MEDI-CAL
MAY 2026
LOCAL ASSISTANCE ESTIMATE
for
FISCAL YEARS
2025-26 *and* 2026-27

The Great Seal

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

MEDI-CAL
MAY 2026
LOCAL ASSISTANCE ESTIMATE
for
FISCAL YEARS
2025-26 and 2026-27

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

GAVIN NEWSOM
Governor
State of California

Kim Johnson
Secretary
California Health and Human Services Agency

Michelle Baass
Director
Department of Health Care Services

MAY 2026 MEDI-CAL ESTIMATE

TABLE OF CONTENTS

The May 2026 Medi-Cal Local Assistance Estimate is organized into several sections, listed below.

REFERENCE DOCUMENTS

The following resources are included immediately following this table of contents, before the Management Summary section:

- Alphabetical List of Policy Changes
- Guide to Key Features of Regular Policy Changes

MANAGEMENT SUMMARY

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

CURRENT YEAR

The Current Year section provides a summary of medical assistance benefits (base and regular policy change) and local assistance administration (county and other administration policy changes) 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 benefits expenditures.

BUDGET YEAR

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

CASELOAD

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

FEE-FOR-SERVICE BASE

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

BASE POLICY CHANGES

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

REGULAR POLICY CHANGES

The Regular Policy Changes section provides detailed benefits expenditures information by policy according to program area. This section includes new program policies and other estimated expenditures that are not captured in the base expenditures. See the Guide to Key Features of Regular Policy Changes in the pages that follow for more information on how to interpret the information in Regular Policy Changes.

COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION

The County and Other Local Assistance 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 County and Local Assistance Administrative costs and Fiscal Intermediary (FI) costs associated with the processing of claims.

ADDITIONAL INFORMATION

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

Fiscal Reference Number	PC Name	Estimate Section	Page
1791	1% FMAP INCREASE FOR PREVENTIVE SERVICES	Regular PC	39
2407	2023 MCO ENROLLMENT TAX MANAGED CARE PLANS	Regular PC	173
2406	2023 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	Regular PC	171
2408	2023 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	Regular PC	146
2585	2027 MCO TAX CAPITATION PAYMENTS	Regular PC	446
2586	2027 MCO TAX FUNDING ADJUSTMENT - CAPITATION	Regular PC	448
2587	2027 MCO TAX FUNDING ADJUSTMENT – GENERAL SUPPORT	Regular PC	450
2591	2027 MCO TAX FUNDING ADJUSTMENT – TRI	Regular PC	457
1937	ACTUARIAL COSTS FOR RATE DEVELOPMENT	Admin	66
1476	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	Regular PC	317
63	AIDS HEALTHCARE CENTERS (OTHER M/C)	Base PC	54
2443	ASSET LIMIT INCREASE & ELIM. - CNTY BH FUNDING	Regular PC	365
2054	ASSISTED LIVING WAIVER EXPANSION	Regular PC	396
110	AUDIT SETTLEMENTS	Regular PC	423
2550	BACKFILL LOST TITLE X FAMILY PLANNING FUNDING	Regular PC	353
127	BASE RECOVERIES	Base PC	84
1433	BCCTP DRUG REBATES	Regular PC	83
2354	BEHAVIORAL HEALTH BRIDGE HOUSING	Regular PC	319
1855	BEHAVIORAL HEALTH TREATMENT	Regular PC	59
2491	BH TRANSFORMATION FUNDING FOR COUNTY BH DEPTS.	Admin	50
2414	BHSF - PROVIDER ACES TRAININGS	Admin	106
3	BREAST AND CERVICAL CANCER TREATMENT	Regular PC	13
2394	CALAIM - BH - CONNECT DEMONSTRATION	Regular PC	115
2398	CALAIM - BH - CONNECT DEMONSTRATION ADMIN	Admin	63
2332	CALAIM - INMATE PRE-RELEASE PROGRAM	Regular PC	11
2413	CALAIM - INMATE PRE-RELEASE PROGRAM ADMIN	Admin	121
2447	CALAIM - JUSTICE INVOLVED MAA	Admin	101
2389	CALAIM - PATH	Admin	18
2439	CALAIM - PATH WPC	Regular PC	341
2288	CALAIM - POPULATION HEALTH MANAGEMENT	Admin	55
2245	CALAIM ECM-COMMUNITY SUPPORTS-TRANSITIONAL RENT	Regular PC	141
2517	CALAIM-BH-CONNECT WORKFORCE INITIATIVE	Admin	48
1679	CALHEERS DEVELOPMENT	Admin	196
257	CALHHS AGENCY HIPAA FUNDING	Admin	220
2355	CALHOPE	Regular PC	362
1228	CALIFORNIA COMMUNITY TRANSITIONS COSTS	Regular PC	50
1680	CALIFORNIA SMOKERS' HELPLINE	Admin	218
217	CALWORKS APPLICATIONS	Admin	9
2581	CAP PACE RATES AT LOWER BOUND	Base PC	88
82	CAPITAL PROJECT DEBT REIMBURSEMENT	Regular PC	271
1318	CAPMAN	Admin	89
2396	CARE ACT	Regular PC	346
1598	CASE MANAGEMENT FOR OTLICP	Admin	10
2031	CCI-QUALITY WITHHOLD REPAYMENTS	Regular PC	167
230	CCS PROGRAM COUNTY ADMINISTRATIVE BUDGET	Admin	29
1562	CCT FUND TRANSFER TO CDSS	Regular PC	64
1556	CCT OUTREACH - ADMINISTRATIVE COSTS	Admin	146

