administers the following services:

- Conducts outreach to pregnant and parenting adolescents who are potentially eligible for Medi-Cal;
- Assists Medi-Cal enrolled members in accessing covered services.
- Recruits providers for Medi-Cal's Comprehensive Perinatal Services Program (CPSP) and provides technical assistance regarding CPSP enhanced services to Medi-Cal members;
- 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 enrolled pregnant women;
- Administers programs for preventive and primary care services for children and youth; and
- Administers programs for family-centered, community-based, comprehensive health services to children with special health care needs;
- MCAH State Operations 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.

The MCAH program includes the following services:

- Black Infant Health (BIH): Group intervention and case management services to pregnant and parenting African American Medi-Cal eligible women in an effort to reduce the high death rate for African American infants as well as decrease health and social inequities for African-American women and infants. Effective July 1, 2014, SB 852 restored the General Fund for the BIH Program.

MATERNAL AND CHILD HEALTH
OTHER ADMIN. POLICY CHANGE NUMBER: 74

- Comprehensive Perinatal Services Program (CPSP) and Prenatal Care Guidance (PCG): Provides a wide range of services to Medi-Cal enrolled pregnant women, from conception through 60 days postpartum, case management services, and conduct follow-up to improve access to early obstetrical and post-partum care (60-days following the delivery) for Medi-Cal enrolled pregnant women.
- Adolescent Family Life Program (AFLP): Case management services for Medi-Cal-eligible pregnant adolescents to address the social, health, educational, and economic consequences of adolescent pregnancy by providing comprehensive case management services to pregnant and parenting adolescents and their children. The AFLP emphasizes the 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.
- The California Home Visiting Program (CHVP) focuses on young, low-income mothers and provides a wider range of home visiting models based on varying family needs.
- Perinatal Equity Initiative (PEI): Expands the scope of interventions that close gaps in current programming offered through the BIH program to further improve black infant birth outcomes and reduce infant mortality.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a decrease due to updated actuals and adjusted projections of anticipated payments. The change from FY 2024-25 to FY 2025-26, in the current estimate, is an increase due to projections of anticipated payments.

Methodology:
1. The Department claims Title XIX federal funds with Certified Public Expenditures from local agencies.

2. The estimates are budgeted on a cash basis based on the anticipated payment timing of invoices.

3. The costs for FY 2024-25 are estimated to be $70,496,000 Federal Funds and FY 2025-26 $87,327,000 Federal Funds.

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

CDDS ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 75
IMPLEMENTATION DATE: 7/1997
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 243

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$93,199,000	$74,097,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$93,199,000	$74,097,000

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 Facility (SOF) Medi-Cal Administration, DC/SOF Medi-Cal Eligibility, 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 in FY 2024-25, from the prior estimate, is due to updated accrual estimates with projected expenditures based on more recent expenditure trends.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to updated FY 2024-25 and FY 2025-26 accrual estimates to reflect updated expenditure trend data and FY 2025-26 includes assumptions on the timing of future paid expenditures.

CDDS ADMINISTRATIVE COSTS
OTHER ADMIN. POLICY CHANGE NUMBER: 75

Methodology:
CDDS provides the following cash estimates of its administrative cost components:

FY 2024-25		DHCS FFP	CDDS GF	IA #
1	DC/SOF Medi-Cal Admin.	$775,000	$775,000	03-75282/83
2	DC/SOF Medi-Cal Elig	$759,000	$759,000	01-15378
3	HCBS Waiver Admin.	$53,434,000	$53,434,000	01-15834
4	RC Medicaid Admin.	$25,511,000	$8,504,000	03-75734
5	NHR Admin.	$621,000	$621,000	03-75285
6	TCM Headquarters Admin.	$11,461,000	$11,461,000	03-75284
	TCM HIPAA	$638,000	$638,000	03-75284
	Total	**$93,199,000**	$76,192,000	

FY 2025-26		DHCS FFP	CDDS GF	IA #
1	DC/SOF Medi-Cal Admin.	$907,000	$907,000	03-75282/83
2	DC/SOF Medi-Cal Elig	$797,000	$797,000	01-15378
3	HCBS Waiver Admin.	$39,158,000	$39,158,000	01-15834
4	RC Medicaid Admin.	$24,080,000	$8,027,000	03-75734
5	NHR Admin.	$625,000	$625,000	03-75285
6	TCM Headquarters Admin.	$7,892,000	$7,892,000	03-75284
	TCM HIPAA	$638,000	$638,000	03-75284
	Total	**$74,097,000**	$58,044,000	

Funding:
100% Title XIX (4260-101-0890)
100% HIPAA FFP (4260-117-0890)

HCPCFC CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 76
IMPLEMENTATION DATE: 7/1999
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 246

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$54,682,000	$54,682,000
STATE FUNDS	$13,671,000	$13,671,000
FEDERAL FUNDS	$41,011,000	$41,011,000

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
Welfare & Institutions Code, Section 16501.4(d)
Welfare & Institutions Code, Section 5328.04(a), (b), and (f)
Civil Code, Section 56.103
AB 1111 (Chapter 147, Statutes of 1999)
SB 1013 (Chapter 35, Statutes of 2012)
SB 238 (Chapter 534, Statutes of 2015)
SB 319 (Chapter 535, Statutes of 2015)
AB 97 (Chapter 14, Statutes of 2017)
Interagency Agreement (IA) 24-40002
Budget Act of 2017
SB 184 (Chapter 47, Statutes of 2022)

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.

HCPCFC CASE MANAGEMENT
OTHER ADMIN. POLICY CHANGE NUMBER: 76

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 for the remaining non-federal costs for counties is 100% General Funds.

SB 184 authorized the Department to sunset the CHDP program on June 30, 2024. Effective July 1, 2024, the Department redirected portions of the CHDP county budget allocation to fund the administrative costs of the HCPCFC, making HCPCFC a standalone program. Remaining portions of the CHDP county budget allocation will be redirected to the California Children's Services (CCS) program to fund the new county workload created due to the implementation of CCS Compliance Monitoring and Oversight, effective July 1, 2025.

Reason for Change:
There is no change from the prior estimate for FY 2024-25, and there is no change from FY 2024-25 to FY 2025-26 in the current estimate.

Methodology:
1. CDSS provides the annual Local Revenue Fund of $13,671,000 for FY 2024-25.

(Dollars in Thousands)

FY 2024-25	**TF**	**GF**	**FF**
Base Allocation	$32,682	$8,171	$24,512
Psychotropic Medication Monitoring and Oversight	$6,600	$1,650	$4,950
Caseload Relief	$15,400	$3,850	$11,550
Total	**$54,682**	**$13,671**	$41,011
FY 2025-26	**TF**	**GF**	**FF**
Base Allocation	$32,682	$8,171	$24,512
Psychotropic Medication Monitoring and Oversight	$6,600	$1,650	$4,950
Caseload Relief	$15,400	$3,850	$11,550
Total	**$54,682**	**$13,671**	$41,011

*Totals may differ due to rounding.

2. Assume CDSS reimburses the GF to the Department 60 days after the end of each fiscal quarter.

HCPCFC CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 76

(Dollars in Thousands)

Fiscal Year	TF	FF	GF Reimb.	CDSS GF	CF*
FY 2024-25	**$54,682**	**$41,011**	**$13,671**	$13,671	$7,594
FY 2025-26	**$54,682**	**$41,011**	**$13,671**	$13,671	$7,594

*County funds and CDSS GF are not included in the Total Fund.

Funding:
100% Title XIX FFP (4260-101-0890)
GF Reimbursement (4260-610-0995)

DEPARTMENT OF SOCIAL SERVICES ADMIN COST

OTHER ADMIN. POLICY CHANGE NUMBER: 77
IMPLEMENTATION DATE: 7/2002
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 256

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$50,501,000	$47,501,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$50,501,000	$47,501,000

Purpose:
This policy change provides Title XIX federal financial participation (FFP) to the California Department of Social Services (CDSS) for administering various programs to Medi-Cal beneficiaries.

Authority:
IHSS PCSP Interagency Agreement (IA) 03-75676
IHSS Health Related IA 01-15931
CWS/CMS for Medi-Cal IA 06-55834
IHSS Plus Option Sec. 1915(j) IA 09-86307
SAWS IA 04-35639
Medi-Cal State Hearings IA 16-93214
Public Inquiry and Response IA 16-93213
Medicaid Disability Evaluation Services IA 16-93215
Estate Recovery Claims IA 20-10026
Electronic Visit Verification IA 18-95714
Income and Eligibility Verification IA 22-20039
Statewide Verification Hub IA 21-10376

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, Electronic Visit Verification, and the California Community Transitions-Money Follows the Persons. 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 an increase from the prior estimate for FY 2024-25, due to updated expenditure data provided by CDSS. There is a decrease in the current estimate from FY 2024-25 to FY 2025-26, due to Electronic Visit Verification costs shifting to the Electronic Visit Verification M&O Costs policy change in FY 2025-26.

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

DEPARTMENT OF SOCIAL SERVICES ADMIN COST

OTHER ADMIN. POLICY CHANGE NUMBER: 77

FY 2024-25	TF	DHCS FFP	CDSS GF
IHSS PCSP	$18,000,000	$9,000,000	$9,000,000
IHSS Health Related	$128,000	$64,000	$64,000
CWS/CMS for Medi-Cal	$2,000,000	$1,000,000	$1,000,000
IHSS Plus Option Sec. 1915(j)	$6,000,000	$3,000,000	$3,000,000
SAWS	$1,600,000	$800,000	$800,000
Medi-Cal State Hearings	$55,534,000	$27,767,000	$27,767,000
Public Inquiry and Response	$500,000	$250,000	$250,000
Medicaid Disability Evaluation Services	$6,328,000	$3,164,000	$3,164,000
Estate Recovery Claims	$8,000	$4,000	$4,000
Electronic Visit Verification	$6,000,000	$3,000,000	$3,000,000
Income and Eligibility Verification	$928,000	$464,000	$464,000
Statewide Verification Hub	$3,976,000	$1,988,000	$1,988,000
TOTAL	$101,002,000	**$50,501,000**	$50,501,000
FY 2025-26	**TF**	**DHCS FFP**	**CDSS GF**
IHSS PCSP	$18,000,000	$9,000,000	$9,000,000
IHSS Health Related	$128,000	$64,000	$64,000
CWS/CMS for Medi-Cal	$2,000,000	$1,000,000	$1,000,000
IHSS Plus Option Sec. 1915(j)	$6,000,000	$3,000,000	$3,000,000
SAWS	$1,600,000	$800,000	$800,000
Medi-Cal State Hearings	$55,534,000	$27,767,000	$27,767,000
Public Inquiry and Response	$500,000	$250,000	$250,000
Medicaid Disability Evaluation Services	$6,328,000	$3,164,000	$3,164,000
Estate Recovery Claims	$8,000	$4,000	$4,000
Electronic Visit Verification	$0	$0	$0
Income and Eligibility Verification	$928,000	$464,000	$464,000
Statewide Verification Hub	$3,976,000	$1,988,000	$1,988,000
TOTAL	$95,002,000	**$47,501,000**	$47,501,000

*Totals may differ due to rounding.

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

HCPCFC ADMIN COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 78
IMPLEMENTATION DATE: 7/2024
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2455

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$23,757,000	$23,757,000
STATE FUNDS	$11,878,500	$11,878,500
FEDERAL FUNDS	$11,878,500	$11,878,500

Purpose:
This policy change estimates the administration costs for Health Care Program for Children in Foster Care (HCPCFC).

Authority:
Welfare & Institutions Code, Section 16501.3
Welfare & Institutions Code, Section 16501.4(d)
Welfare & Institutions Code, Section 5328.04(a), (b), and (f)
Civil Code, Section 56.103
AB 1111 (Chapter 147, Statutes of 1999)
SB 1013 (Chapter 35, Statutes of 2012)
SB 238 (Chapter 534, Statutes of 2015)
SB 319 (Chapter 535, Statutes of 2015)
AB 97 (Chapter 14, Statutes of 2017)
Interagency Agreement (IA) 21-10019
Budget Act of 2017
SB 184 (Chapter 47, Statutes of 2022)
SB 108 (Chapter 35, Statutes of 2024)

Interdependent Policy Change:
Not Applicable

Background:
Senate Bill (SB 184) authorized the Department to sunset the Child Health and Disability Prevention (CHDP) program on June 30, 2024. Effective July 1, 2024, the Department redirected the CHDP budget allocation to fund the administrative costs of the HCPCFC and the California Children's Services (CCS) Compliance Monitoring and Oversight Program to support retention of existing local CHDP positions through the exploration of new partnerships and roles and/or through bolstering existing programs that can leverage CHDP expertise.

Where CHDP was the source of funding for HCPCFC administrative activities, the program will operate autonomously to cover allowable non-clinical expenses and existing non-clinical local positions. Remaining portions of the CHDP county budget allocation will be redirected to the CCS program to fund new county workload created due to the implementation of CCS Monitoring and Oversight, effective July 1, 2025. Counties will receive the funds in FY 2024-25 to assist with implementation activities.

HCPCFC ADMIN COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 78

SB 108 was amended, which extends flexibility to the counties regarding appropriate staffing necessary to implement and operationalize the HCPCFC program manual requirements and readiness activities for CCS Compliance Monitoring and Oversight Program.

Reason for Change:
There is no change for FY 2024-25 from the prior estimate. There is no change from FY 2024-25 to FY 2025-26 in the current estimate.

Methodology:
1. On July 1, 2024, HCPCFC administrative activities began.

2. The estimate costs are as follows:

Fiscal Years	TF	GF	FF
FY 2024-25	$23,757,000	$11,879,000	$11,878,000
FY 2025-26	$23,757,000	$11,879,000	$11,878,000

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

FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG

OTHER ADMIN. POLICY CHANGE NUMBER: 79
IMPLEMENTATION DATE: 7/2020
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2244

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$9,657,000	$8,064,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$9,657,000	$8,064,000

Purpose:
This policy change estimates the federal reimbursement process between the Department and the Department of Health Care Access and Information (HCAI) for the Health Care Payments Data Program (HPD).

Authority:
Health & Safety Code 127671-12674
Interagency Agreement (IA) # 20-10306 A1

Interdependent Policy Changes:
Not Applicable

Background:
The HPD creates a process to collect health care data in a standardized format in one statewide system and provides greater transparency regarding health care costs, quality, and equity. The system is managed by HCAI and includes data for all Medi-Cal members. The information can be used to inform policy decisions regarding the provision of quality health care, reduce disparities, and reduce health care costs while preserving consumer privacy.

This policy change provides the Department the appropriate mechanism to transfer the federal portion of the HPD system costs to HCAI. HCAI is providing the state share.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase due to a large invoice for services for prior year expenses being paid in July 2024. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due to the anticipation of receiving invoices timelier in FY 2025-26.

Methodology:
1. Costs are estimated at $9,657,000 for FY 2024-25 and $8,064,000 for FY 2025-26.

Fiscal Years	TF	GF	FF
FY 2024-25	**$9,657,000**	**$0**	**$9,657,000**
FY 2025-26	**$8,064,000**	**$0**	**$8,064,000**

FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG

OTHER ADMIN. POLICY CHANGE NUMBER: 79

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

DEPARTMENT OF AGING ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 80
IMPLEMENTATION DATE: 7/1984
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 253

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$8,124,000	$7,896,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$8,124,000	$7,896,000

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 eligible members in Community-Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP), and Medicaid Electronic Visit Verification (EVV).

Authority:
Interagency Agreements:
CBAS 03-76137
MSSP 01-15976
MSSP/CBAS 22-20173

Interdependent Policy Changes:
Not Applicable

Background:
CDA coordinates with the Department to obtain FFP for the administrative costs for services related to Medi-Cal members. CDA budgets the matching General Fund (GF). In addition, CDA is implementing the Medicaid EVV in conjunction with the Department and the Office of Systems Integration. The EVV project is anticipated to end on June 30, 2025. CDA will receive an enhanced matching rate for this project.

Reason for Change:
There is a decrease for FY 2024-25, from the prior estimate, due to updated actuals and revised CDA projections. There is a decrease from FY 2024-25 to FY 2025-26, in the current estimate, primarily due to the EVV costs shifting into the Electronic Visit Verification M&O Costs policy change.

DEPARTMENT OF AGING ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 80

Methodology:

1. Assume EVV costs shift into the Electronic Visit Verification M&O Costs policy change beginning in FY 2025-26.

2. The estimates below were provided by CDA on a cash basis.

Program Support	FY 2024-25		FY 2025-26	
CBAS Support	**CDA GF**	**FFP**	**CDA GF**	**FFP**
FY 2023-24	$615,000	$885,000	$0	$0
FY 2024-25	$3,206,000	$4,242,000	$641,000	$848,000
FY 2025-26	$0	$0	$3,206,000	$4,242,000
Total CBAS	$3,821,000	$5,127,000	$3,847,000	$5,090,000
MSSP Support				
FY 2023-24	$387,000	$442,000	$0	$0
FY 2024-25	$1,639,000	$2,338,000	$328,000	$468,000
FY 2025-26	$0	$0	$1,639,000	$2,338,000
Total MSSP	$2,026,000	$2,780,000	$1,967,000	$2,806,000
MSSP/CBAS EVV Support				
FY 2023-24	$15,000	$46,000	$0	$0
FY 2024-25	$33,000	$171,000	$0	$0
FY 2025-26	$0	$0	$0	$0
Total EVV Support	$48,000	$217,000	$0	$0
Grand Total	$5,895,000	**$8,124,000**	$5,814,000	**$7,896,000**

*Totals differ due to rounding.

Funding:

100% Title XIX (4260-101-0890)

FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 81
IMPLEMENTATION DATE: 7/2007
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1192

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$12,722,000	$7,442,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$12,722,000	$7,442,000

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 members.

Authority:
Interagency Agreement
IA 07-65693 A01
IA 10-87042 A02
IA 22-20588
IA 23-30396
IA 07-65642
IA 19-96544
IA 25-50008
AB 1559 (Chapter 565, Statutes of 2014)
SB 853 (Chapter 717, Statutes of 2010)

Interdependent Policy Changes:
Not Applicable

Background:
The Department has existing IAs with CDPH to allow for the provision of Title XIX federal funds as reimbursement to CDPH. The non-federal matching funds will be budgeted by CDPH. This policy change is for the following program support costs:

- Office of Acquired Immunodeficiency Syndrome (AIDS)
- Center for Health Care Quality (CHCQ)
- Skilled Nursing Facilities (SNF)

The Office of AIDS operates and administers the Human Immunodeficiency Virus (HIV)/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 CHCQ program has the responsibility for regulatory oversight of health facilities, certified nurse assistants, home health aides, certified hemodialysis technicians, and licensed nursing

FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS
OTHER ADMIN. POLICY CHANGE NUMBER: 81

home administrators. The CHCQ contract estimate includes reimbursements for the following programs:

- Healthcare Workforce Branch - Registry Unit,
- Nurse Aide Training and Competency Evaluation Program,
- Centralized Application Branch – Provider Certification Unit, and
- Intermediate Care Facility for the Developmentally Disabled Continuous Nursing Pilot Project Waiver.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase due to delays in CHCQ invoicing, a new CHCQ interagency agreement, and adjusted projections of anticipated payments. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due to projections of anticipated payments.

Methodology:
1. CDPH provides the General Fund match.