May 2026 Medi-Cal Estimate
Alphabetic List of Policy Changes

Fiscal Reference Number	PC Name	Estimate Section	Page
243	CDDS ADMINISTRATIVE COSTS	Admin	202
2512	CELL AND GENE THERAPY ACCESS MODEL	Regular PC	69
2474	CHILDREN'S HOSPITAL SUPPLEMENTAL PAYMENT PROGRAM	Regular PC	169
1087	CIGARETTE AND TOBACCO SURTAX FUNDS	Regular PC	374
239	CLPP CASE MANAGEMENT SERVICES	Admin	216
2034	CMS DEFERRED CLAIMS	Regular PC	380
2123	CMS DEFERRED CLAIMS - OTHER ADMIN	Admin	151
2499	COMMUNITY CLINIC DIRECTED PAYMENT PROGRAM	Regular PC	163
1595	COMMUNITY FIRST CHOICE OPTION	Regular PC	35
1963	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	Admin	40
1704	COUNTY ADMINISTRATION ALLOCATION	Admin	4
2343	COUNTY BH RECOUPMENTS	Regular PC	402
1823	COUNTY CHILDREN’S HEALTH INITIATIVE PROGRAM	Base PC	52
2334	COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE	Admin	114
57	COUNTY ORGANIZED HEALTH SYSTEMS & SINGLE PLAN	Base PC	25
1906	COUNTY SHARE OF OTLICP-CCS COSTS	Regular PC	400
1721	COUNTY SPECIALTY MENTAL HEALTH ADMIN	Admin	21
2218	COVID-19 END OF UNWINDING FLEXIBILITIES	Regular PC	311
2363	COVID-19 VACCINE FUNDING ADJUSTMENT	Regular PC	309
86	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	Regular PC	292
2155	CS3 PROXY ADJUSTMENT	Regular PC	22
2289	CYBHI - BH SERVICES AND SUPPORTS PLATFORM	Admin	34
2424	CYBHI - FEE SCHEDULE THIRD PARTY ADMINISTRATOR	Regular PC	330
2375	CYBHI - URGENT NEEDS AND EMERGENT ISSUES	Regular PC	359
2457	CYBHI WELLNESS COACH BENEFIT	Regular PC	56
1902	DATA ANALYTICS	Admin	125
2006	DENTAL FI ADMINISTRATION 2016 CONTRACT	Admin	189
2380	DENTAL FI-DBO ADMIN 2022 CONTRACT	Admin	186
1029	DENTAL MANAGED CARE (OTHER M/C)	Base PC	45
135	DENTAL SERVICES	Base PC	68
253	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	Admin	213
256	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	Admin	204
2459	DESIGNATED STATE HEALTH PROGRAMS	Admin	153
77	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	Base PC	77
2572	DMPH GME IGT ADMIN. & PROCESSING FEE	Regular PC	428
1152	DPH INTERIM & FINAL RECONS	Regular PC	189
1162	DPH INTERIM RATE GROWTH	Regular PC	210
1078	DPH PHYSICIAN & NON-PHYS. COST	Regular PC	261
1724	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	Regular PC	111
1813	DRUG MEDI-CAL COUNTY ADMINISTRATION	Admin	45
2012	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	Base PC	3
2206	DRUG MEDI-CAL PARITY RULE ADMINISTRATION	Admin	117
1723	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	Regular PC	108
2320	DRUG MEDI-CAL STATE PLAN SERVICES	Base PC	7
1073	DSH PAYMENT	Regular PC	246
2002	ELECTRONIC ASSET VERIFICATION PROGRAM	Admin	97
2505	ELECTRONIC VISIT VERIFICATION M&O COSTS	Admin	81