2. The following estimates have been provided on a cash basis by CDPH.

3. Cash basis expenditures vary from year to year based on when claims are actually paid.

4. Total costs are estimated to be:

FY 2024-25	TF	FF
FY 2022-23 Claims	$1,382,000	$1,382,000
FY 2023-24 Claims	$5,858,000	$5,858,000
FY 2024-25 Claims	$5,482,000	$5,482,000
Total	**$12,722,000**	**$12,722,000**

FY 2025-26	TF	FF
FY 2023-24 Claims	$7,376,000	$7,376,000
FY 2024-25 Claims	$66,000	$66,000
Total	**$7,442,000**	**$7,442,000**

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

CLPP CASE MANAGEMENT SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 82
IMPLEMENTATION DATE: 7/1997
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 239

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$4,936,000	$4,494,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$4,936,000	$4,494,000

Purpose:
This policy change estimates the federal match provided to the California Department of Public Health (CDPH) for administrative costs associated with Childhood Lead Poisoning Prevention (CLPP) Program case management services.

Authority:
Interagency Agreement 07-65689

Interdependent Policy Changes:
Not Applicable

Background:
The CLPP Program provides services to the community for the purpose of increasing awareness regarding the hazards of lead exposure, reducing lead exposure, and increasing the number of children assessed and appropriately blood tested for lead poisoning as defined by the Medi-Cal State Plan and CDPH. Specifically, the program services include the following:

- Offers home visitation, environmental home inspections, and nutritional assessments to families of children found to be severely lead-poisoned.
- Provides telephone contacts and educational materials to families of lead-poisoned and lead-exposed children.
- Provides information and education to the general public, medical providers, and community-based organizations.
- Provides targeted case management and environmental investigation services with associated administrative activities to lead-burdened children who are Medi-Cal members and meet the case definition of lead poisoning.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase due to updated actuals and adjusted projections. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due to the projection of anticipated payments.

Methodology:
1. Cash basis expenditures vary from year to year based on when claims are actually paid.

2. The estimates are provided by CDPH on a cash basis.

CLPP CASE MANAGEMENT SERVICES
OTHER ADMIN. POLICY CHANGE NUMBER: 82

3. The costs for FY 2024-25 are estimated to be $4,936,000 and FY 2025-26 $4,494,000.

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

CALIFORNIA SMOKERS' HELPLINE

OTHER ADMIN. POLICY CHANGE NUMBER: 83
IMPLEMENTATION DATE: 1/2014
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1680

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$2,954,000	$2,875,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$2,954,000	$2,875,000

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 members.

Authority:
Affordable Care Act Section 4107
Interagency Agreement (IA) 13-90417

Interdependent Policy Change:
Not Applicable

Background:
CDPH funds statewide smoker helpline services and counseling to Medi-Cal members through the University of California, San Diego. The Helpline services follow the Centers for Medicare and Medicaid Services guidelines and the Department policies for providing services to Medi-Cal members. CDPH ensures the Helpline services include specially trained counselors to provide free telephone-based counseling, education, and support to Medi-Cal members who currently smoke or have recently quit smoking.

The Department has an existing IA with CDPH to enable the State to receive 50% FFP for Helpline services administrative costs beginning July 1, 2013.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is an increase due to updated actuals from an increase in Medi-Cal clients served. The change from FY 2024-25 to FY 2025-26, in the current estimate, is a decrease due to projection of anticipated payments.

Methodology:
1. The Helpline services administrative costs are based on expenditure data for services provided to Medi-Cal members. CDPH submits invoices for 50% reimbursement of actual and allowable administrative costs.

2. The estimates are budgeted on a cash basis based on the anticipated payment timing of invoices.

CALIFORNIA SMOKERS' HELPLINE
OTHER ADMIN. POLICY CHANGE NUMBER: 83

3. The estimated administrative cost reimbursements, for FY 2024-25 and FY 2025-26, on a cash basis are:

FY 2024-25	TF	FF
FY 2023-24 Claims	$1,037,000	$1,037,000
FY 2024-25 Claims	$1,917,000	$1,917,000
Total	**$2,954,000**	**$2,954,000**

FY 2025-26	TF	FF
FY 2024-25 Claims	$958,000	$958,000
FY 2025-26 Claims	$1,917,000	$1,917,000
Total	**$2,875,000**	**$2,875,000**

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

HCBS SP CDDS - OTHER ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 84
IMPLEMENTATION DATE: 6/2022
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2349

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$245,000	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$245,000	$0

Purpose:
This policy change estimates the federal reimbursements as a one-time payment or ongoing payments for the California Department of Developmental Services (CDDS) home and community-based services (HCBS) spending plan other administrative items.

Authority:
American Rescue Plan (ARP) Act (2021)
Section 11.95, 2021 Budget Act

Interdependent Policy Changes:
Not Applicable

Background:
The American Rescue Plan Act of 2021 (ARP) provides additional Coronavirus Disease 2019 (COVID-19) relief to states. Section 9817 of the ARP provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for HCBS. Increased FMAP is available from April 1, 2021 through March 31, 2022. States must use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021, and states must use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. State funds equivalent to the amount of federal funds attributable to the increased FMAP are deposited in the Home and Community-Based Services American Rescue Plan Fund pursuant to Section 11.95 of the 2021 Budget Act. Section 11.95 appropriates this funding to eligible HCBS activities identified in the HCBS Spending Plan.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to an updated spending plan based on the progress of the actual spending and estimated timing of the payments which are affected by claiming lags.

The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to the sunset of the ARP funding in FY 2024-25.

HCBS SP CDDS - OTHER ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 84

Methodology:

1. The cash basis estimate for the HCBS spending plan administrative items for CDDS are:

(Dollars in Thousands)

FY 2024-25	TF	HCBS ARP Fund-CDDS	FF
Developmental Services Rate Model Implementation (Other Admin)	$54	$44	$10
Modernize Regional Center Information Technology Systems	$961	$726	$235
Total	$1,015	$770	**$245**

Funding:

100% Title XIX (4260-101-0890)

CALHHS AGENCY HIPAA FUNDING

OTHER ADMIN. POLICY CHANGE NUMBER: 85
IMPLEMENTATION DATE: 7/2001
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 257

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$1,376,000	$1,407,000
STATE FUNDS	$688,000	$703,500
FEDERAL FUNDS	$688,000	$703,500

Purpose:
This policy change estimates and reimburses the California Health and Human Services (CalHHS) Agency the total funds for qualifying Health Insurance Portability and Accountability Act (HIPAA) activities related to Medi-Cal.

Authority:
Interagency Agreement (IA) 23-30066

Interdependent Policy Changes:
Not Applicable

Background:
The Policy and Governance group has been established at the Center for Data Insights and Innovation (formerly Office of Health Information Integrity), within the CalHHS 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.

A three-year IA beginning July 1, 2023, has been executed and payments started in August 2023.

Reason for Change:
The change from the prior estimate, for FY 2024-25, is a slight decrease due to a lower than expected invoice for July 2024. The change from FY 2024-25 to FY 2025-26, in the current estimate, is due to increased contract costs from the associated IA with CalHHS.

Methodology:
The CalHHS Agency prioritizes HIPAA projects so that the most critical projects are implemented first.

Cash Basis	Total Funds	DHCS FF	DHCS GF
FY 2024-25	**$1,376,000**	**$688,000**	**$688,000**
FY 2025-26	**$1,407,000**	**$703,500**	**$703,500**

Funding:
50% HIPAA FF/ 50% HIPPA GF (4260-117-0890/0001)

MEDI-CAL INPATIENT SERVICES FOR INMATES

OTHER ADMIN. POLICY CHANGE NUMBER: 86
IMPLEMENTATION DATE: 3/2011
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 1665

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$1,212,000	$1,212,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,212,000	$1,212,000

Purpose:
This policy change estimates the federal match provided to the California Department of Corrections and Rehabilitation (CDCR)/California Correctional Health Care Services (CCHCS) for administrative costs related to the Inmate Eligibility Program.

Authority:
AB 1628 (Chapter 729, Statutes of 2010)
SB 1399 (Chapter 405, Statutes of 2010)
AB 396 (Chapter 394, Statutes of 2011)
AB 80 (Chapter 12, Statutes of 2020)
SB 184 (Chapter 47, Statutes of 2022)
Interagency Agreement #20-10027

Interdependent Policy Changes:
Not Applicable

Background:
AB 1628 (Chapter 729, Statutes of 2010) authorizes the Department and the CDCR/CCHCS to:

- Claim federal reimbursement for inpatient hospital services to Medi-Cal eligible adult inmates in State correctional facilities when these services are provided off the grounds of the facility. As part of these provisions, the CCHCS is claiming federal financial participation (FFP) for their administrative costs to operate the Inmate Eligibility Program. The federal funds provided to the CCHCS are included in the Medi-Cal inpatient hospital costs policy changes.

SB 1399 (Chapter 405, Statutes of 2010) authorizes the Board of Parole Hearings to:

- Grant medical parole to permanently medically incapacitated State inmates. State inmates granted medical parole are potentially eligible for Medi-Cal. When a State inmate is granted medical parole, the CCHCS submits a Medi-Cal application to the Department to determine eligibility. Previously these services were funded through the CDCR with 100% GF.

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

- Claim FFP for inpatient hospital services provided to Medi-Cal eligible juvenile inmates in State and county correctional facilities when these services are provided off the grounds of the facility. Previously, these services were paid 100 percent by the CDCR or

MEDI-CAL INPATIENT SERVICES FOR INMATES
OTHER ADMIN. POLICY CHANGE NUMBER: 86

the county. The County Administration Allocation Policy Change covers the county FFP associated with Medi-Cal eligibility determination activities for county inmates.

AB 80 (Chapter 12, Statutes of 2020) conforms the suspension of benefits for juveniles, as defined under state law, with the existing federal law, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act). The definition of juvenile has changed (both State and County) to include individuals under the age of 21 or individuals enrolled in the former foster youth group under the age of 26. “Eligible Juveniles,” as defined by the SUPPORT Act, only impacts Medi-Cal suspension of benefits policies and does not impact eligibility age restrictions or age requirements for general Medi-Cal programs.

SB 184 (Chapter 47, Statutes of 2022) requires County Welfare Departments to suspend Medi-Cal benefits for all inmates of a public institution for the duration of their incarceration. State law requires the suspension of Medi-Cal benefits for any individual, regardless of age, who is a Medi-Cal beneficiary at the time of their incarceration. This amendment allows counties to activate suspended Medi-Cal benefits upon release from the public institution without requiring a new application, as long as they remain otherwise eligible for Medi-Cal throughout their incarceration.

Reason for Change:
There is no change from the prior estimate for FY 2024-25. There is no change, from FY 2024-25 to FY 2025-26, in the current estimate.

Methodology:
1. Implementation of the Inmate Eligibility Program began April 1, 2011.

2. Administrative costs are in accordance with Interagency Agreement #20-10027.

3. Reimbursements for administrative costs began in March 2011.

4. The federal share of ongoing administrative costs is **$1,212,000** in **FY 2024-25** and **$1,212,000** in **FY 2025-26**.

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

VETERANS BENEFITS

OTHER ADMIN. POLICY CHANGE NUMBER: 87
IMPLEMENTATION DATE: 12/1988
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 232

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$1,100,000	$1,100,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,100,000	$1,100,000

Purpose:
This policy change estimates the Title XIX federal funding provided to the California Department of Veterans Affairs (CDVA) for distribution to County Veteran Service Officers (CVSO) for identifying veterans eligible for Veterans Affairs (VA) benefits.

Authority:
AB 1807 (Chapter 1424, Statutes of 1987)
California Military & Veterans Code 972.5
Interagency Agreement (IA) #20-10053 A1

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 members, thereby reducing costs to Medi-Cal. An IA exists with the CDVA. CVSOs help identify additional VA benefits and refer the veteran to utilize those services instead of Medi-Cal. This process avoids costs for the Medi-Cal program. The previous IA expired on June 30, 2020, and was renewed effective July 1, 2020, as an evergreen contract.

Reason for Change:
There is no change from the prior estimate for FY 2024-25. There is no change from FY 2024-25 to FY 2025-26 in the current estimate.

Methodology:
1. The contract amount is estimated to be $1,100,000 for FY 2024-25 and FY 2025-26. The non-federal match is budgeted by CDVA.

FY	FY 2024-25			FY 2025-26		
Cash Basis	**TF**	**CDVA GF**	**DHCS FF**	**TF**	**CDVA GF**	**DHCS FF**
Administrative	$724,000	$362,000	$362,000	$724,000	$362,000	$362,000
Workload Units	$1,476,000	$738,000	$738,000	$1,476,000	$738,000	$738,000
Total	$2,200,000	$1,100,000	**$1,100,000**	$2,200,000	$1,100,000	**$1,100,000**

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

VITAL RECORDS

OTHER ADMIN. POLICY CHANGE NUMBER: 88
IMPLEMENTATION DATE: 5/2016
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1774

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$883,000	$883,000
STATE FUNDS	$4,000	$4,000
FEDERAL FUNDS	$879,000	$879,000

Purpose:
This policy change estimates the expenditures related to improving delivery of Vital Records data and to provide certified copies of birth and death records, as needed, to the Department.

Authority:
Contract 15-92272
Contract 22-20189

Interdependent Policy Changes:
Not Applicable

Background:
California birth, death, fetal death, still birth, marriage, and divorce records are maintained by the CDPH Vital Records. Information collected in these records is necessary to support core functions of the Department as represented in the Medicaid Information Technology Architecture (MITA) business functions. The MITA, a Centers for Medicare and Medicaid Services (CMS) initiative, fosters an integrated business and information technology transformation across the Medicaid enterprise in an effort to improve the administration and operation of the Medicaid program.

Historically, the Department has received Vital Records data from CDPH in a case-by-case and manual manner. In order to improve efficiency and advance MITA maturity, the Department has received CMS approval for enhanced FFP to establish automated and timely processes to receive Vital Record data from CDPH. CMS approved the contract in June 2016.

Beginning July 2018, the Department entered into a contract with CDPH to provide certified copies of vital records as required for business needs.

Reason for Change:
There is no change from the previous estimate for FY 2024-25. There is no change from FY 2024-25 to FY 2025-26 in the current estimate.

Methodology:
1. On a cash basis, the estimated cost to deliver records data is $1,167,000 TF in FY 2024-25 and $1,167,000 TF in FY 2025-26. The Department receives 75% FFP for ongoing costs to obtain vital records data, with the 25% state share provided by the CDPH Health Statistics Special Fund (HSSF).

VITAL RECORDS
OTHER ADMIN. POLICY CHANGE NUMBER: 88

2. On a cash basis, the annual contract to provide certified copies is $8,000 TF ($4,000 GF).

3. On a cash basis, for both contracts, assume three quarters will be paid in the current fiscal year and the remaining quarter will be paid in the subsequent fiscal year. The estimated reimbursements for FY 2024-25 and FY 2025-26 on a cash basis are:

FY 2024-25	TF	HSSF	GF	FF
FY 2023-24 Records Data	$292,000	$73,000	$0	$219,000
FY 2023-24 Certified Copies	$2,000	$0	$1,000	$1,000
FY 2024-25 Records Data	$875,000	$219,000	$0	$656,000
FY 2024-25 Certified Copies	$6,000	$0	$3,000	$3,000
Total	**$1,175,000**	**$292,000**	**$4,000**	**$879,000**

FY 2025-26	TF	HSSF	GF	FF
FY 2024-25 Records Data	$292,000	$73,000	$0	$219,000
FY 2024-25 Certified Copies	$2,000	$0	$1,000	$1,000
FY 2025-26 Records Data	$875,000	$219,000	$0	$656,000
FY 2025-26 Certified Copies	$6,000	$0	$3,000	$3,000
Total	**$1,175,000**	**$292,000**	**$4,000**	**$879,000**

*Totals may differ due to rounding.

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

KIT FOR NEW PARENTS

OTHER ADMIN. POLICY CHANGE NUMBER: 89
IMPLEMENTATION DATE: 7/2001
ANALYST: Whitney Li
FISCAL REFERENCE NUMBER: 249

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$583,000	$583,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$583,000	$583,000

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) #23-30146

Interdependent Policy Changes:
Not Applicable

Background:
The Department entered into an IA with the CCFC to allow the Department to claim Title XIX federal funds (FF) for the "Kit for New Parents" distributed to parents of Medi-Cal eligible newborns by the CCFC (Proposition 10).

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to a decrease in the FY 2024-25 amount assumed to be paid in the same year.

There is no change from FY 2024-25 to FY 2025-26, in the current estimate.

Methodology:
1. The annual number of kits estimated at full ramp up is 175,000.

2. An estimated 171,822 kits are estimated to be distributed in FY 2024-25 and FY 2025-26. Of these kits, 43.38% are expected to be distributed to Medi-Cal eligible newborns.

3. Each kit, basic or custom, costs $15.63.

4. In prior years, CCFC invoiced DHCS on a yearly basis. In FY 2022-23, CCFC started invoicing on a quarterly basis.

5. On a cash basis for FY 2024-25, assume the Department will be paying approximately 25.5% of FY 2023-24 invoices and 74.5% of FY 2024-25 invoices. On a cash basis for FY 2025-26, assume the Department will be paying 25.5% of FY 2024-25 invoices and 74.5% of FY 2025-26 invoices.

KIT FOR NEW PARENTS
OTHER ADMIN. POLICY CHANGE NUMBER: 89

6. The Department will pay for the estimated cost of kits distributed to parents of Medi-Cal eligible newborns, shown in the table below.

	Annual Number of Kits	Medi-Cal	Total Medi-Cal Kits	Cost per kit	Total Cost (Accrual)
FY 2023-24	171,822	43.38%	74,536	$15.63	$1,165,004
FY 2024-25	171,822	43.38%	74,536	$15.63	$1,165,004
FY 2025-26	171,822	43.48%	74,536	$15.63	$1,165,004

7. Assume the Department will pay $583,000 TF in FY 2024-25 and $583,000 TF in FY 2025-26 for kits to new parents of Medi-Cal eligible newborns.

FY 2024-25	TF	FF
FY 2023-24	$297,000	$297,000
FY 2024-25	$868,000	$868,000
Total	$1,165,000	$1,165,000
Total (50%)	**$583,000**	**$583,000**

FY 2025-26	TF	FF
FY 2024-25	$297,000	$297,000
FY 2025-26	$868,000	$868,000
Total	$1,165,000	$1,165,000
Total (50%)	**$583,000**	**$583,000**

Fiscal Year	TF	FF
FY 2024-25	**$583,000**	**$583,000**
FY 2025-26	**$583,000**	**$583,000**

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

MERIT SYSTEM SERVICES FOR COUNTIES

OTHER ADMIN. POLICY CHANGE NUMBER: 90
IMPLEMENTATION DATE: 7/2003
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 263

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$190,000	$190,000
STATE FUNDS	$95,000	$95,000
FEDERAL FUNDS	$95,000	$95,000

Purpose:
This policy change estimates the cost for the interagency agreement (IA) with the California Department of Human Resources (CalHR).

Authority:
IA #12-89476

Interdependent Policy Changes:
Not Applicable

Background:
Federal regulations require that any government agency receiving federal funds have a civil service exam, classification, and pay process. Many counties do not have a civil service system that meets current state regulations. The Merit System Services Program was established under the State Personnel Board and is now administered by CalHR to administer personnel services for the counties that do not have a civil service system. In addition, CalHR reviews the merit systems in the remaining counties to ensure that they meet federal civil service requirements.