Fiscal Reference Number	PC Name	Estimate Section	Page
2563	ELIMINATE DENTAL FOR ADULT UIS	Regular PC	390
2520	ELIMINATE GLP-1 COVERAGE FOR WEIGHT LOSS	Regular PC	92
2522	ELIMINATE MEDI-CAL OPTIONAL BENEFIT - ACUPUNCTURE	Regular PC	454
2536	ELIMINATE PPS FOR STATE-ONLY SERVICES	Regular PC	222
2402	EMSA - CALIFORNIA POISON CONTROL SYSTEM SVCS.	Admin	83
1835	ENHANCED FEDERAL FUNDING	Admin	16
252	ENTERPRISE DATA ENVIRONMENT	Admin	71
2562	EPTP - STATEWIDE LEARNING COLLABORATIVE	Admin	231
2346	EQUITY & PRACTICE TRANSFORMATION PAYMENTS	Regular PC	334
51	FAMILY PACT DRUG REBATES	Regular PC	85
1	FAMILY PACT PROGRAM	Regular PC	48
1675	FAMILY PACT PROGRAM ADMIN.	Admin	138
55	FEDERAL DRUG REBATES	Regular PC	102
2244	FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG	Admin	215
1192	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	Admin	211
104	FFP FOR LOCAL TRAUMA CENTERS	Regular PC	269
2541	FFS - CO. & COMM. OUTPATIENT	Base PC	108
2543	FFS - COMMUNITY INPATIENT	Base PC	96
2542	FFS - COUNTY INPATIENT	Base PC	105
2548	FFS - HOME HEALTH	Base PC	114
2545	FFS - ICF-DD	Base PC	120
2546	FFS - MEDICAL TRANSPORTATION	Base PC	117
2544	FFS - NURSING FACILITIES	Base PC	102
2539	FFS - OTHER MEDICAL	Base PC	93
2547	FFS - OTHER SERVICES	Base PC	99
2540	FFS - PHARMACY	Base PC	90
2538	FFS - PHYSICIANS	Base PC	111
1329	FQHC/RHC/CBRC RECONCILIATION PROCESS	Regular PC	194
2303	FREE CLINICS AUGMENTATION	Regular PC	298
2588	FULL REINSTATEMENT OF ASSET LIMIT	Regular PC	452
2530	FULL-SCOPE MEDI-CAL EXPANSION ENROLLMENT FREEZE	Regular PC	33
2184	GDSP NBS & PNS FEE ADJUSTMENTS	Regular PC	196
1661	GEMT SUPPLEMENTAL PAYMENT PROGRAM	Regular PC	306
58	GEOGRAPHIC MANAGED CARE	Base PC	31
1951	GLOBAL PAYMENT PROGRAM	Regular PC	137
2573	GRADUATE MEDICAL EDUCATION PAYMENTS TO DMPHS	Regular PC	430
2024	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	Regular PC	239
2081	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	Regular PC	185
2152	HCBA WAIVER ADMINISTRATIVE COST	Admin	85
2010	HCBA WAIVER EXPANSION	Regular PC	398
2052	HCO COST REIMBURSEMENT	Admin	182
2053	HCO ESR HOURLY REIMBURSEMENT	Admin	184
2051	HCO OPERATIONS	Admin	180
2455	HCPCFC ADMIN COSTS	Admin	209
246	HCPCFC CASE MANAGEMENT	Admin	206
2484	HEALTH CARE SVCS. FINES AND PENALTIES	Regular PC	387
2422	HEALTH ENROLLMENT NAVIGATORS FOR CLINICS	Regular PC	16