The Department reimburses CalHR via an IA for Merit System Services. The agreement continues indefinitely, until terminated, or until there is a change in scope of work affecting the cost.

Reason for Change:
There is no change from the prior estimate for FY 2024-25. There is no change from FY 2024-25 to FY 2025-26 in the current estimate.

Methodology:
1. CalHR provided the estimates on a cash basis.

2. The estimated reimbursement is $190,000 TF ($95,000 GF) in FY 2024-25 and $190,000 TF ($95,000 GF) in FY 2025-26.

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

PIA EYEWEAR COURIER SERVICE

OTHER ADMIN. POLICY CHANGE NUMBER: 91
IMPLEMENTATION DATE: 7/2003
ANALYST: Whitney Li
FISCAL REFERENCE NUMBER: 1114

	FY 2024-25	FY 2025-26
TOTAL FUNDS	$944,000	$944,000
STATE FUNDS	$472,000	$472,000
FEDERAL FUNDS	$472,000	$472,000

Purpose:
This policy change estimates courier services costs for Prison Industry Authority (PIA) eyewear.

Authority:
Interagency Agreement (IA) #23-30067

Interdependent Policy Changes:
Not Applicable

Background:
The California PIA fabricates eyeglasses for Medi-Cal members. 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 members have continued access with no disruption to optical services. SB 78 (Chapter 38, Statutes of 2019) restored optician and optical lab services, including providing eyeglasses, to eligible individuals 21 years of age and older beginning January 1, 2020.

Reason for Change:
The change in FY 2024-25, from the prior estimate, is due to fewer packages anticipated after review of past records and trends.

There are no changes from FY 2024-25 to FY 2025-26, in the current estimate, due to an anticipated stable utilization trend for lens orders.

Methodology:
1. PIA contracts with a courier service company for the pick-up and delivery of orders to optical providers. The Department is responsible for one-half of the delivery cost per package, with no fuel surcharge. There is a one-quarter lag between services provided and payment of the invoice. Four quarterly invoices are estimated to be paid in each fiscal year.

2. The PIA courier contract delivery cost of $2.95 per package is effective from September 1, 2022 to June 30, 2026.

PIA EYEWEAR COURIER SERVICE
OTHER ADMIN. POLICY CHANGE NUMBER: 91

3. The cost for the estimated packages in FY 2024-25 and FY 2025-26 are assumed below:

Fiscal Year	Total Packages	Cost per Package	TF	GF	FF
FY 2024-25	320,000	$2.95	**$944,000**	**$472,000**	**$472,000**
FY 2025-26	320,000	$2.95	**$944,000**	**$472,000**	**$472,000**

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

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ADDITIONAL INFORMATION

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

MEDI-CAL INFORMATION ONLY
November 2024
FISCAL YEARS 2024-25 & 2025-26

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
- Portable X-Ray
- Prosthetists
- Genetic Disease Testing
- Medicare Crossover Provider Only
- Certified Hospice Service
- Local Education Agency
- EPSDT Supplemental Services Provider
- HCBS Congregate Living Health Facility
- HCBS Personal Care Agency
- RVN Individual Nurse Provider
- HCBS Professional Corporation
- AIDS Waiver Provider
- Multipurpose Senior Services Program
- CCS/GHPP Non-Institutional
- Independent Diagnostic Center (Medicare Crossover Provider Only)
- ALWPP Residential Care Facility for the Elderly
- ALWPP Care Coordinator
- HCBS Private Non-Profit Proprietary Agency
- Clinical Nurse Specialist (Medicare Crossover Provider Only)

Home Health

- Home Health Agency (except Home & Community Based Services)

Effective January 1, 2014, the Affordable Care Act (ACA) established 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 simplified the enrollment process and eliminated the asset test for MAGI eligible. Existing income eligibility rules for aged, blind, and disabled persons did not change.

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

AFFORDABLE CARE ACT

The ACA also imposed a tax upon those without health coverage, which will likely encourage many individuals who are currently eligible, but not enrolled in Medi-Cal to enroll in the program. Since January 2014, the Department has experienced significant growth in Medi-Cal enrollment as result of the ACA. The tax upon those without health coverage ceased to be effective, January 1, 2019. Effective January 1, 2020, California established an equivalent penalty on individuals without health coverage.

For those newly eligible adults in the expansion group, the ACA provides California with enhanced Federal Financial Participation (FFP) at the following rates:

- 100% FFP from calendar years 2014 to 2016,
- 95% FFP in 2017,
- 94% FFP in 2018,
- 93% FFP in 2019,
- 90% FFP in 2020 and beyond.

For those who are currently eligible, but not enrolled in Medi-Cal, enhanced FFP will not be available.

Beginning in October 2015, the ACA increased the Children's Health Insurance Program (CHIP) Federal Medical Assistance Percentage provided to California by 23 percent, to 88 percent FFP, up from 65 percent. This increase has now phased out and the state once again receives 65 percent FFP for CHIP, effective October 2020.

In response to the federal ACA mandate and State legislative direction, the Department chose the Health and Human Services Secretary-approved plan option, which allows the Department to seek approval for the same full scope Medi-Cal benefits received by existing ~~beneficiaries~~ **members**. 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~~ **members**.

HOME AND COMMUNITY BASED SERVICES

Long-Term Care Alternatives

Medi-Cal includes various Long-Term Services and Supports (LTSS) that allow medically needy, frail older adults, and persons with disabilities to avoid unnecessary institutionalization. The Department administers these alternatives either as State Plan benefits or through various types of waivers.

State Plan Benefits

In-Home Supportive Services (IHSS)

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

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

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

The four IHSS programs are:

1. Personal Care Services Program (PCSP)
   This program provides personal care services including but not limited to non-medical personal services, paramedical services, domestic services, and protective supervision.
2. IHSS Plus Option (IPO)
   This program provides personal care services but also allows the recipient of services to select a family member as a provider.
3. Community First Choice Option (CFCO)
   This program provides personal care services to those who would otherwise be institutionalized in a nursing facility.
4. Residual (~~beneficiaries~~ **members** are not full-scope Medi-Cal; State-only program with no FFP)

Senate Bill 616 was enacted on October 4, 2023 and provided additional sick leave benefits to all employees working within the state of California, including IHSS workers. Beginning ~~January~~ **July** of 2024, IHSS workers were granted up to five days per year of sick leave usage. Prior to SB 616, IHSS workers were only granted up to three days per year of sick leave usage.

HOME AND COMMUNITY BASED SERVICES

Targeted Case Management (TCM)

The TCM Program provides specialized case management services to Medi-Cal ~~eligible individuals~~ **members** who are developmentally disabled. These ~~clients~~ **members** 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~~ **Home** and ~~community-based services~~ **Community-Based Services** (HCBS) to persons with developmental disabilities (DD) who are Regional Center consumers but do not meet nursing facility level of care criteria required for enrollment in the HCBS Waiver of Persons with DD. As of February 1, 2016, Behavioral Health Treatment (BHT) services for 1915(i) participants under the age of 21 is a state plan benefit and paid through the managed care delivery system or fee-for-service for members not eligible to enroll into managed care. The 1915(i) State Plan Amendment (SPA) was approved from October 1, 2011**,** through September 30, 2016. The Department submitted a SPA to renew the 1915(i) Waiver, effective October 1, 2016, through September 30, 2021. CMS approved the 1915(i) State Plan for a new 5-year term, effective October 1, 2021, through September 30, 2026.

The DD rate increase, as outlined in ABX2-1 (Chapter 3, Statutes of 2016). The Department and the California Department of Developmental Services (CDDS) submitted a SPA reflecting the rate changes. CMS approved the SPA on September 29, 2016 with a July 1, 2016 effective date. Rate increases include several different increase models including a 5% rate increase on services and survey based increases on wages.

The Department submitted a SPA to update the service specifications for respite care as required by CMS' companion letter to:

- Remove group-supported employment and specialized therapeutic services,
- Add housing access, family support, occupational therapy, physical therapy, and family/consumer training services, and
- Add Enhanced Behavioral Supports Home (EBSH) as a new setting for habilitation-community living arrangement services.

This amendment also established reimbursement methodologies for EBSH and incentive payments for individual supported employment providers, effective July 1, 2018.

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The Department submitted a SPA to add the following:

- Community Crisis as a provider type under Behavioral Intervention Services,
- Categorically and medically needy limits, and
- The associated rate methodology.

The approved effective date was October 2, 2018.

The Department submitted a SPA to make changes to the reimbursement methodology to implement a one-year rate increase for certain services in high cost counties. CMS approved the SPA, effective May 1, 2019.

The Department submitted a Disaster Relief (DR) SPA renewal for the 1915(i) Home and Community-Based Service State Plan Benefit. CMS approved the State Plan for a five-year term effective October 1, 2021, through September 30, 2026.

The Department submitted a SPA to add state-operated mobile crisis teams as a provider type under Behavioral Intervention Services and rate methodologies for state-operated services for the developmentally disabled. CMS approved DR SPA 21-0049 on December 15, 2021.

The Department submitted a consolidated DR SPA, which included reimbursement rates for specified providers from January 1, 2020, to December 31, 2021, as authorized under W&I Code section 4691.12, effective March 1, 2020. Additionally, the DR SPA added Intensive Transition Services and Speech-Language Pathology Assistants as a new provider type, effective July 1, 2020, as well as increased payment rates through the end of the Public Health Emergency, effective January 16, 2021. CMS approved the consolidated DR SPA 21-0050 on December 22, 2021.

The Department submitted DR SPA 21-0031 to implement a rate increase for minimum wage. CMS approved the SPA, effective January 1, 2022.

The Department submitted a SPA 21-0040 to begin implementation of the rate models as described in the 2019 Rate Study. CMS approved the SPA, effective April 1, 2022.

The Department submitted a DR SPA 22-0037 for a temporary modification of the service scope for selected services in response to the public health emergency. This DR SPA requests a retro-effective date of September 1, 2020. CMS approved the SPA on July 22, 2022, effective March 1, 2020.

The Department submitted a DR SPA 22-0038 to add Self-Directed Services and Technology Services, as well as the increase to incentive payments for Prevocational and Supported Employment Services. This SPA was approved on September 28, 2022, effective July 1, 2021.

The Department submitted SPA 22-0058 for a rate increase per the California Budget Act of 2022. CMS approved the SPA on December 7, 2022, effective January 1, 2023.

The Department submitted a DR SPA 22-0050 to expand participation direction for habilitation services. CMS approved the SPA on December 16, 2022, effective March 1, 2020.

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The Department submitted SPA 22-0048 proposing to make various flexibilities under the public health emergency permanent, as well as additional services and a new provider type. CMS approved the SPA on April 14, 2023, effective April 14, 2023.

The Department submitted SPA 23-0024 to add Coordinated Family Supports service that provides coordination of services and supports that allow adults to continue living in their family home. CMS approved the SPA on November 1, 2023, effective November 1, 2023.

The Department submitted SPA 23-0036 to authorize reimbursement rate increases for Independent Living services, Habilitation/Community Living Arrangement services, Participant-directed Day services and Supported Employment services, and Day Services paid rates pursuant to a cost study. CMS approved the SPA on December 29, 2023, for dates of service on or after January 1, 2024.

On January 9, 2024, the Department submitted SPA 24-0001 to CMS requesting to modify the definition of target population to include children under five, add participant-directed services as a new service, add budget authority for participant direction of services, and add additional incentive payments for assisting individuals to obtain competitive integrated employment. The Department has requested an effective date of January 10, 2024, for SPA 24-0001.

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: Medi-Cal Waiver Program (MCWP), formerly known as the Acquired ~~Immune Deficiency~~ **Immunodeficiency** Syndrome (AIDS) Waiver; Assisted Living Waiver (ALW); Home and Community Based Alternatives (HCBA) Waiver; Multipurpose Senior Services Program (MSSP); HCBS Waiver for Persons with DD; and Self-Determination Program (SDP) Waiver for Persons with DD. A ~~beneficiary~~ **member** may be enrolled in only one HCBS waiver at a time. If a ~~beneficiary~~ **member** is eligible for services from more than one waiver, the ~~beneficiary~~ **member** may choose the waiver that is best suited to ~~his or her~~ **their** needs.

Assisted Living Waiver (ALW)

The ALW pays for assisted services and supports, care coordination, and community transition in 15 counties (Sacramento, San Joaquin, Los Angeles, Riverside, Sonoma, Fresno, San Bernardino, Alameda, Contra Costa, San Diego, Kern, San Mateo, San Francisco, Santa Clara and Orange). Waiver participants can elect to receive services in a Residential Care Facility for the Elderly (RCFE), an Adult Residential Facility (ARF) or through a home health agency while residing in publicly subsidized housing. CMS approved a renewal of the ALW on February 28, 2019**,** effective from March 1, 2019 to February 28, 2024.

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Through California's ~~Home and Community-Based Services (~~HCBS~~)~~ Spending Plan, CMS approved the Department's proposal to add 7,000 slots to the ALW in the effort to eliminate the current ALW waitlist. The addition of these slots is enabling the Department to provide sufficient capacity to enroll all waitlisted ~~beneficiaries~~ **members** and to clear pending enrollments, while still providing a cushion for continued growth.

On October 27, 2021, the Department submitted an ALW technical amendment to increase the maximum number of waiver slots to CMS for approval with a retroactive implementation date of July 1, 2021. On January 7, 2022, CMS approved the amendment with a retroactive implementation date of July 1, 2021. CMS informed the Department that agencies could immediately start enrolling ~~clients~~ **members** on the waitlist. As of December 2023, approximately 5,100 slots have been released for transitioning ~~individuals~~ **members** for placement into the ALW.

On ~~November 22, 2023, the Department submitted its waiver renewal application to CMS requesting a~~ **February 16, 2024, CMS approved a** new five-year waiver term for the ALW effective ~~February 29~~ **March 1**, 2024. ~~The Department also submitted an additional~~ **CMS also approved an** ALW technical amendment to increase the maximum number of waiver slots for waiver year (WY) 5 of the ~~current~~ **2019-2024** waiver term ~~to CMS for approval on December 29, 2023~~ **on January 22, 2024**. This amendment ~~will increase~~ **increases** the number of waiver slots for waiver year 5 by 1,800 and ~~will have~~ **had** a retroactive effective date of January 1, 2024. ~~The Department is requesting an increase in the number of allocated slots each WY, as follows~~ **Due to the growth of the program and continued high demand, the Department submitted a slot increase amendment to CMS for approval. On May 20, 2024, CMS approved the amendment to increase the allocated slot by about 1,800 for Waiver Years 2-5 of the current waiver term. The approved number of waiver slots are as follows**:

- WY 1 (2024) 14,544
- WY 2 (2025) 16,344
- WY 3 (2026) 18,144
- WY 4 (2027) 19,944
- WY 5 (2028) 21,744

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~~ **members**. 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 an 1115 waiver called the California Medi-Cal 2020 Demonstration, which was approved on

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December 30, 2015, for five years. CBAS continued to be a waiver benefit under this new waiver until December 31, 2020. There is no cap on enrollment into this service. The Department received CMS approval of its proposal to apply a one-year extension of this waiver to December 31, 2021 due to the COVID-19 public health emergency. On December 29, 2021, the Department received approval of the new CalAIM Section 1115 demonstration waiver **for a five-year renewal, with an amendment**. This new waiver period is ~~January 1, 2022~~ **December 31, 2021**, through December 31, 2026 and maintains the CBAS benefit.

Due to the COVID-19 pandemic, CBAS centers were not able to provide services in a congregate setting beginning the second half of March 2020. In response, the Department and the California Department of Aging (CDA) developed a new CBAS service delivery model, known as Temporary Alternative Services (TAS). Under this model, CBAS centers provided limited individual in-center activities, as well as telephonic, telehealth and in-home services to CBAS ~~participants~~ **members**. This temporary model was effective through September 30, 2022, at which point CBAS returned to full congregate in-person service delivery.

The renewed 1115 Waiver includes an ongoing remote services option for CBAS. Under certain unique circumstances, CBAS Emergency Remote Services (ERS) may be provided in response to the individual's person-centered needs. This is for CBAS members who have unique circumstances and are time limited to facilitate availability for services when ~~beneficiaries~~ **members** are not able to access in person services. CBAS ERS became available on October 1, 2022.

Pursuant to the Budget Act of 2019, the Department implemented the structure of provider supplemental payments for qualified CBAS services funding the state share with revenues from the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56). The supplemental payments structure was subject to suspension on June 30, 2021. The Budget Act of 2021 removed this suspension. The 2022 Governor's Budget shifted the state funding source of these supplemental payments to the General Fund.

Home and Community-Based Alternatives (HCBA) Waiver

The HCBA Waiver provides Medi-Cal members with long-term medical conditions, who meet the adult or pediatric acute hospital, subacute, or nursing facility (NF) Level of Care (LOC), with the option of returning to and/or remaining in their home or home-like setting in the community in lieu of institutionalization. The Department contracts with Waiver Agencies for the purpose of performing waiver administration functions and providing the Comprehensive Care Management waiver service. The Waiver Agencies are responsible for functions**,** including: ~~participant~~ **member** enrollment, LOC evaluations, person-centered care/service plan review and approval, waiver service authorization, utilization management, provider enrollment/network development, quality assurance activities and reporting to the Department.

The Department maintains an active role in the waiver administration by determining all waiver participant eligibility, setting enrollment goals, and providing continuous, ongoing monitoring and oversight. On September 29, 2021, the Department submitted a waiver renewal application for the HCBA Waiver for a new five-year term, January 1, 2023, through December 31, 2027. The waiver was set to expire on December 31, 2021; however, the Department received a fifth 90-

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day temporary extension, to March 26, 2023. CMS issued a formal approval for the new waiver on February 2, 2023, and the new HCBS Waiver term became effective on January 1, 2023. The Department's new HCBA waiver was not scheduled to add slots until January 1, 2025, based on past projected enrollment and attrition trends. However, as a result of increased enrollments, it was determined that the waiver would reach capacity before the end of 2023. To address this, the Department submitted a waiver amendment to CMS to add 1,800 additional slots to each of the four remaining waiver years, beginning with waiver year two, effective January 1, 2024. CMS approved the waiver amendment on December 11, 2023.

The following changes included in the waiver renewal application will have an impact on the Medi-Cal budget: the addition of new waiver services, a rate increase for Personal Care Agencies in response to the statewide minimum wage increase, and additional waiver slots beginning on January 1, 2024, based on projected enrollment and attrition trends.

Medi-Cal Waiver Program (MCWP) ~~(Previously known as the Acquired Immune Deficiency Syndrome (AIDS) Medi-Cal Waiver)~~

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

The Department, on behalf of CDPH, submitted a waiver renewal application for the MCWP for a new five-year term, effective January 1, 2022, through December 31, 2026. In December 2022, the Department received its fifth 90-day temporary extension of the waiver that was set to expire**,** December 31, 2021. This temporary extension expired **on** March 26, 2023. Due to the delay in the review/approval process, CMS and the Department agreed to a new five-year term.

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Rather than retroactively authorizing the MCWP to a January 1, 2022, start date, CMS agreed to set the effective date to January 1, 2023, extending the waiver term to December 31, 2027.

Multipurpose Senior Services Program (MSSP) Waiver

The California Department of Aging (CDA) 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~~ **Members** 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 ~~center~~ **centers**, household and personal care assistance, protective supervision, care management, respite, transportation, meal services, social services, minor home repair/maintenance~~,~~ and communication services. The program provides services under a federal 1915(c) home and community-based services waiver. The Department submitted a waiver renewal application on March 28, 2019. The MSSP Waiver ended on June 30, 2019, and CMS approved a 90-day temporary extension ~~in order~~ to resolve CMS questions related to the renewal application. The Department responded to all requests for additional information, and CMS approved and renewed the MSSP Waiver on November 1, 2019~~,~~ for an additional five-year term, effective July 1, 2019 through ~~June 30~~ **September 28**, 2024. CDA is in **the** process of finalizing ~~a~~ **an MSSP** waiver renewal ~~application to renew the MSSP Waiver for a new five-year waiver term~~ effective ~~July 1~~ **September 29**, 2024. ~~DHCS will submit the waiver renewal application to CMS on behalf of CDA in March 2024.~~

The MSSP benefit was scheduled to be carved out from the Coordinated Care Initiative (CCI), subject to CMS approval, effective January 1, 2021. This proposed carveout was delayed to January 1, 2022, due to the postponement of the California Advancing and Innovating Medi-Cal (CalAIM) initiative and the COVID-19 public health emergency. With the delay of CalAIM, the Department submitted a 12-month extension request to CMS for the Medi-Cal 2020 waiver, extending its term through December 31, 2021.

The Department carved out the MSSP benefit through the MSSP waiver within CCI counties, effective January 1, 2022. MSSP operates as a waiver benefit in all CCI demonstration counties (except San Mateo County), as it did prior to the implementation of CCI in 2014.

In 2019, AB 74 (Chapter 23, Statutes of 2019) was approved, which provides a one-time-only supplemental funding for expenditure over a three-year period. The supplemental funding will fund waiver care management and care management support payments. The Budget Act of 2021 extended this supplemental funding and increased the number of program slots, effective January 1, 2022.

CMS approved the waiver amendment on May 16, 2023, effective July 1, 2023, to transition ~~of~~ MSSP billing codes to be converted to the National HCPCS codes. The Department is submitting a subsequent amendment to CMS to change the effective date for the code

conversion to January 1, 2024, to allow for sufficient time for MSSP sites to implement the code conversion.

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

The HCBS-DD Waiver provides home and community-based services to persons with developmental disabilities who are Regional Center consumers as an alternative to care provided in a facility that meets the Federal requirement of an intermediate care facility for the developmentally disabled; in California, Intermediate Care Facility/Developmentally Disabled-type facilities, or a State Developmental Center. As of February 1, 2016, BHT services for Waiver participants under the age of 21 is a state plan benefit paid through fee-for-service or the managed care delivery system.

The Department submitted a renewal application to CMS on December 22, 2016**,** and received approval on December 7, 2017. ~~Approved~~ **The approved** capacity of unduplicated recipients for this waiver is 130,000 in 2018, 135,000 in 2019, 140,000 in 2020, 145,000 in 2021, 150,000 in 2022, ~~and~~ 155,000 in 2023**, and up to 179,000 individuals by December 31, 2027**. The waiver is approved from January 1, 2023, through December 31, 2027.

The Department submitted a Waiver Amendment to reflect a rate increase to Home Health Aide and Skilled Nursing Services to align them with increases to Medi-Cal, as authorized by the 2018 Budget Act. The appropriation in the 2018 Budget Act will be applied to increase the payment rates for certified Home Health Aides, Licensed Vocational Nurses, and Registered Nurses. This does not result in a change to the rate methodology. The Amendment was approved with an effective date of July 1, 2018.

The Department submitted a Waiver Amendment to provide time limited rate increases in specific geographic areas for providers of Community-Based Day Services, In-Home Respite Agencies, and providers of Community Living Arrangement Services under the Alternative Residential Model. This amendment also includes Community Crisis Homes as a new provider type under Behavioral Intervention Services, adds Community-Based Adult Services as a new waiver service, and adds Adult Day Health Care Center as a provider type under Community-Based Adult Services. The approved effective date was May 1, 2019.

The Department submitted an additional Waiver Amendment as a result of SB 81 (Chapter 28, Statutes of 2019), which provided CDDS with time-limited funding to provide supplemental rate increases for specified services, effective January 1, 2020 through December 31, 2021. The amendment was approved with an effective date of January 1, 2020.

The Department submitted a Waiver Amendment to add **the** State-Operated Mobile Crisis Team as a provider type under Behavioral Intervention Services. The amendment also adds rate methodologies for specified provider types under Behavior Intervention Services and Community Living Arrangement Services. The amendment was approved with an effective date of April 1, 2020.

The Department submitted a Waiver Amendment to **a** add Speech-Language Pathologist Assistant as a provider type for Speech, Hearing, and Language services. The amendment also

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adds services to transition ~~consumers~~ **members** placed at Institutions for Mental Diseases into alternative community settings. The amendment was approved with an effective date of January 19, 2021.

The Department submitted a Waiver Amendment for a time-limited rate increase for Independent Living Program (ILP) providers, pursuant to AB 79, with an effective term of January 1, 2021 through December 31, 2021. The amendment was approved with an effective date of January 1, 2021.

The Department submitted a Waiver Amendment to implement a rate model as described in the 2019 DDS Rate Study. The Waiver Amendment was approved by CMS with an effective date of April 1, 2022.

The Department submitted an Appendix K to implement a rate increase for minimum wage that was approved by CMS with an effective date of January 1, 2022.

The Department submitted an Appendix K to increase incentive payments to be paid to service providers of Supported Employment (Individual) and Prevocational Services. CMS approved the Appendix K on August 11, 2022, effective July 1, 2021.

The Department submitted the HCBS-DD waiver renewal to CMS on September 30, 2022. CMS approved the waiver renewal for a new five-year term effective January 1, 2023, through December 31, 2027. The waiver renewal contains changes to include previously approved Appendix K flexibilities made permanent, provides rate increases for the second stage of the 2019 Rate Study, and adds Group Homes for Children with Special Health Care Needs as a provider type under Community Living Arrangement Services.

The Department submitted an Appendix K making retainer payments available from August 19 through September 18, 2023, due to Hurricane Hilary. CMS approved the Appendix K on September 6, 2023.

The Department submitted a Waiver Amendment to add Coordinated Family Supports as a waiver service. The Waiver Amendment was approved by CMS with an effective date of December 1, 2023.

The Department submitted a Waiver Amendment to modify the definition of target population to include children under 5 years of age, increase rates for independent living programs, adult residential homes and participant directed Day Service and Supported Employment, add participant-directed services as a new service, add budget authority for participant direction of services, add additional incentive payments for assisting individuals to obtain competitive integrated employment, and add supplemental payments for: completion of surveys for eligible providers of community living arrangement services and direct service providers as workforce capacity initiatives, certifications gained in trained employment services, and for direct service professionals who use a language or medium of communication other than English more than 50% of their time. The Waiver Amendment was approved by CMS, effective January 10, 2024.

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The Department submitted an Appendix K making retainer payments from February 3, 2024, through March 3, 2024; for the following services in this waiver: community living arrangement services, behavioral intervention services, and day services; due to waiver participants impacted by the storms in Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Luis Obispo, Santa Barbara, and Ventura counties. CMS approved the Appendix K on March 28, 2024.

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

The SDP waiver provides home and community-based services to persons with developmental disabilities that are able to self-direct and are Regional Center consumers. The SDP waiver is an alternative to care provided in a facility that meets the federal requirement of an Intermediate Care Facility/Developmentally Disabled-type facility, or a State Developmental Center. The estimated capacity of unduplicated recipients for the SDP is 1,000 for waiver year 1, and 2,500 for waiver years 2 and 3. The SDP will transition DD waiver participants, who can self-direct their care, at no additional cost to the General Fund. CMS approved this waiver on June 6, 2018, with an effective date of July 1, 2018. This waiver is for a three-year period, ending June 30, 2021. The State renewed the waiver for a five-year period with an effective date of July 1, 2021, ending on June 30, 2026.

As of February 1, 2016, BHT services for Waiver participants under the age of 21 is a state plan benefit and paid through fee-for-service, or the managed care delivery system.
The California Department of Developmental Disabilities engaged in a stakeholder process to obtain stakeholder input regarding recommended changes to include in the waiver renewal application that was submitted to CMS in March 2021. CMS approved the waiver renewal for a new five-year term, effective July 1, 2021, through June 30, 2026.

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~~ **members** 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 dually eligible Medicare/Medi-Cal beneficiaries residing in Los Angeles, Riverside, San Bernardino, and San Diego counties. SCAN provides all services in the Medi-Cal State Plan, including home and community-based services to SCAN members who are

assessed at the Nursing Facility Level of Care and nursing home custodial care. The eligibility criteria for SCAN specifies that a member be at least 65 years of age, have Medicare A and B, have full scope Medi-Cal with no share of cost and live in SCAN's approved service. SCAN does not enroll individuals with End Stage Renal Disease.

Special Grant

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

In January 2007, CMS awarded the Department a grant for the Money Follows the Person Rebalancing Demonstration Grant, called California Community Transitions. This grant is authorized under section 6071 of the federal Deficit Reduction Act of 2005 and was extended by the Patient Protection and Affordable Care Act of 2010.

On April 18, 2018, the federal Medicaid Services Investment and Accountability Act of 2019 was signed into law and appropriated additional federal funding for CMS to allocate state grantees for FY 2019-20.

On January 24, 2019, the Medicaid Extenders Act of 2019 was signed and authorized MFP state grantees to continue to transition eligible ~~beneficiaries~~ **members** through December 31, 2019, using available MFP funding. The Extenders Act provided CMS with the authority to allocate new funding to state grantees for calendar year 2019, to allow funding appropriated through the Extenders Act to be spent through 2023.

On August 6, 2019, the Sustaining Excellence in Medicaid Act of 2019 was signed and appropriated additional federal funds for allocation to MFP state grantees.

On December 20, 2019, the Further Consolidated Appropriations Act, 2020 amended the DRA of 2005 to extend the term of the MFP grant by five months, from January 1, 2020, to May 22, 2020.

On March 18, 2020, the Families First Coronavirus Response Act (FFCRA) was enacted. Section 6008 of the FFCRA provides a temporary 3.1% Federal Medical Assistance Percentage (FMAP) increase to MFP services under Section 1905(b) of the Social Security Act. The increase is being applied retroactively beginning January 1, 2020**,** and extends through the last day of the calendar quarter in which the COVID-19 public health emergency period, including any extensions, terminates.

On March 27, 2020, the Coronavirus Aid, Relief, and Economic Security Act extended the term of the MFP grant from May 22, 2020, to November 30, 2020. On December 27, 2020, the President signed the Consolidated Appropriations Act of 2021, which includes an extension of the MFP grant through federal fiscal year (FFY) 2023 and appropriates $450 million for FFY 2022, and $450 million for FFY 2023. Under the Act, the CCT Program will receive grant funding

to continue to transition eligible ~~beneficiaries~~ **members** through September 2023 and up to four years after, as long as grant funding remains available.

On September 23, 2020, CMS notified state MFP grantees of a supplemental funding opportunity for states that operate MFP Demonstration programs, and that plan to continue participating in MFP after FFY 2019-20. California developed a proposal to submit to CMS to receive up to $5 million in supplemental funding for planning and capacity building activities to accelerate long-term care system transformation design and implementation, and to expand HCBS capacity. The Department submitted its application to CMS on June 30, 2021. On July 27, 2021, CMS approved the Department's MFP Supplemental Funding application. CMS approved the Department's request for $5 million in supplemental funding to conduct a statewide Gap Analysis and Multiyear Roadmap of its Home and Community-Based Services (HCBS) and Managed Medi-Cal Long-Term Supports and Services (MLTSS) programs and networks. The Department's project narrative identified how the funding will be utilized for planning and capacity building activities to accelerate long~~pro~~-term care system transformation design and implementation, and to expand HCBS capacity. The Department selected Mathematica as its contractor to perform the Gap Analysis and prepare the Multiyear Roadmap. The Department finalized the contract on October 6, 2022, with a retroactive state date of September 1, 2022.

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. Under the Consolidated Appropriations Act of 2021, effective January 26, 2021, the 90**-**day minimum stay requirement was reduced to 60 days.

In April 2022, CMS issued a Memorandum to state grantees to announce a change to the FFP available for MFP supplemental services as well as the types of allowable services. Effective January 1, 2022, CMS-approved supplemental services will be fully covered by MFP grant funds at a federal reimbursement rate of 100%. The Department continues to evaluate options for implementing additional supplemental services through the updated process identified by CMS.

Beginning January 1, 2021, SB 214 created a temporary program that revises the current requirement for ~~individuals~~ **members** residing in an inpatient facility from 90 days and longer to less than 90 days. The temporary program requires the Department to end enrolling specified ~~individuals~~ **members** by the end of December 31, 2022, and end providing services at the end of December 31, 2023. However, SB 214 was invalidated due to federal legislation that modified **the** criteria for the MFP grant. As a result, the Department proposed amendments to the statute through trailer bill language to align the state-funded CCT population with the new federal requirements.

On July 27, 2021, AB 133 was approved by the Governor and chaptered by the Secretary of State. Approval of AB 133 allowed for the ~~roll out~~ **rollout** of a state-funded~~, California Community Transitions (~~CCT~~)~~ -like program. AB 133 aligns state statute with the amended federal statute, by reducing the required period of residence in an inpatient facility from 90 days to 60 days. The State-funded, CCT-like program allows CCT Lead Organizations to provide transition services to Medi-Cal ~~beneficiaries~~ **members** who have not yet met the federal, MFP

residency eligibility criteria, as a way to help reduce the amount of time ~~beneficiaries~~ **members** are required to remain in an institution during the COVID-19 PHE.

On December 29, 2022, the President signed the Consolidated Appropriations Act of 2023 into law, which extends the MFP grant indefinitely and appropriates additional funding for each fiscal year through 2024-27. Unexpended grant funds awarded for any fiscal year can continue to be spent for up to four additional years, through September 30, 2031.

The population that is eligible for the state-funded program are residents of inpatient facilities who meet the eligibility criteria to enroll in the federally-funded Money Follows the Person (MFP) Rebalancing Demonstration, with one exception (MFP is known as California Community Transitions (CCT) in our state). To be eligible for the federally-funded program, a ~~beneficiary~~ **member** is required to have been a resident of an inpatient facility for at least 60 days the state-funded program removes the 60-day eligibility criteria to provide transition coordination services to ~~beneficiaries~~ **members** residing in SNF who meet all other MFP/CCT enrollment criteria, including:

- At least one day of their stay in the facility must be funded by Medicaid; and
- The ~~beneficiary~~ **member** would continue to require skilled nursing care in a facility if not for the transition coordination and home and community-based long-term services and supports provided/secured for them through the CCT program.

1115 WAIVER-MH/UCD, BTR, MEDI-CAL 2020, AND CALAIM 1915(b) WAIVER

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. Due to the COVID-19 pandemic impact on the state's health care delivery systems CMS approved a one-year extension. The Medi-Cal 2020 waiver ended on December 31, 2021.

The CalAIM Section 1115 Demonstration, for the service period of January 1, 2022, through December 31, 2026, has been approved by CMS. In addition, the CalAIM Section 1915(b) Demonstration was also approved for the same January 1, 2022, through December 31, 2026, service period. Together, the CalAIM Section 1115 and the 1915(b) waivers, along with State Plan Amendments approved by CMS, move tested initiatives from prior federal waivers to statewide rollout, benefiting all Medi-Cal ~~enrollees~~ **members**. More information about CalAIM impacts is included in the CalAIM section later in this document.

With the 1115 and 1915(b) waiver renewals, nearly all elements of the Medi-Cal managed care, SMHS, dental managed care, and the DMC-ODS delivery systems are streamlined to a single authority under the CalAIM Section 1915(b) Waiver. See the Department's website for more information about the CalAIM waivers: https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM-1115-and-1915b-Waiver-Renewals.aspx

MANAGED CARE

Medi-Cal Managed Care Rates

Managed care capitation rates paid to Medi-Cal managed care plans are developed to provide for the reasonable, appropriate, and attainable projected costs under the plan's contract. Base rates are developed utilizing primarily plan-reported cost and utilization data by category of service (e.g., Inpatient Hospital, Emergency Room, Physician Primary Care, Physician Specialty) for each rating category of aid (COA). Actuaries review the base data for reasonableness and make adjustments to remove identified inefficiencies and align the base data to the services and populations that are covered in the future rating period.

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

In counties with more than one non-specialty plan, capitation rates are risk adjusted to better reflect the match of a plan's expected costs to their members' health risk. Capitation rates are risk adjusted for the Child, Adult, Seniors**,** and Persons with Disabilities (SPD), and Affordable Care Act Optional Expansion (ACA OE) COAs.

Historically, risk adjustment was performed using the Medicaid Rx risk adjustment model developed by the University of California, San Diego. Each member in the Child, Adult, SPD, and ACA OE COAs who meets certain criteria is assigned a risk score. Member scores are aggregated for each plan operating in a county and a county-average rate is then developed for each COA in a budget-neutral manner based on the sum of the plan-specific rates weighted for each plan's enrollment. For rating periods from July 2018 through December 2022, each plan's final rate is a blend that gives 75% weight to the county-average rate and 25% weight to the plan-specific rate. County Organized Health Systems (COHS) rates are not risk adjusted due to the presence of only one plan in each county.

The risk adjustment policy is examined on an annual basis and adjusted if necessary. As of January 2023, the Department transitioned to the CDPS+Rx risk adjustment model, which combines the diagnostic-based Chronic Illness and Disability Payment System (CDPS) model and the pharmacy-based Medicaid Rx model. For more information on CDPS+Rx, see https://cdps.ucsd.edu/.

For the calendar year (CY) 2023 rating period, subject to federal approval, the Department considers plans' performance on select quality measures to inform adjustments to the 75%/25% blend. In all Two-Plan and Regional Model counties (except San Benito) where a significant difference in quality performance between the two plans is observed, the blend will be adjusted in the direction that is favorable to the higher-performing plan. The weight given to the county-average rate may be reduced to as little as 50% or increased to as much as 100%. For the CY 2024 rating period, 100% of the rate, except for select services, are risk adjusted. In addition, the CY 2024 rating period rates for ~~beneficiaries~~ **members** with unsatisfactory immigration status (UIS) are subject to risk adjustment.

Occasionally, when deemed necessary, the State will implement supplemental payments to help mitigate risk for unpredictable utilization trends. For example, the State has implemented supplemental payments for the costs of maternity services related to labor/delivery and

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Behavioral Health Treatment (BHT) for children. BHT supplemental payments ~~will be~~ **are** discontinued~~,~~ and ~~associated costs will be~~ captured within base rates, as of the CY 2023 rating period.

The State implemented a one-time 18-month rating period for the period of July 1, 2019, through December 31, 2020, to aid in future prospective rate development as federally required. Beginning with CY 2021, rates are developed annually on a calendar year basis thereafter.

Managed Care Organization Taxes

~~SBX2-2 (Chapter 2, Statutes of 2016) implemented a statewide tax on managed care plans based on their enrollment. The tax is tiered based on whether an enrollee is a Medi-Cal enrollee, alternate health care service plan enrollee, or other enrollee. This Managed Care Organization (MCO) Enrollment Tax was effective July 1, 2016, through June 30, 2019. AB 115 (Chapter 348, Statutes of 2019) authorized a modified MCO Enrollment Tax. On April 3, 2020, CMS approved the Department's waiver of the broad-based and uniformity provisions of Sections 1903(w)(3)(B) and (C) of the Social Security Act for the modified MCO Enrollment Tax model. The effective date range from this approval is January 1, 2020, through December 31, 2022.~~ AB 119 (Chapter 13, Statutes of 2023) authorized a new MCO Enrollment Tax effective April 1, 2023, through December 31, 2026. Similar to the prior tax, this tax is tiered based on whether an enrollee is a Medi-Cal enrollee or other enrollee. **CMS approved the proposed tax structure in December 2023. On March 27, 2024, the Department submitted an MCO tax structure amendment to CMS for CY 2024 and forward. On June 30, 2024, a modification to that amended MCO tax waiver request was submitted. Approval of the amended MCO tax structure is currently pending with CMS.**

~~Prior to the enrollment-based MCO taxes, SB 78 (Chapter 33, Statutes of 2013) introduced a 3.9375% revenue-based MCO tax. The Department is currently in the process of reconciling the MCO tax fund for the July 1, 2013, through June 30, 2016, time period in which the revenue-based tax was applicable. The final reconciliation is expected to be completed in FY 2023-24.~~

Federally Qualified Health Center Alternative Payment Methodology (FQHC APM)

The FQHC APM is a voluntary program aimed towards moving FQHCs from their current volume-based reimbursement model to a capitated value-based model. The program will fund FQHCs through Managed Care Plans with a Per Member Per Month payment for each assigned member to their site. This funding will be equivalent to what they were projected to have received under their Prospective Payment System (PPS) volume-based model. For FQHCs that are suited to participating in the APM, the capitation payment will improve revenue stability and provide additional flexibilities to provide alternative services that are not rendered by a PPS eligible provider. The FQHC APM is currently targeted for implementation date of no sooner than July 1, 2024, subject to CMS approval. The program is currently working toward finalizing program policies as well as preparing a SPA for submission to CMS.

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Coordinated Care Initiative (CCI) Program

The 2017 Budget extended the Cal MediConnect (CMC) program and the mandatory enrollment of dual eligible members and the integration of long-term services and supports, except In-Home Supportive Services (IHSS), into managed care. IHSS was removed from capitation rate payments effective January 1, 2018. MSSP was removed from capitation rate payments effective January 1, 2022.

As part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative's standardized mandatory enrollment of dual eligible~~s~~ **members** and statewide integration of long-term care into managed care, the CCI pilot program sunset December 31, 2022.

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

Managed care contracts require health plans to provide specific services to Medi-Cal enrolled ~~beneficiaries~~ **members**. Medi-Cal services that are not delegated to contracting health plans remain the responsibility of the Medi-Cal FFS program. When a ~~beneficiary~~ **member** 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 Medi-Cal FFS 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 Medi-Cal FFS program to Federally Qualified Health Center/Rural Health Clinic providers who have rendered care to ~~beneficiaries~~ **members** 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.

Excluding pharmacy costs covered under Medi-Cal Rx, FQHC "wrap-around" payments and California Children's Services "carve-out" expenditures account for the largest share of FFS expenditures generated by Medi-Cal ~~beneficiaries~~ **members** enrolled in managed care plans.

Under CalAIM, long term care (LTC) services that were previously "carved-out" of managed care in non-COHS, non-CCI counties, were integrated into managed care. Under the historical policy, managed care ~~beneficiaries~~ **members** in non-COHS, non-CCI counties were disenrolled from managed care plans one month after the month of admission to an LTC facility, at which point the FFS delivery system would be responsible for providing all State Plan services. With the managed care "carve-in," both the ~~beneficiary~~ **member** and related ongoing LTC expenditures will remain in the managed care delivery system. The carve-in is effective January 1, 2023, for skilled nursing facility services, and January 1, 2024, for other institutional LTC services including intermediate care facility for the developmentally disabled and subacute care facility services.

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LTC services were not "carved-out" of managed care in COHS and CCI counties. Therefore, there was no change to managed care plans' responsibility regarding LTC services within these counties.

COVID-19 Risk Corridor

As a result of the unprecedented effects of the COVID-19 pandemic, Section 14301.11 of the Welfare and Institutions Code established a two-sided risk corridor for rating periods occurring within July 1, 2019, through December 31, 2020, to mitigate potentially significant upward or downward risk associated with the pandemic that were not determinable at the time of rate development. The risk corridor calculation will be performed at the MCP level (statewide) across all counties or rating regions in which the MCP operates, and across all population groups and applicable rate cells. The Department has collected and is reviewing data from MCPs needed to perform the calculations. Payments and recoupments are anticipated to occur in FY 2024-25.

Managed Care Procurement

The objective of the managed care procurement process is to procure commercial plans to provide high quality, accessible, and cost-effective health care through established networks of organized systems of care, which emphasize primary and preventive care. The draft Request for Proposal (RFP) 20-10029 was released on June 1, 2021. The RFP provided procurement information and a sample of the updated and restructured MCP Contract. The RFP process was used to procure commercial health plans in the following Plan Model types: Two-Plan, Geographic Managed Care (GMC), and Regional Models. The Department released the final RFP on February 9, 2022**,** and announced the intent to award contracts to selected managed care plans on August 25, 2022. On December 30, 2022, the Department cancelled RFP #20-10029 for the Medi-Cal Managed Care Plans and announced an agreement to deliver Medi-Cal services to Medi-Cal managed care members in 21 counties across the state with an operational start date of January 1, 2024.

The RFP was not used to procure the COHS Plans, or Local Initiative Plans in Non-COHS counties, or Plans operating in Single-Plan Model counties. Based on conditional approvals for County Plan Model changes effective January 1, 2024, San Benito County and Mariposa County will join Central California Alliance for Health (CCAH) and Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba Counties will join Partnership Health Plan as part of the COHS Plan model. As with the commercial plans in the Managed Care Procurement, all final County Plans Model changes have an operational start date of January 1, 2024, contingent on passing all Plan operational readiness activities.

Quality Withhold and Incentive Program

For the CY 2024 rating period and future periods, subject to CMS approval, the Department ~~is~~ implemented a hybrid Quality Withhold and Incentive program for contracted Medi-Cal managed care plans. This program withholds a percentage of the lower bound capitation for all categories of aid. The lower bound capitation withhold percentage may change across rating periods, subject to actuarial soundness and quality goals. No sooner than July 1, 2025, the CY 2024

results can be calculated and earned withhold dollars distributed back to the managed care plans. Unearned withhold dollars will roll over into a separate incentive program to pay managed care plans for meeting specified performance metrics on the quality measures.

Unsatisfactory Immigration Status Risk Corridor

For the CY 2024 rating period, the department will utilize a two-sided risk corridor for the UIS Adult and UIS Optional Expansion categories of aid rates due to the potential impact of the expansion of full scope coverage to all beneficiaries ages 26 to 49, regardless of immigration status. Also, for the CY 2024 rating period, a two-sided risk corridor will be utilized for the San Benito County capitation rates. This risk corridor is related to the shift from voluntary managed care to mandatory managed care. Calculations will occur after the rating periods have concluded.

Directed Payments

~~No sooner than~~ **Effective with** the CY ~~2025~~ **2026**~~R~~rating period **and authorized by SB 177 (2023-24)**, ~~the department will implement a Martin Luther King Jr. Community Hospital Directed Payment as well as~~ a Cost-Based Reimbursement Clinics Directed Payment **shall be implemented**. ~~A Federally Qualified Health Centers Directed Payment program is also expected for the CY 2025 rating period. These~~ **This** direct~~ed~~ payment~~s~~ would shift program funds from existing pass-through payment programs. Payments are not expected to occur by ~~FY 2024-25~~ **FY 2026-27**.

Hospital Directed Payment Increases

Consistent with the 2024-25 Budget Act, the Department is increasing state-directed payments to private and public hospitals beginning with the CY 2025 program year. All increases are contingent on receipt of all necessary federal approvals. On a cash basis, these increased amounts will pay starting in FY 2026-27 due to the time lag associated with complete claims and/or performance data being available and other requirements necessary to operate a federally compliant directed payment program.

For private hospitals, the Department anticipates increasing the annual amount of Private Hospital Directed Payments (PHDP) by approximately $6 billion. This increase will correspond with increased hospital quality assurance fee revenues beginning with the HQAF IX program period commencing January 1, 2025. These increased revenues will provide additional support for health care coverage for children in the Medi-Cal program estimated at over $700 million annually. The PHDP increases are in addition to new directed payments for children's hospitals, which are budgeted in the Children's Hospital Directed Payment policy change.

For designated public hospitals (DPH), the Department anticipates increasing the annual amount of Enhanced Payment Program (EPP) and DPH Quality Incentive Pool (QIP) payments by more than $2.6 billion. For district and municipal public hospitals (DMPH), the Department anticipates increasing the annual amount of District Hospital Directed Payments (DHDP) and DMPH QIP payments by more than $500 million.

PROVIDER RATES

Provider Rates Reimbursement Methodology and the Quality Assurance Fee for Freestanding Nursing Facility Level Bs & Freestanding Subacute Level B Facilities

The Medi-Cal Long-Term Care Reimbursement Act (Article 3.8 of Chapter 7 of Part 3 of Division 9 of Welfare and Institutions Code, beginning with section 14126) requires the Department to develop a cost-based, facility-specific reimbursement rate methodology for Freestanding Nursing Facility Level-Bs (FS/NF-Bs), and Freestanding Subacute Nursing Facility, Level Bs (FSSA/NF-Bs). Rates are updated annually and are established based on the most recent audited cost report data.

The rate methodology developed by the Department computes facility-specific, cost-based per diem payments for FS/NF-Bs and FSSA/NF-Bs based on five cost categories, which are subject to limits. Limits are set based on expenditures within geographic peer groups. Costs specific to one category may not be shifted to another cost category. Additionally, the budget and authorizing legislation sets maximum annual year-over-year increases.

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 95th 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 95th 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.

PROVIDER RATES

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.

Reimbursement Methodology for Other Long-Term Care Facilities

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 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.

Mandates & Quality Assurance Fee. The Department projects the cost of complying with new state or federal mandates and the Quality Assurance Fee (QAF).

Methodology by Type of LTC Facility

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

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

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

Intermediate Care Facilities for the Developmentally Disabled, Developmentally Disabled-Habilitative, and Developmentally Disabled-Nursing (ICF/DD, ICF/DD-H, ICF/DD-N) are peer

grouped by level of care and bed size. Reimbursements are established at the 65th percentile of the group's projected costs.

Adult Subacute Care Facilities are grouped into two statewide peer groups: hospital-based providers and freestanding nursing facility providers. Subacute care providers are reimbursed their projected costs up to the median of their peer group.

Pediatric Subacute Care Units/Facilities are grouped into two peer groups: hospital-based nursing facility providers (Distinct Part Pediatric Subacute (DP/PSA) facilities) and Freestanding Pediatric Subacute (FS/PSA) facilities. There are different rates for ventilator and non-ventilator patients. Reimbursement is based on a model since historical cost data were not previously available. The FS/PSA reimbursement rates equal the lesser of the facility's costs as projected by the Department, or the rate based on the class median rates, broken down by ventilator and non-ventilator.

COVID-19 Impact on Long-Term Care Facilities

In response to the increased cost pressures incurred by the COVID-19 outbreak, the Department with CMS's approval has provided the following long-term care facilities with rate increase equal to 10 percent of their regular 2019-20 total reimbursement amount:

- Freestanding Skilled Nursing Facilities Level-B (FS/SNF-B)
- Nursing Facilities Level-A (NF-A)
- Distinct Part Skilled Nursing Facilities Level-B (DP/SNF-B)
- Freestanding Adult Subacute Facilities (FSSA)
- Distinct Part Adult Subacute Facilities (DP/SA)
- Distinct Part Pediatric Subacute Facilities (DP/PSA)
- Freestanding Pediatric Subacute Facilities (FS/PSA)
- ICF/DD (including ICF/DD-Habilitative, and ICF/DD-Nursing)

This increase does not apply to state-owned Skilled Nursing Facilities or ICFs, including Developmental Centers and Veterans Homes. The increased amounts are inclusive of add-ons, and the FS/PSA and the ICF/DD Proposition 56 supplemental payments.

The COVID-19 rate increases are effective March 1, 2020. For FS/SNF-Bs and FSSAs, the COVID-19 rate increase will continue through December 31, 2023. For ICF-DDs, rates after the end of the public health emergency (PHE) will be the greater of the annually updated regular rate or the total reimbursement on the last day of the PHE, inclusive of the COVID-19 rate increase.

PROVIDER RATES

In accordance with the 2023 Budget Act, and pending federal approval, for dates of service July 1, 2023, through December 31, 2023, FS/PSA reimbursement rates will be set at the total per diem rate in effect on August 1, 2022, inclusive of an amount equivalent to the COVID-19 PHE rate increase then in effect. For dates of service on or after January 1, 2024, FS/PSA rates shall be the greater of:

(1) the reimbursement rate established by the applicable State Plan reimbursement methodology, or

(2) the reimbursement rate in effect for the facility on December 31, 2023, inclusive of the amount equivalent to the COVID-19 PHE rate increase.

For all other facilities, the COVID-19 rate increase continued until the expiration of the PHE on May 11, 2023. Following expiration of the PHE, rates reverted to their regular levels.

AMERICAN RESCUE PLAN ACT

CalAIM is a comprehensive set of proposals that collectively are intended to: (1) identify and manage member risk and need through whole person care approaches and addressing the social determinants of health, (2) move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility, and (3) improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform. See https://www.dhcs.ca.gov/calaim for more information.

Initial components of CalAIM launched in the beginning of 2022 and the remaining components will go live over the next several years. Where fiscal impacts have been identified, policy changes have been included in the Medi-Cal Estimate to budget needed funding. Other components of the CalAIM proposal do not have estimated fiscal impacts in the Medi-Cal Estimate at this time, but are described hereafter:

1. Managed Care Specialty Mental Health Services Carve-Out

   Under CalAIM, the Department is standardizing benefits provided through Medi-Cal managed care plans statewide. With some exceptions, regardless of a ~~beneficiary's~~ **member's** county of residence or the plan they are enrolled in, they will have the same set of benefits delivered through their Medi-Cal managed care plan as they would in another county or plan. Effective July 1, 2023, the Specialty Mental Health Services benefits that are currently within the scope of services delivered by Kaiser Permanente in Solano and Sacramento Counties are planned to be carved out and instead provided through the Specialty Mental Health Services delivery system. This resulted in a reduction in capitation paid to managed care plans, accounted for in the appropriate managed care base policy changes in the Estimate.

2. Updated Criteria for Specialty Mental Health Services

   The Department is modifying the criteria for specialty mental health services to align with state/federal requirements and more clearly delineate and standardize the benefit statewide, effective January 1, 2022. As part of this effort, the Department is also seeking to identify and implement screening and transition of care tools that shall be used to determine the appropriate level of care for mental health services, effective January 1, 2023.

3. BH Administrative Integration

   Research indicates that approximately 50% of individuals who have a serious mental illness have a co-occurring substance use disorder and that those individuals benefit from integrated treatment. The State provides Medi-Cal covered SUD and SMHS through two separate county-operated delivery systems, which makes it difficult for counties to provide integrated treatment to individuals who have co-occurring disorders. For example, counties participating in mental health and substance use disorder managed care are subject to two separate annual quality assessments, two separate post payment chart audits, and two separate reimbursement and cost reporting methods. In order to comply with these separate processes, counties providing integrated treatment to a Medi-Cal ~~beneficiary~~ **member** must

document the SUD service separately from the specialty mental health service. The purpose of this proposal is to make necessary state and county changes that would provide SUD and SMHS through one delivery system. Efforts to begin working on integration are targeted for January 1, 2022, aiming for a single county contract for SUD and mental health treatment starting January 1, 2027.

4. BH Regional Contracting

The Department recognizes that some counties have resource limitations often due simply to their size and the number of ~~beneficiaries~~ **members** residing in their county. Therefore, the Department is encouraging counties to develop regional approaches to administer and deliver SMHS and SUD services to Medi-Cal ~~beneficiaries~~ **members**. There are a variety of options available to counties, including a Joint Powers Authority to operate such services for a multi-county region (e.g., Sutter/Yuba). Counties could also pool resources to contract with an administrative services organization/third-party administrator or other entity, such as the County Medical Services Program, to create administrative efficiencies across multiple counties. Small counties, rural/frontier counties, and counties with shared population centers or complementary resources should consider opportunities for regional partnership. Furthermore, the Department is interested in discussing how counties not currently seeking DMC-ODS participation may be more interested in doing so through a regional approach and/or how services provided under SUD fee-for-service might also be provided through a regional approach. The Department is committed to working with counties to offer technical assistance and support to help develop regional contracts and establish innovative partnerships.

5. Enhancing CCS Oversight and Monitoring

The California Children's Services (CCS) program provides case management, diagnostic, treatment, and physical and occupational therapy services to children and youth with special health care needs.

CCS ~~beneficiaries~~ **members** are best served when their care is delivered in a standardized and consistent manner across the State. Through the CalAIM initiative, the State shall ensure consistent high quality standard of care, compliant with federal and State guidelines, is provided to all qualified ~~beneficiaries~~ **members**. As part of this initiative, the Department will implement new processes and procedures to provide enhanced monitoring and oversight of all 58 counties to ensure optimal care is provided for this medically fragile population. To implement this enhanced monitoring and oversight, the Department will develop a robust strategic compliance program that includes, but is not limited to review of all current standards and guidelines for the CCS program; development and implementation of auditing tools to assess county operations and compliance; analysis and evaluation of the findings gathered during audits (desk, on-site and/or virtual) to identify gaps and vulnerabilities across counties within these programs; implementation of corrective action plans as necessary; tracking trends; and, along with input from our county partners and other stakeholders, establishing goals, metrics, performance measures, and milestones to ensure counties are conducting provider oversight and providing the necessary medical and

dental care for ~~beneficiaries~~ **members**. The Department will also enter into a Memorandum of Understanding with each county that will outline the State and county responsibilities to hold both entities accountable for action/in-action.

After initial deployment of the enhanced monitoring and oversight, the Department will continue to conduct ongoing surveys, be proactive with emerging developments, and monitor trends to ensure high-quality consistent care. The Department will allow sufficient time for counties to implement and adjust to this new structure prior to engaging in any sort of progressive action. The Department will continue this robust strategic compliance oversight in order to preserve and improve the overall health and well-being of these vulnerable populations.

6. Enhancing Eligibility Oversight & Monitoring

The Enhancing County Eligibility Oversight and Monitoring initiative within the CalAIM proposal was precipitated by recent audits performed by federal and state oversight agencies which found weaknesses in the Department's oversight practices, and suggest that both increased monitoring and the development and implementation of additional oversight activities are needed to reduce erroneous eligibility determinations and facilitate increased accuracy in the administration of the Medi-Cal and CHIP programs. Due to the continuous coverage requirement in the federal Families First Coronavirus Response Act (FFCRA) signed into law on March 18, 2020, and instruction to counties to halt all Medi-Cal renewal processes and negative actions through the duration of the Public Health Emergency (PHE), this CalAIM initiative will be delayed accordingly. The implementation dates selected will be based on resumption of normal county business processes as we continue to navigate the PHE, with a measure of time built in afterward for counties to process and clean-up the resulting backlog. By December 31, 2023, DHCS will have implemented enhanced county oversight and monitoring activities to include lifting the current hold-harmless policy and reinstating county performance standards, publishing a public facing county performance dashboard, and taking steps toward fiscal sanctions for counties which do not demonstrate sufficient improvement in meeting performance expectations or are unresponsive.

7. Regional Managed Care Capitation Rates

As part of the CalAIM initiative, the Department is transitioning the development of Medi-Cal managed care plan rates from a county-based model to a regional rate model over the course of multiple years. The move to regional rates has two main benefits. The first benefit is a decreased number of distinct actuarial rating cells that are required and submitted to the Centers for Medicare and Medicaid Services (CMS) for review and approval. The reduction in rating cells simplifies the presentation of rates to CMS with a goal of allowing the Department to pursue/implement financing advancements and innovations utilizing a more flexible rate model. The second benefit of regional rates is that it allows cost averaging across multiple plans. This will continue to incentivize plan cost efficiencies, as plan rates will be inclusive of the costs within the multi-county region. This shift produces a larger base for averaging rather than just the experience of plans within a single county.

AMERICAN RESCUE PLAN ACT

8. CalAIM DMC-ODS Renewal

   The Department received CMS approval to renew the DMC-ODS program and incorporate additional services and benefits, effective January 2022. Through the new CalAIM 1115 Demonstration, the Department will continue the:
   - Waiver of the IMD exclusion to secure federal Medicaid matching funds for DMC-ODS services that are provided in an IMD to individuals over 21 and under 65, and
   - Continuation of the DMC-ODS Certified Public Expenditure (CPE) Protocols. CPE protocols would continue until Behavioral Health Payment Reform begins.

   Effective January 1, 2022, the rest of the DMC-ODS transitioned from the 1115 Waiver Demonstration to the 1915(b) waiver authority, and corresponding State Plan Amendments (SPA) and Behavioral Health Information Notices, incorporating improvements to improve quality and access, based on the experience of the first five pilot years. The Department has conducted outreach efforts to encourage counties to participate in the DMC-ODS waiver and new counties have expressed interest in participating.

9. CalAIM Major Organ Transplant Risk Corridor

   Effective January 1, 2022, all organ transplant benefits were standardized and carved into MCP covered benefits statewide for all Medi-Cal managed care members. This will continue to reduce complexity and ensure continuity of care without burdening ~~beneficiaries~~ **members** transitioning from one delivery system to another.

   To protect the managed care health plans and the State against excessive gains/losses due to the implementation of the new benefits, the Department has established a two-sided, symmetrical risk corridor for the CY 2022 rating period, subject to CMS approval. Calculations are anticipated to begin no sooner than January 1, 2024. A risk corridor will also be in place for the CY 2023 **and CY 2024** rating ~~period~~ **periods**, with calculations starting no sooner than ~~January 1, 2025~~ **12 months after the end of each rating period**.

10. Transitional Care Services

    Effective January 1, 2025, the Department proposes transitional rent services as a new Community Support for qualifying individuals in the Medi-Cal Managed Care delivery system. The California BH-CONNECT demonstration would cover these transitional rent services for individuals in the Specialty Mental Health Services, Drug Medi-Cal (DMC), and DMC-Organization Delivery System. Transitional rent services will be closely coordinated across delivery systems, with other housing-related supports offered as Medi-Cal Community Support services, and with other non-Medi-Cal funded housing services.

11. Foster Care Model of Care

    Effective January 1, 2025, the Department proposes to revise the model of care for current and former foster children or youth, children or youth entering or at risk of re-entering the

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foster system, and the families and caregivers of these children and youth, including the Former Foster Youth program and those individuals transitioning out of foster programs and services at age 26 to the Medi-Cal managed care delivery system.

On March 11, 2021, the President signed the American Rescue Plan Act (ARPA) of 2021. ARPA includes several major provisions related to Medicaid. Most notably, ARPA: (1) provides 100 percent federal funding for COVID-19 vaccine administration, as described in the COVID-19 Vaccine Administration policy change; (2) adjusts the allocation of federal Disproportionate Share Hospital payments to account for an unintended interaction with increased FMAP previously provided under the Families First Coronavirus Response Act; (3) provides an additional temporary increase in the FMAP for certain home and community-based services, including behavioral health services; and (4) provides various funding streams related to behavioral health, described in greater detail below.

12. Behavioral Health Funding in ARPA

The ARPA provides various funding streams related to behavioral health. Some of these funding streams, such as that provided through Section 9813 (described immediately below) would come through the Medicaid program. Others would come in the form of additional grant funding outside of Medicaid.

Section 9813 provides 85 percent Medicaid match for qualifying community-based mobile crisis intervention services for twelve quarters during the five-year period starting April 1, 2022. Crisis response is a key gap in the state's system of behavioral health (BH) care. The Estimate includes a policy change to use the 85 percent Medicaid match in the Mobile Crisis Services policy change.

Sections 2701 and 2702 provide additional funding that would be made available to California counties using existing processes with additional workload to amend allocations and contracts. The funding is administered by Substance Abuse and Mental Health Services Administration and must be spent by September 23, 2025.

Section 2703 provides grant funding to support mental and behavioral health training for health care professionals, para-professions, and public safety offers. In order to spend the additional unanticipated funding made available through ARPA, the Department will need to develop policy and administration protocols. At this time, additional amounts allocated to California is still unknown.

Sections 2706 and 2707 provide funding to award grants to support states, local, tribal, and territorial governments; tribal organizations, nonprofit community-based organizations; and primary behavioral health organizations. Section 2706 grant awards will go toward supporting community-based overdose prevention programs, syringe services programs, and other harm reduction services, with a focus on drug misuse. Section 2707 grant awards will go towards addressing increased community behavioral health needs exacerbated by the COVID-19 pandemic (e.g., training the mental and behavioral health workforce using telehealth to deliver services).

AMERICAN RESCUE PLAN ACT

In addition to the funding above, the American Rescue Plan Act also included funding to state and local governments. The funds are distributed to states, tribes, and territories based on a formula that considers the state's share of the nation's unemployment. The ARPA funds can be used for specific purposes including addressing public health impacts, negative economic impacts, and water, sewer, and broadband. State and local governments have until December 31, 2024 to expend the ARPA funds. Specified ARPA funds to California are deposited into the Coronavirus Fiscal Recovery Fund of 2021.

INFORMATION ONLY

REVENUES

1. Revenues

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

FY 2024-25:	$26,498,000	ICF-DD Quality Assurance Fee
	$576,710,000	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	$9,989,000	ICF-DD Transportation/Day Care Quality Assurance Fee
	$8,597,541,000	MCO Enrollment Tax (Item 4260-601-3428)
	$5,375,976,000	Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)
	$0	Emergency Medical Air Transportation (EMATA) Fund (Item 4260-101-3168)
	$61,429,000	Medi-Cal Emergency Medical Transport (MEMTF) (Item 4260-601-3323)
	$2,258,631,000	Medi-Cal Drug Rebates Fund (Item 4260-601-3331)
	$19,391,146,000	Total
FY 2025-26:		ICF-DD Quality Assurance Fee
		Skilled Nursing Facility Quality Assurance Fee (AB 1629)
		ICF-DD Transportation/Day Care Quality Assurance Fee
		MCO Enrollment Tax (Item 4260-601-3428)
		Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)
		Emergency Medical Air Transportation (EMATA) Fund (Item 4260-101-3168)
		Medi-Cal Emergency Medical Transport (MEMTF) (Item 4260-601-3323)
		Medi-Cal Drug Rebates Fund (Item 4260-601-3331)
	$	Total

Effective August 1, 2009, the Department expanded the amount of revenue upon which the quality assurance (QA) fee for AB 1629 facilities is assessed, to include Medicare.

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~~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 Centers for Medicare and Medicaid Services approval.~~

~~SBx2-2 (Chapter 2, Statutes of 2016) provides that the new tax will apply to the Medi-Cal revenue of most managed care plans in the state, with some exemptions. The new tax structure will meet federal requirements while achieving the same GF savings as the previous tax and also providing sufficient funding to restore the 7% reduction in the In-Home Supportive Services Program.~~

~~AB 1383 (Chapter 627, Statutes of 2009) authorized the implementation of a quality assurance fee on applicable general acute care hospitals. The fee is deposited into the Hospital Quality Assurance Revenue Fund (Item 4260-601-3158). This fund is used to provide supplemental payments to private and non-designated public hospitals, grants to designated public hospitals, and enhanced payments to managed health care and mental health plans. The fund is also used to pay for health care coverage for children, staff and related administrative expenses required to implement the Quality Assurance Fee (QAF) program. SB 90 (Chapter 19, Statutes of 2011) extended the hospital QAF through June 30, 2011. SB 90 also ties changes in hospital seismic safety standards to the enactment of a new hospital QAF that results in revenue for FY 2011-12 children's services of at least $320 million.~~

~~SB 335 (Chapter 286, Statues of 2011) authorized the implementation of a new Hospital QAF program for the period of July 1, 2011 to December 31, 2013. This new program authorizes the collection of a quality assurance fee from non-exempt hospitals. The fee is deposited into the Hospital Quality Assurance Revenue and is used to provide supplemental payments to private hospitals, grants to designated public hospitals and non-designated public hospitals, increased capitation payments to managed health care plans, and increased payments to mental health plans. The fund is also used to pay for health care coverage for children and for staff and related administrative expenses required to implement the QAF program.~~

~~SB 239 (Chapter 657, Statutes of 2013) extended the Hospital QAF program from January 1, 2014, through December 31, 2016. This extension authorizes the collection of a quality assurance fee from non-exempt hospitals. The fee is deposited into the Hospital Quality Assurance Revenue and is used to provide supplemental payments to private hospitals, grants to designated public hospitals and non-designated public hospitals, and increased capitation payments to managed health care plans. The fund is also used to pay for health care coverage for children and for staff and related administrative expenses required to implement the QAF program.~~

~~AB 1607 (Chapter 27, Statutes of 2016) extended the inoperative date of the Hospital QAF program to January 1, 2018, creating a one-year extension of the program.~~

~~Proposition 52, approved by California voters on November 8, 2016, permanently extends the Hospital QAF program.~~

INFORMATION ONLY

~~The California Department of Public Health (CDPH) lowered Licensing and Certification (L&C) fees for long-term care providers for FY 2010-11. The aggregate amount of the reductions allowed the QA fee amounts collected from the freestanding NF-Bs and ICF/DDs (including Habilitative and Nursing) to increase by an equal amount. Currently, the QA fee amounts are calculated to be net of the L&C fees in order to be within the federally designated cap, which provides for the maximum amount of QA fees that can be collected. For FY 2011-12, CDPH increased L&C fees which resulted in a reduction in the collection of the QA fee by an equal amount to the L&C fee increase for free-standing NF-Bs, Freestanding Pediatric Subacute Facilities and ICF/DDs (including Habilitative and Nursing).~~

~~Effective January 1, 2011, AB 2173 (Chapter 547, Statutes of 2010) imposes an additional penalty of $4 for convictions involving vehicle violations.~~

~~AB 119 (Chapter 17, Statutes of 2015) extends the AB 1629 facility-specific rate methodology, QAF, and QASP program through July 31, 2020. Further, beginning rate year 2015-16, the annual weighted average rate increase is 3.62%, and the QASP will continue at FY 2014-15 levels, rather than setting aside a portion of the annual rate increase. Additionally, beginning FY 2015-16, the legislation requires the Department to incorporate direct care staff retention as a performance measure into the QASP Program.~~

~~SB 523 (Chapter 773, Statutes of 2017) implements a Ground Emergency Medical Transportation (GEMT) Quality Assurance Fee (QAF) on all ground emergency medical transports, effective July 1, 2018. The QAF will be assessed on each GEMT transport for base ground emergency medical services. The revenue generated by the QAF collections will be deposited directly into the Medi-Cal Emergency Medical Transportation Fund (MEMTF).~~

ELIGIBILITY

1. Impact of SB 708 on Long-Term Care for Individuals with Unsatisfactory Immigration Status

   Section 4 of SB 708 (Chapter 148, Statutes of 1999) reauthorizes state-only funded long-term care for individuals with unsatisfactory immigration status 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 individuals with unsatisfactory immigration status 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~~ **members** 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~~ **members**. Because the number of undocumented immigrants receiving State-only long-term care has not increased above the number in the 1999-00 base year, no fiscal impact is expected due to the spending limit.

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AFFORDABLE CARE ACT

1. Realignment

   Under the Affordable Care Act, county costs and responsibilities for indigent care are expected to decrease as uninsured individuals obtain health coverage. The State, in turn will bear increased responsibility for providing care to these newly eligible ~~individuals~~ **members** 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~~ **members** 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.

BENEFITS

1. Child Health and Disability Prevention (CHDP)

   The CHDP program administered by the state and implemented by the counties provides Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) preventive health screening examinations (i.e., well child health assessments) and immunizations to Medi-Cal eligible children under 21 years of age and to the former non-Medi-Cal eligible children under 19 years of age whose family income was at or below 200% of the Federal Poverty Level (FPL).

   In May 2016, the passage of SB 75 expanded Medi-Cal for all income eligible children, including the former CHDP non-Medi-Cal population. All persons under 19 years of age who were eligible for state-only CHDP service (the former CHDP non-Medi-Cal population) were shifted to full-scope Medi-Cal and budgeted in the EPSDT Screens policy change. EPSDT costs now are captured in the Fee-For-Service base expenditures and the policy change was retired in the May 2020 Medi-Cal Local Assistance Estimate.

   The Department ~~will be sunsetting~~ **discontinued the** CHDP **program,** effective July 1, 2024. A transition planning process, including key stakeholders, commenced on September 22, 2022. ~~Transition planning will ensure~~ **The transition plan ensures** the successful continuity of ~~current~~ CHDP activities beyond July 1, 2024, as well as identify necessary supplemental administrative and fiscal resources necessary to replace ~~the~~ services **the** CHDP ~~currently performs~~ **program provided** for other **Medi-Cal** programs. The Department's ~~proposal~~ **transitions plan** preserves presumptive eligibility enrollment

activities currently offered through ~~the~~ CHDP Gateway. Further, ~~this proposal ensures~~ **the transition plan includes** the continuation of the Health Care Program for Children in Foster Care (HCPCFC) as a standalone program.

On July 1, 2024, the Department ~~will launch~~ **launched** the Children's Presumptive Eligibility **(CPE)** Program to replace ~~the~~ CHDP Gateway. The ~~Children's Presumptive Eligibility~~ **CPE** Program ~~will expand~~ **expanded** provider access to include all applicable Medi-Cal providers. The majority of children and youth under the age of 21 will be enrolled into ~~a~~ **an** MCP, through which they will receive all medically necessary services. This aligns with the Department's goal under CalAIM to reduce administrative complexities. T~~he proposal will also enhance~~ **This transition enhances** coordination of care and ~~increase~~ **increases** standardization of care across Medi-Cal by consolidating care responsibilities for children/youth under the Medi-Cal managed care plans.

2. Palliative Care Services Implementation

SB 1004 (Chapter 574, Statutes of 2014) requires the Department to:

- Establish standards and provide technical assistance for Medi-Cal managed care plans to ensure delivery of palliative care services;
- Establish guidance on the medical conditions and prognoses that render a beneficiary eligible for the palliative care services;
- Develop a palliative care policy that, to the extent practicable, is cost neutral to the General Fund on an ongoing basis;
- Define palliative care services; and
- Provide access to curative care for ~~beneficiaries~~ **members** eligible for palliative care.

Services are available concurrently with curative care and care is provided through a coordinated interdisciplinary team.

HOME & COMMUNITY BASED-SERVICES

1. No additional information.

BREAST AND CERVICAL CANCER TREATMENT

1. No additional information.

PHARMACY

1. No additional information.

INFORMATION ONLY

DRUG MEDI-CAL

1. Traditional Healers and Natural Helpers

   The Department proposes to add Traditional Healers and Natural Helpers as allowable provider types of DMC-ODS services when delivered by DMC-certified Indian Health Care Providers (IHCPs). IHCPs are limited to a health care program operated by the Indian Health Service (IHS), or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603). The purpose of this request is to support the Department's focus on advancing health equity and provide culturally appropriate options and improve access to SUD treatment for American Indians and Alaska Natives with SUD. In the CalAIM Section 1115 demonstration renewal request submitted June 30, 2021, DHCS requested that CMS grant expenditure authority as necessary for federal reimbursement for covered DMC-ODS services delivered to DMC-ODS ~~beneficiaries~~ **members** by Natural Helpers and Traditional Healers at DMC-certified IHCPs. CMS did not approve this request as part of their December 29, 2021 CalAIM Section 1115 demonstration approval. This proposal to add Traditional Healers and Natural Helpers is still contingent on CMS approval.

MENTAL HEALTH

1. Short-Term Residential Therapeutic Program/Qualified Residential Treatment Programs

   Congress enacted the Family First Prevention Services Act (FFPSA) on February 9, 2018. One of the intents of the FFPSA is to restrict the use of congregate care, unless absolutely necessary, by limiting Title IV-E maintenance payments to specific congregate care settings meeting defined requirements. The FFPSA added Qualified Residential Treatment Programs (QRTP) as one of those congregated care settings that may be used when specific criteria are met. In California, STRTPs are equivalent to QRTPs. QRTPs may be determined to meet criteria as an Institution for Mental Disease (IMD) in Title XIX, which prohibits federal reimbursement for covered services provided to ~~beneficiaries~~ **members** who are residents of an IMD. The Department wrote CMS and asked for STRTPs not to be considered as IMDs; CMS responded that it could not give this blanket approval, and would require the Department to individually assess each STRTP to determine if it is an IMD. The Department completed its assessments and determined that three facilities are IMDs. Pending approval and implementation of the SMI/SED Demonstration Waiver, the state anticipates receiving federal reimbursement for services provided to ~~beneficiaries~~ **members** in those STRTP facilities that are assessed to be IMDs, exempting STRTPs from the standard length of stay limitations for a two-year period.

2. 9-8-8 Crisis Line

   The National Suicide Hotline Designation Act of 2020 launched a national 9-8-8 suicide prevention and mental health crisis line on July 16, 2022, and gives authority for states to issue a fee to support state operations. Vibrant Health funded California to do

implementation planning in this fiscal year; funding was granted to the Department, and the Department in turn contracted with the Lifeline Call Centers, with Didi Hirsch as lead, to lead a stakeholder process that started on February 1, 2021 and ended on January 31, 2022, with a final report by February 15, 2022. The Department will fund crisis call centers with $20 million to support building capacity during the current fiscal year. In addition, the American Rescue Plan Act allows states to implement a new Medicaid benefit, Mobile Crisis Response Services, with an 85% federal match for the first three years of services for 12 quarters during the five year period starting April 2022. The interplay between this mobile crisis benefit and the 9-8-8 implementation is still to be determined.

1115 WAIVER—MH/UCD & BTR/WAIVER 2020

1. Waiver 2020 Negative Balance and Deferral Repayment

The Special Terms and Conditions (STC) of the California Medi-Cal 2020 Demonstration Waiver (Medi-Cal 2020) requires California's resolution of all existing negative Payment Management System (PMS) subaccount balances and deferred claims.

- Negative PMS subaccount balances: Pursuant to STC 164 of the Medi-Cal 2020 waiver, negative PMS subaccount balances for federal fiscal year (FFY) 2013 and prior must be resolved by the end of the Medi-Cal 2020 waiver period (December 31, 2021). California and the Centers for Medicare and Medicaid Services (CMS) continue to actively work toward the resolution of these negative PMS subaccount balances. In June of 2017, due to the progress made to date, the CMS waiver team verbally declared that the STC 164 requirements had been met and that they would be sending written confirmation. Written confirmation from CMS is still pending. STC 164 requires that, for any negative PMS subaccount balances remaining after June 30, 2017, CMS will issue a demand letter and require California to return sufficient funding to bring the PMS subaccount balances to $0. California has submitted adjustments to resolve a significant portion of the negative PMS subaccount balances via Quarters 1 and 2 of the 2016 grant year. If CMS disallows adjustments or claims, California will have the right to appeal them. STC 164 further requires that, for negative PMS subaccount balances identified in CMS' demand letter, California will need to repay CMS, in regular quarterly installments, with interest, by the end of the Medi-Cal 2020 waiver (December 31, 2021) or in three years from CMS' approval of California's repayment schedule, whichever is longer. Interest begins on the date of CMS' demand letter.

Repayment of deferred claims: Claims for which California has drawn down federal funding but CMS has deferred on or before June 30, 2017, CMS will issue a disallowance, triggering the appeal process. However, if the appeal is unsuccessful, California will be required to reimburse the federal funding. The deferred claims reimbursement will not be subject to interest. Some deferred claims contribute to the negative PMS subaccount balances, mentioned above, and may be liquidated through the negative PMS subaccount balance resolution. California is actively working to resolve these deferrals and the total federal funding reimbursement is unknown at this time. California will begin the FFY quarterly payments when the amounts are finalized.

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Ongoing deferred claims repayment: In the past, California has not returned federal funding on CMS deferred claims until after the deferred claim was officially disallowed. Pursuant to the STCs of the Medi-Cal 2020 waiver, California must begin complying with 42 Code of Federal Regulations 430.40, which requires the immediate repayment of federal funding for deferred claims while the deferral is being resolved. Upon its determination that the claim is allowable, CMS will release the funding and allow California to utilize the federal funding. CMS disallowances fluctuate quarter to quarter, resulting in an unpredictable federal fund repayment amount.

The County Administration CMS Deferred Claims policy change will be deactivated until funds are available in the ADM-16 account to be reclaimed, of which $8.21 million remains.

MANAGED CARE

1. CalAIM – Managed Care SMHS Carve-Out

Specialty Mental Health Services (SMHS) benefits are currently within the scope of certain Medi-Cal managed care plans in two counties (Partnership in Solano, for certain enrollees, and Kaiser in Sacramento). Effective ~~no sooner than July 1, 2023~~ **January 1, 2025**, the SMHS benefits will be **fully** carved out from these managed care plans' responsibility and be provided through the Behavioral Health delivery system.

PROVIDER RATES

1. No additional information.

SUPPLEMENTAL PAYMENTS

1. Capital Project Debt Reimbursement

In February 2014, Los Angeles County requested reimbursement of a $322 million bond project for the Construction, Renovation and Reimbursement Program (CRRP). The project was completed in April 2014.

The Department determined Los Angeles County's Harbor UCLA Surgery Emergency Replacement project was eligible under the CRRP and proceeded to provide CRRP supplemental reimbursement of $176M in allowable principal, with an effective date of April 1, 2018.

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

~~SPA 19-0009: The Department submitted SPA 19-0009 in March 2019, with a proposed effective date of January 1, 2019. The proposed SPA seeks to improve the health of low-income children by increasing their access to needed vision services by providing~~

~~comprehensive eye exams, corrective lenses, and frames at school sites. In addition, CMS has indicated that the Department has the option to restructure how school-based services are written into the State Plan and remove any duplicative or unnecessary State Plan language. This new approach also includes removing references to all licensing, credentialing and supervision practitioner requirements for the LEA Program in SPA 19-0009. SPA-19-0009 is currently under Department review.~~

COVID-19

1. No additional information.

OTHER: AUDITS AND LAWSUITS

1. Managed Care Potential Legal Damages

   Three health plans filed lawsuits against the Department challenging the Medi-Cal managed care rate-setting methodology for rate years 2002 through 2005. The cases are referred to as:

   - *Health Net of California, Inc. v. DHCS*
   - *Blue Cross of California, Inc., dba Anthem Blue Cross v. DHCS*
   - *Molina Healthcare of California, Inc., v. DHCS*

   On June 13, 2011, judgment was issued in favor of Plaintiffs in the Health Net, Blue Cross, and Molina Healthcare cases. In all of the cases, the trial court determined that the Department had breached its contract with the managed care plans for the years in question. On November 2, 2012, the Department and Health Net entered into a settlement agreement resolving the Health Net lawsuit. Similarly, the Department has entered into settlement agreements with Blue Cross and Molina in mid/late 2013. The amount of payment due is contingent on each plan's profits, and the settlement accounting is scheduled to occur as follows, subject to applicable run-out and reconciliation periods provided in the settlement terms, and contractual risk corridor calculations: *Molina* (January 1, 2018); *Blue Cross* (January 1, 2019); *Health Net* (January 1, 2020).

2. ~~MALDEF, et al. Title VI Administrative Complaints; Analina Jimenez Perea, et al., v. et al., *Deuschel v. CHHS et. al.*~~

   ~~On December 15, 2015, the Mexican American Legal Defense and Educational Fund (MALDEF), the National Health Law Program (NHeLP), and several other advocacy groups filed an administrative complaint with the U.S. Department of Health & Human Services' Office for Civil Rights (DHHS OCR) pursuant to Title VI of the 1964 Civil Rights Act. The groups allege, on behalf of several Medi-Cal beneficiaries, that inadequate Medi-Cal reimbursement rates, coupled with the Department's failure to ensure timely access to services, constitute discrimination against the Latino population. They seek a finding from DHHS OCR that the Department's reimbursement rates violate Title VI and an order requiring the Department to raise the rates. On December 22, 2015, MALDEF sent a copy of~~

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the administrative complaint to the attention of CHHS Secretary Diana Dooley and Department Director Jennifer Kent, along with a cover letter citing the Department's regulations governing Title VI complaint investigations. The letter demands immediate action from the Department to raise reimbursement rates and improve monitoring of access. There has been no DHHS OCR activity known to the Department since the administrative complaint was filed.

On July 12, 2017, five individuals and three organization filed a class action suit (Perea, et al.) against CHHS and DHCS in Alameda County Superior Court seeking injunctive relief against the same Medi-Cal reimbursement and access policies identified in the above described Title VI Administrative Complaints. Plaintiffs allege that the Department's failure to provide adequate access to providers disparately impacts Latinos. Plaintiffs allege that Medi-Cal is "disproportionately and majority Latino," and that while all beneficiaries receive poorer treatment than whites covered by other insurance plans (such as Medicare and employer-provided insurance), Latinos are impacted more than other non-Latino Medi-Cal beneficiaries. They also allege that administrative burdens in the Medi-Cal program hinder access to "meaningful" health care. Plaintiffs also contend that the Department fails to monitor Medi-Cal beneficiaries' access to health care services, and fails to ensure managed care plans have adequate networks of providers. Finally, plaintiffs contend that as the percentage of Latino Medi-Cal beneficiaries has increased, the Department has "disinvested" in the Medi-Cal program by reducing Medi-Cal rates relative to Medicare. All of these acts, plaintiffs contend, have disparately impacted Latinos, and constitute purposeful discrimination.

Plaintiffs allege violations of Government Code section 11135 (prohibiting discrimination in state programs), and the California Constitution, Articles I and IV (equal protection, substantive due process). Plaintiffs seek injunctive relief as taxpayers, under California Code of Civil Procedure section 526a, and seek a writ of mandate under Code of Civil Procedure section 1085. Plaintiffs contend that the Department's actions also violate federal Medicaid statutes, including 42 U.S.C. section 1396b (m)(1)(a)(i), and 42 U.S.C. section 1396a(a)(30)(A). Plaintiffs do not seek monetary relief for any of the individual plaintiffs. Rather, they are seeking an order requiring the Department to increase the rates it pays to Medi-Cal providers. On April 12, 2018, the court sustained the Department's demurrer but granted Plaintiffs leave to amend their complaint. Plaintiffs filed their first amended complaint on May 18, 2018, and the Department demurred on June 20, 2018. On September 21, 2018, the court sustained the Department's demurrer to the first amended complaint but granted Plaintiffs leave to amend. Plaintiffs filed their second amended complaint on October 29, 2018, and the Department demurred on November 30, 2018. On January 31, 2019, the court again sustained the Department's demurrer with leave to amend. On June 21, 2019, the court overruled the Department's demurrer allowing the case to continue to discovery. The Department filed its answer to the third amended complaint on August 30, 2019. Discovery had commenced, but was later stayed under multiple stipulations due to the COVID-19 public health emergency. The stay was lifted on April 9, 2021, and discovery is continuing. The Department filed a Motion for Judgment on the Pleadings (MJOP) which was heard on December 17, 2021. The parties stipulated to continue the class certification motion deadline until after the MJOP is decided. On March 9, 2022, the court granted the Departments' MJOP with respect to plaintiffs' disparate impact claim, but allowed plaintiffs' other claims to advance. On June 8, 2022, the court of appeal

~~denied plaintiffs' writ petition seeking review of the court's dismissals of the disparate impact claim. On June 29, 2022, plaintiffs filed a request for dismissal of their disparate treatment, substantive due process, and derivative claims, and the court entered judgment dismissing those claims without prejudice on the same day. On August 29, 2022, petitioners filed a Notice of Appeal. Appellants filed the Opening Brief on February 14, 2023. The Department filed the respondents' brief on May 15, 2023. On August 4, 2023, the court granted two applications (the National Health Law Program and the Impact Fund and thirteen additional civil rights organizations) for leave to file an amicus curiae brief. On September 18, 2023, the Department filed a combined answer to the amici briefs. The parties await a hearing date which is likely to be Spring of 2024.~~

3. **Analina Jimenez Perea, et al., v. et al.**

   On July 12, 2017, five individuals and three organizations filed a class action suit against California Health and Human Services and the Department of Health Care Services (the Department) in Alameda County Superior Court seeking injunctive relief. Plaintiffs allege that the Department's failure to provide adequate reimbursement to providers discriminates against Latino Medi-Cal members. Plaintiffs allege that Medi-Cal is "disproportionately and majority Latino," and that while all members receive poorer treatment than whites covered by other insurance plans (such as Medicare and employer-provided insurance), Latinos are impacted more than other non-Latino Medi-Cal members because they are the majority. They contend that as the percentage of Latino Medi-Cal members has increased, the Department has "disinvested" in the Medi-Cal program by reducing Medi-Cal rates relative to Medicare.

   On November 19, 2021, the Department filed a Motion for Judgment on the Pleadings. On March 9, 2022, the court issued its order granting the Department's motion as to the petitioner's disparate impact claim but denying it as to the intentional discrimination and substantive due process claims. On May 6, 2022, petitioners filed a writ of petition to the Court of Appeal challenging the adverse ruling on the disparate impact claim and challenging the order sustaining the Department's demurrer. On June 8, 2022, the 1st District Court of Appeal denied the writ. On June 29, 2022, plaintiffs requested dismissal of the remaining claims for disparate treatment and substantive due process which the court granted without prejudice and issued judgment. On August 29, 2022, petitioners filed a Notice of Appeal.

   On May 29, 2024, the Court of Appeal for the first Appellate District issued a unanimous decision affirming the trial court's dismissal of plaintiffs' disparate impact claims. On July 8, 2024, the plaintiffs filed a petition for review with the California Supreme Court.

4. Hinkle, et al. v. Kent, et al.

   Plaintiffs (individual Medi-Cal members and other similarly situated individuals) and Plaintiff California Council of the Blind allege that the Defendants (including the Department, Alameda County, Contra Costa County, and San Diego County) have failed to provide effective communication to blind individuals, by neglecting to identify and track people who

need alternative, accessible formats and neglecting to respond appropriately to requests for alternative, accessible formats. These failures allegedly denied Plaintiffs and other putative class members' critical information about their health benefits, discriminate against them on the basis of their disabilities, and violate their due process rights under the United States Constitution. Plaintiffs seeks certification of the class action, a declaration from the court that all Defendants are in violation of Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act, the California Unruh Civil Rights Act, and other California statutes and implementing regulations. Plaintiffs also seek injunctive relief ordering Defendants to comply with the law and to: 1) provide all information provided to Medi-Cal applicants and members to Plaintiffs and similarly situated individuals in their requested alternative format; and 2) in consultation with Plaintiffs, develop a plan that includes any policy changes necessary for a durable remedy.

Plaintiffs filed their Complaint on October 22, 2018. Initial disclosures and an answer to the Complaint were filed on February 1, 2019. ~~Settlement discussions and mediation are ongoing.~~ **Settlement discussions and mediation have been taking place over the last several years, and the parties are close to executing a settlement agreement. The parties also negotiated attorney fees, and the Department has agreed to pay Plaintiffs $1.55 million.**

5. Kent v. Phillip

The Department filed an estate recovery complaint to recover capitation payments made on behalf of a Medi-Cal members, consistent with state and federal policy. In response, the member's heirs filed a **class action** cross-complaint in San Luis Obispo Superior Court alleging the Department only has authority to recoup the costs of actual services rendered, and not the cost of capitation payments made on behalf of members enrolled in Medi-Cal managed care. ~~The cross-complaint was subsequently amended to include similarly situated individuals.~~ On January 16, 2019, the court denied the Department's motion for judgement on the pleadings. On October 27, 2021, the court denied the Department's ~~Motion~~ **motion** for ~~Summary Judgement~~ **summary judgment**, and the Department filed a writ petition, which the Court of Appeal summarily denied. Subsequently, a class action was certified, and the parties stipulated to consolidate the trial and hearing on writ of mandate. ~~Per the stipulation, the case is to be decided at a hearing on March 26, 2024, unless the Court determines it needs additional evidence at that time. The Department received the opening brief on December 13, 2023. The response brief was due on February 9, 2024.~~ **On June 7, 2024, the Court held that under Welfare and Institutions Code section 14009.5, the Department can only recoup the value of actual services rendered and cannot recover capitation payments. On July 1, 2024, the Court determined that its interpretation of section 14009.5 applied retroactively and requires the Department to reprocess all past and present estate recovery claims. The parties are presently awaiting entry of judgment. The Department will appeal the ruling.**

6. Avenal Community Health Center, et al. v. Michelle Baass, et al.

This case was originally designated as Community Health Center Alliance, et al. v. Will Lightbourne, et al. On October 29, 2020, the Community Health Center Alliance for Patient Access (CHCAPA) and its constituent Federally Qualified Health Center (FQHC) members

sued the Department and Director Lightbourne in the Eastern District Court of California. Plaintiffs' Complaint alleges that the Department's transition of the pharmacy benefit from Medi-Cal managed care to the Medi-Cal Rx fee-for-service delivery system will prevent FQHCs from receiving the full extent of the cost-based Prospective Payment System (PPS) reimbursement for pharmacy services mandated under federal law. Plaintiffs seek to enjoin the implementation of the Medi-Cal Rx transition, along with the State's extension of the Medi-Cal 2020 demonstration project (which authorizes managed care generally) on procedural grounds.

Plaintiffs contend that the primary impact of the transition of the pharmacy benefit from Medi-Cal managed care to Medi-Cal Rx on FQHCs will be to deprive California FQHCs of the opportunity to profit on their drug sales to Medi-Cal managed care plans, which FQHCs purchase at discounted 340B rates. Furthermore, Plaintiffs claim that other aspects of the State's PPS reimbursement to FQHCs violate federal law, particularly for FQHCs who decide to "carve-in" the costs of pharmacy services to their PPS rate. In this regard, Plaintiffs allege that the inflation-based growth rate for PPS rates will prevent FQHCs from receiving adjustments to their PPS rate to account for increases in pharmaceutical costs that exceed inflation, and that California's process for adjusting PPS rates violates federal law by limiting those adjustments to 80 percent of the per visit increase in costs.

On November 9, 2020, Plaintiffs filed a Motion for Temporary Restraining Order (TRO), seeking to enjoin the implementation of Medi-Cal Rx on January 1, 2021. Then, on November 16, 2020, the Department announced that it was deferring implementation of Medi-Cal Rx transition until April 1, 2021. On November 24, 2020, the Court denied Plaintiffs' TRO Motion without a hearing. Thereafter, on December 15, 2020, the Court ordered the Department to file its Motion to Dismiss and Plaintiffs to file its Motion for Preliminary Injunction on December 24, 2020.

On February 17, 2021, the Department announced it was postponing the prior April 1, 2021, effective date for the Medi-Cal Rx transition (to a later effective date to be subsequently determined).

On March 9, 2021, the court held a hearing on the Department's Motion to Dismiss and Plaintiffs' Motion for Preliminary Injunction. In a ruling from the bench, the court granted the Department's Motion to Dismiss, without prejudice, in light of the postponed effective date and the still pending federal administrative process associated with the transition and denied the Plaintiffs' motion on mootness grounds.

On December 29, 2021, the federal Centers for Medicare and Medicaid Services (CMS) announced its approval of the State's CalAIM Section 1915(b) waiver, including the transition of pharmacy coverage from managed care to the fee-for-service delivery system. As a result, on December 30, 2021, plaintiffs filed an amended complaint against both the Department and CMS seeking to enjoin the Medi-Cal Rx transition. On January 10, 2022, the court denied Plaintiffs' motion for a temporary restraining order. The Department filed a motion to dismiss on February 8, 2022. On July 17, 2023, the District Court granted defendants' Motions to Dismiss. The court found that CMS's determinations and approvals were not arbitrary and capricious. With the dismissal of the underlying claims, the court also granted dismissal of the purported claim for declaratory relief. The defendants' Motions to

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Dismiss were granted without leave to amend. Plaintiffs appealed the dismissal and filed their opening brief on December 26, 2023. The Departments' answering brief is due on March 25, 2024. On January 29, 2024, CHCAPA filed a motion to dismiss its appeal. Only CHCAPA requested dismissal, and the FQHC members will remain appellants in the appeal. On February 1, 2024, CHCAPA's motion was granted, and the case was redesignated as Avenal Community Health Center, et al v. Michelle Baass, et al.

7. Angel Care Enterprises, Inc. Dba Cole Home v. CDPH et al.

   On January 5, 2023, Cole Home filed a petition for writ of mandate pursuant to Code of Civil Procedure section 1085. The petitioner alleges that it was not paid for Medi-Cal services provided to its clients from March 12, 2020, to April 21, 2021, which was allegedly improperly decertified. These payments total over $643,336. Cole Homes wants the Departments to rescind their prior decertification, from March 12, 2020, to April 21, 2021, and process and pay its claims from the period during which it was decertified.

8. AHMC Anaheim Regional Medical Center, et al. v. DHCS, et al.

   On April 13, 2022, 31 California hospitals filed a petition for writ of mandate under California Code of Civil Procedure section 1085 challenging the Department's payments to hospitals for inpatient services under the All Patients Refined Diagnosis Related Groups (APR-DRG) methodology. Under APR-DRG, some hospitals receive cost outlier payments, which are add-on payments to the APR-DRG base payment for hospital stays that are exceptionally expensive. Petitioners assert that the Department failed to follow procedural requirements prior to implementing this methodology, exceeded statutory authority and failed to ensure the APR-DRG program, including outlier payments, remained budget neutral. Prior to filing their writ petition, Petitioners filed approximately 30 administrative appeals with the Department's Office of Administrative Hearings and Appeals (OAHA) wherein they disputed the Department's implementation of APR-DRG and the outlier policy. Appeals that reached the formal appeal level were dismissed by OAHA for lack of jurisdiction or withdrawn by the Petitioners. On May 24, 2022, petitioners filed an Amended Verified Writ Petition and Complaint adding an allegation that the challenged policy is arbitrary and capricious. On May 1, 2023, the court overruled the Department's demurrer The next court ordered Informal Discovery Conference (IDC) is set for January 10, 2024. At the previous IDC, the Department agreed to produce aggregate reports but rejected petitioner's demand for paid claims data. A hearing on the writ petition is scheduled for August 14, 2024.

9. Joe Leighkendall v. Department of Health Care Services, et al.

   On May 14, 2020, a lawsuit was filed against the Department and the Director, by a Medi-Cal FFS member. Plaintiff alleges that the Director and the Department failed to provide them with Non- Medical Transportation (NMT) services, or alternatively, mileage reimbursement, thus forcing a delay in necessary medical care. Plaintiff appealed the denial of NMT at a state fair hearing and subsequent rehearing. This Petition challenges the rehearing decision on the grounds of prejudicial abuse of discretion.

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Plaintiff seeks an administrative writ of mandate pursuant to Code of Civil Procedure (CCP) section 1094.5 either ordering the Director to authorize NMT reimbursement or provide them with necessary transportation, or to set aside the hearing decision and remand for a new hearing. Additionally, Plaintiff seeks a writ of mandate pursuant to CCP section 1085 ordering the Department and the Director to ensure access to NMT to all members, including but not limited to, mileage reimbursement. Given the number of inquiries received from members and attorneys regarding the NMT benefit and mileage reimbursement, the potential for this lawsuit to evolve into a class action is high. On August 28, 2020, the Department filed its Answer with the Sacramento County Superior Court. The Department prepared and disseminated the Administrative Record shortly thereafter.

The court issued its ruling on January 30, 2024, agreeing with Plaintiff that the Department violated its duty to provide FFS members with access to and reimbursement for NMT services and ordered the Department to comply. While the Department has discretion to develop and implement its programs, the Department must report to the court by the end of March detailing steps taken to comply with the order. **The Department submitted the report to the court, and the parties are negotiating attorney fees.**

10. ~~Yalung v. Department of Health Care Services, et al.~~

~~The complaint asserts that the Department and California Department of Social Services (CDSS) are vicariously liable as employers for the wrongful actions of a Medi-Cal In-Home Supportive Services (IHSS) provider who was driving while providing IHSS and crashed into a car carrying a family.~~

~~Appellants appealed the Tulare County Superior Court's order sustaining a demurrer to the vicariously liability cause of action without leave to amend. In Respondents' brief, the Department and CDSS argue that the ruling on the demurrer was appropriate because the Department and CDSS are not employers of IHSS workers for the purpose of injuries from IHSS provider negligence and criminal acts, and that they are statutorily immune from liability for administration of the IHSS program. Oral argument was held on December 14, 2023. The case was decided in the Departments' favor and Appellants have sought review by the California Supreme Court.~~

11. Ocean S. v. County of Los Angeles, et. al.

Plaintiffs are several individuals ages seventeen to twenty who are either in extended foster care or will be in extended foster care in Los Angeles County and purport to be a representative class for a class action lawsuit. The Department, the California Health and Human Services Agency (CHHSA), the California Department of Social Services (CDSS), and Los Angeles County (including the Department of Children and Family Services, and Department of Mental Health) are also named as defendants, including the respective directors of these entities.

Plaintiffs primarily allege that the County of Los Angeles did not provide sufficient support and placement settings to transition age foster youth. The Department is named as a defendant to the extent that Plaintiffs and similarly situated members of the class do not

have access to behavioral health services covered under Medicaid/Medi-Cal and have been placed in more restrictive settings than is necessary for their condition **("Medicaid Act claim," "Integration Mandate (Olmstead) claim," and "general discrimination/methods of administration claim").** Plaintiffs are seeking declaratory relief, preliminary and permanent injunctive relief, and attorneys' fees and costs.

On September 21, 2023, Plaintiffs served a First Amended Complaint. The Department, CHHSA, CDSS, and the County of Los Angeles filed motions to ~~dismiss the complaint on November 29, 2023~~. **With respect to the Department, the motion to dismiss: (1) the Medicaid Act claim was granted with leave to amend; (2) the Integration Mandate (Olmstead) claim was granted with leave to amend; and (3) the general discrimination/methods of administration claim was denied. The court also determined that as to one of the named plaintiffs (Monaie T.), the First Amended Complaint did not plead sufficient facts to demonstrate that the plaintiff has a disability.**

Los Angeles County filed a motion to certify for appeal the court's order denying its motion to dismiss for lack of subject matter jurisdiction. This motion is calendared for a hearing on September 16, 2024. Plaintiffs have until August 12, 2024, to file a Second Amended Complaint to address the insufficient pleadings for the claims that have been dismissed.

~~The Departments' reply brief to Plaintiffs' opposition is due February 20, 2024. The motions to dismiss will be heard by the court on March 25, 2024.~~

12. **Wise v. Humboldt County Board of Supervisors et al.**

Petitioner is a Medi-Cal member and resident of Humboldt County. Petitioner has complex mental health needs that require psychotherapy and medication management. Petitioner sought specialty mental health services (SMHS) from the Humboldt County Mental Health Plan (MHP) on several occasions from 2021 to 2023. Petitioner claims that the MHP placed her on waitlists to receive services. The Petitioner alleges she never reached the top of the waitlists and went without medically necessary services for over eighteen (18) months. Petitioner filed an appeal with the MHP and then filed a State Fair Hearing (SFH). During the SFH proceedings, the MHP identified available providers to treat Petitioner. On March 17, 2023, the Department adopted the Administrative Law Judge's decision to dismiss in part and deny in part Petitioner's claim.

Petitioner claims in her Petition for Writ of Administrative Mandate (Code Civ. Proc. §§ 1085, 1094.5) that the Humboldt County MHP failed to provide medically necessary services in a timely manner; failed to record requests for specialty mental health services; and failed to issue a notice of adverse benefit determination. She also claims that the MHP continues to maintain a network that fails to comply with network adequacy standards. As against the Department specifically, Petitioner alleges the Departments' adoption of the SFH decision on her claims constitutes a prejudicial

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abuse of discretion, and that the Department has failed to adequately monitor the MHP.

On June 7, 2024, the Petitioner filed her First Amended Petition alleging the same causes of action against the Department.

13. ~~K.M. v. County of Los Angeles, et al.~~

~~Plaintiff is a nineteen-year-old with mental health disabilities who is in the County of Los Angeles' extended foster care program, and who is a dependent of the Los Angeles County Superior Court. The Department, the California Department of Social Services (CDSS), the County of Los Angeles, and College Hospital (a free-standing, non-profit psychiatric hospital) are named as defendants, among others. Plaintiff claims that, throughout the years, the Department did not provide necessary health care services to Plaintiff, including intensive mental health and behavioral health services.~~

~~On June 7, 2023, defendant Los Angeles County filed for removal to federal court. The case has now been assigned to Central District of California, District Judge George Wu. On June 14, 2023, the Deputy Attorney General filed a motion to dismiss on behalf of the Department. On August 10, 2023, the court heard arguments on the motion to dismiss. The court granted the Departments' motion to dismiss, allowing Plaintiff leave to amend their first cause of action and dismissing Plaintiff's sixth cause of action with prejudice.~~

~~On September 13, 2023, Plaintiff filed their Second Amended Complain, and then a Third Amended Complaint on October 30, 2023. The Departments' motion to dismiss the Third Amended Complaint was heard on January 4, 2024. The court granted the Departments' motion to dismiss the Third Amended Complaint, but granted Plaintiff leave to amend their complaint. Plaintiff filed a Fourth Amended Complaint on February 2, 2024. Plaintiff dropped all causes of action against the Department in their Fourth Amended Complaint.~~

14. **Audit of California Department of Health Care Services Capitation Payments (A-04-21-07097)**

The Office of Inspector General (OIG) conducted an audit to determine if California made unallowable capitation payments on behalf of ~~beneficiaries~~ members with multiple Client Index Numbers (CINs). Based on OIG's sample results, California made unallowable capitation payments totaling approximately $31.4 million ($15.7 million Federal share) on behalf of members who had multiple CINs during the audit period of July 1, 2015, through June 30, 2019.

As of December 31, 2022, the Department repaid $15,722,587 and continues to review capitation payments outside of OIG's audit period. The Department will refund any unallowable payments identified, but any amounts to be repaid and the timing of repayments is currently unknown.

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OTHER: REIMBURSEMENTS

1. Federal Upper Payment Limit

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

2. Accrual Costs Under Generally Accepted Accounting Principles

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

3. Refund of Recovery

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

4. Payment Deferrals

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

OTHER: RECOVERIES

1. Recovery Audit Contractor (RAC)

   Title 42 Code of Federal Regulations Section 455.500 through 455.518 requires that States enter into contract with one or more RACs for the purpose of identifying underpayments and overpayments and recouping overpayments. The RAC Program's mission is to reduce improper Medi-Cal payments through the efficient detection and collection of overpayments,

the identification of underpayments, the reporting of fraudulent and/or criminal activities, and the implementation of actions that will prevent future improper payments.

State Plan Amendment (SPA) 20 – 0017 provided the Department exemption from contracting with a RAC through February 1, 2022. Effective February 1, 2022, CMS approved SPA 21-0067 to establish a new RAC. The ~~new~~ **previous** RAC contract ~~is~~ **was** effective from July 1, 2021, to June 30, 2024. **The new RAC contract is effective from July 1, 2024, to June 30, 2027.** The RAC will be paid on a contingency basis determined by the amounts recovered from overpayments identified, and the refunded amounts of identified underpayments not to exceed the contract amount of $3 million **without a contract amendment to increase the contract amount**.

OTHER: MISCELLANEOUS

1. Vital Records

The Department has two contracts with CDPH to obtain vital records data. One contract allows the Department to obtain electronic data files of birth, death, and fetal death records from CDPH. The second contract allows the Third Party Liability Recovery Division, the Audits & Investigations Division, and the Medi-Cal Eligibility Division to request certified copies of birth, death, marriage, divorce, and fetal death records of Medi-Cal ~~beneficiaries~~ **members** from CDPH. The Department may amend the contract for certified copies to include other divisions as appropriate.

2. Electronic Visit Verification

Electronic Visit Verification (EVV) is a telephone and computer-based method that electronically verifies in-home service visits. EVV systems must verify type of service performed; individual receiving the service; date of the service; location of service delivery; individual providing the services; and time the service begins and ends. Section 1903 of the SSA [42 U.S.C. 1396b(l)] requires all states to implement EVV for Medicaid-funded Personal Care Services (PCS) and Home Health Care Services (HHCS) that require an in-home visit by a provider. In California, EVV impacts all PCS and HHCS provided under the Medi-Cal state plan and under several Medicaid waiver programs, including those Medicaid programs administered by the Department, CDSS, the California Department of Developmental Services (CDDS), the California Department of Aging (CDA), and the California Department of Public Health (CDPH).

The State implemented two EVV systems, EVV Phase I known as Case Management Information and Payrolling System (CMIPS) and EVV Phase II known as California Electronic Visit Verification (CalEVV). CMIPS was implemented on July 1, 2023 via the existing CMIPS for PCS with a self-directed model and primarily impacts self-directed In-Home Supportive Services and Waiver Personal Care Services. CalEVV for PCS was implemented on January 1, 2022, and January 1, 2023 for HHCS, via a new ~~California Electronic Visit Verification (~~CalEVV~~)~~ solution for PCS and HHCS with an agency model. This model includes all PCS and HHCS provided under all Medicaid authorities, including

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the State Plan, and waiver programs administered by the Department, DDS, CDA, CDSS, and CDPH.

FISCAL INTERMEDIARY: MEDICAL

1. No additional information.

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

1. No additional information.

FISCAL INTERMEDIARY: DENTAL

1. State Controller's Office Interagency Agreement

   The Department initiated an interagency agreement with the State Controller's Office (SCO) in FY 2016-17 to transition checkwrite services away from the Fiscal Intermediary (FI). Due to competing priorities, the Department put this project on hold. The Department initially planned to restart this work in FY 2017-18. However, due to lack of resources to fully support the project, a pending enterprise solution to the Federal Drawdown Reporting (FDR) system, as well as no legal mandate to transition the services at the time, the Department halted the project until the FDR could be properly implemented.

   The Department does intend to work in the future with the SCO to alter the current check write function, which the FI is currently responsible for. The FI will continue to fulfill duties related to checkwrite until a new process has been implemented between the SCO and the Department. This complex effort will require multiple phases in order to alter the current system to allow for SCO takeover of the check write function. Costs to consider in the future pertain to analyzing business processes, system testing, updating the CD-MMIS and enabling the SCO systems the ability to perform the check write function.

DISCONTINUED POLICY CHANGES

Fully Incorporated into Base Data/Ongoing

ELIGIBILITY
PC 1 Undocumented Expansion Ages 26 Through 49
PC 2 Postpartum Care Extension
PC 5 Phasing In The Medi-Cal Asset Limit Repeal

AFFORDABLE CARE ACT
Not applicable.

BENEFITS
PC N/A CYBHI – Dyadic Services Base Adjustment
PC 29 Doula Benefit
PC 229 Biomarker Testing
PC 230 Pharmacogenomic Testing

HOME & COMMUNITY-BASED SERVICES
Not applicable.

BREAST AND CERVICAL CANCER
Not applicable.

PHARMACY
Not applicable.

DRUG MEDI-CAL
Not applicable.

MENTAL HEALTH
Not applicable.

1115 WAIVER—MH/UCD & BTR
Not applicable.

MANAGED CARE
Not applicable.

PROVIDER RATES
PC 103 AB 97 Eliminations
PC 108 Acupuncture Rate Increase
PC 117 Prop 56 — Physician Services Supplemental Payments

SUPPLEMENTAL PAYMENTS
Not applicable.

DISCONTINUED POLICY CHANGES

Fully Incorporated into Base Data/Ongoing

COVID-19
PC 148 COVID-19 Eligibility

OTHER: AUDITS AND LAWSUITS
Not applicable.

OTHER: REIMBURSEMENTS
Not applicable.

OTHER: RECOVERIES
Not applicable.

OTHER: MISCELLANEOUS
PC 236 CalAIM ICF/DD & Subacute Transition FFS Base Adj.
PC 183 Peer Support Specialist Services

FISCAL INTERMEDIARY: MEDICAL
Not applicable.

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS
Not applicable.

FISCAL INTERMEDIARY: DENTAL
Not applicable.

DISCONTINUED POLICY CHANGES

Time Limited/No Longer Available

ELIGIBILITY
Not applicable.

AFFORDABLE CARE ACT
Not applicable.

BENEFITS
Not applicable.

HOME & COMMUNITY-BASED SERVICES
Not applicable.

BREAST AND CERVICAL CANCER
Not applicable.

PHARMACY
Not applicable.

DRUG MEDI-CAL
Not applicable.

MENTAL HEALTH
PC 51 CalAIM – BH Quality Improvement Program

1115 WAIVER—MH/UCD & BTR
Not applicable.

MANAGED CARE
PC 26 CCS Demonstration Project
PC 86 Family Mosaic Capitated Case Mgmt (Oth. M/C)
PC 249 2023 MCO Tax Amendment– Medicare
PC 250 2023 MCO TAX – General Fund Offset
PC 233 Prop 56 – Value Based Payment Program
PC 85 – Prop 56 – Behavioral Health Incentive Program

PROVIDER RATES
PC 102 DPH Interim Rate COVID-19 Increased FMAP Adjust

SUPPLEMENTAL PAYMENTS
PC 135 Emergency Medical Air Transportation Act
PC 231 Prop 56 – Funding Reduction

DISCONTINUED POLICY CHANGES

Time Limited/No Longer Available

COVID-19
COVID-19 Increased FMAP – Other Admin
COVID-19 Increased FMAP – DHCS

STATE ONLY CLAIMING
Not applicable.

OTHER: AUDITS AND LAWSUITS
Not applicable.

OTHER: REIMBURSEMENTS
PC 202 Urban Indian Organizations Funding Shift

OTHER: RECOVERIES
Not applicable.

OTHER: MISCELLANEOUS
PC 197 CLPP Fund
OA PC 16 CHDP County Allocation
PC 251 Reconciliation – Benefits
OA 107 Reconciliation – Administration
PC 48 Gender-Affirming Care
OA 25 Care Act – Other Admin
OA 30 CalAIM MLTSS & D-SNP Integration Activities
PC 162 CalAIM – BH Payment Reform
PC 170 LA County Justice-Involved Pop. Svcs & Supports
OA 58 CMS Deferred Claims – Other Admin
PC 62 Medi-Cal 2020 Dental Transformation Initiative
PC 194 Proposition 56 – Provider ACEs Trainings
PC 212 CalAIM Dental Initiatives

FISCAL INTERMEDIARY: MEDICAL
Not applicable.

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS
Not applicable.

FISCAL INTERMEDIARY: DENTAL

DISCONTINUED POLICY CHANGES

Withdrawn

ELIGIBILITY
OA 43 Field Testing of Medi-Cal Materials
OA 104 Health Enrollment Navigators Reduction

AFFORDABLE CARE ACT
Not applicable.

BENEFITS
Not applicable.

HOME & COMMUNITY-BASED SERVICES
Not applicable.

BREAST AND CERVICAL CANCER
Not applicable.

PHARMACY
Not applicable.

DRUG MEDI-CAL
Not applicable.

MENTAL HEALTH
PC 57 Chart Review
PC 242 Behavioral Health Continuum Infra. Reduction

1115 WAIVER—MH/UCD & BTR
Not applicable.

MANAGED CARE
PC 246 IGT Admin Fee for the EPP and QIP
PC 237 COVID-19 Risk Corridor

PROVIDER RATES
PC 112 GDSP Prenatal Screening Program Fee Increase

SUPPLEMENTAL PAYMENTS
Not applicable.

COVID-19
Not applicable.

OTHER: AUDITS AND LAWSUITS
PC 204 Audit Settlements

DISCONTINUED POLICY CHANGES

Withdrawn

OTHER: REIMBURSEMENTS
Not applicable.

OTHER: RECOVERIES
Not applicable.

OTHER: MISCELLANEOUS
CA 9 Freeze Medi-Cal County Administration Increase
OA 54 Reproductive Health Access Demo 1115 Waiver
OA 101 Quality Sanctions
OA 103 LGBT Disparities Reduction Act (AB 1163)
PC 48 Gender-Affirming Care
PC 241 Behavioral Health Bridge Housing Reduction
PC 247 CYBHI – Evidence-Based BH Practices Reduction
PC 248 CYBHI – School BH Partnerships and Capacity Reduction
PC 252 Hope the Mission for Mobile Mental Health Equip.

FISCAL INTERMEDIARY: MEDICAL
Not applicable.

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS
Not applicable.

FISCAL INTERMEDIARY: DENTAL
Not applicable.