May 2026 Medi-Cal Estimate
Alphabetic List of Policy Changes

Fiscal Reference Number	PC Name	Estimate Section	Page
2159	HEALTH INFORMATION EXCHANGE INTEROPERABILITY	Admin	144
2438	HEALTH PLAN OF SAN MATEO DENTAL INTEGRATION EVAL	Admin	149
233	HEALTH-RELATED ACTIVITIES - CDSS	Admin	194
2189	HEARING AID COVERAGE FOR CHILDREN PROGRAM	Regular PC	62
91	HIPP PREMIUM PAYOUTS (MISC. SVCS.)	Base PC	82
2524	HIV/AIDS AND CANCER DRUG REBATES	Regular PC	79
23	HOME & COMMUNITY-BASED SVCS.-CDDS (MISC.)	Base PC	63
96	HOSPICE RATE INCREASES	Regular PC	206
78	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	Regular PC	258
1967	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	Regular PC	37
1821	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	Regular PC	42
1760	HOSPITAL QAF - CHILDREN'S HEALTH CARE	Regular PC	376
1475	HOSPITAL QAF - FFS PAYMENTS	Regular PC	231
1761	HOSPITAL QAF - MANAGED CARE PAYMENTS	Regular PC	236
2580	HR 1 - COUNTY ADMINISTRATION ALLOCATION	Admin	238
2575	HR 1 - DEATH MASTER FILE AUTOMATION	Regular PC	435
2555	HR 1 - FED WORK & COMMUNITY ENGAGEMENT REQUIREMENT	Regular PC	412
2567	HR 1 - HEALTH ENROLLMENT NAVIGATORS	Admin	237
2564	HR 1 - PROHIBITED ENTITIES SYSTEMS COSTS	Admin	236
2553	HR 1 - REDUCED RETROACTIVE MEDI-CAL TIMEFRAMES	Regular PC	407
2554	HR 1 - RESTRICTED FEDERAL FUNDING FOR CERTAIN QNCS	Regular PC	409
2551	HR 1 - UIS EMERGENCY ACA FMAP ADJUSTMENT	Regular PC	388
1526	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	Regular PC	355
1232	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	Regular PC	332
1601	IGT ADMIN. & PROCESSING FEE	Regular PC	303
35	IMD ANCILLARY SERVICES	Regular PC	369
1660	IMPERIAL AND SISKIYOU COUNTY MHP OVERPAYMENT	Regular PC	130
2569	IMPROVEMENTS AND EFFICIENCIES	Regular PC	421
111	INDIAN HEALTH SERVICES	Regular PC	349
2156	INDIAN HEALTH SERVICES FUNDING SHIFT	Regular PC	383
2009	INFANT DEVELOPMENT PROGRAM	Regular PC	351
1713	INTERIM AND FINAL COST SETTLEMENTS - SMHS	Regular PC	133
1757	INTERIM AND FINAL COST SETTLEMENTS-SMHS	Admin	26
249	KIT FOR NEW PARENTS	Admin	226
1703	LABORATORY RATE METHODOLOGY CHANGE	Regular PC	219
2080	LAWSUITS/CLAIMS	Base PC	74
1449	LITIGATION SETTLEMENTS	Regular PC	81
25	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	Regular PC	44
1784	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	Regular PC	212
213	LOS ANGELES COUNTY HOSPITAL INTAKES	Admin	12
1046	LTC RATE ADJUSTMENT	Regular PC	200
2437	MANAGED CARE DISTRICT HOSPITAL DIRECTED PAYMENTS	Regular PC	160
2061	MANAGED CARE HEALTH CARE FINANCING PROGRAM	Regular PC	148
2055	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	Regular PC	227
2448	MANAGED CARE PUBLIC DP-NF PASS-THROUGH PYMT PROG	Regular PC	165
2060	MANAGED CARE PUBLIC HOSPITAL EPP	Regular PC	150
2063	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	Regular PC	175

Fiscal Reference Number	PC Name	Estimate Section	Page
2576	MANAGED CARE RISK CORRIDORS	Regular PC	437
1899	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	Regular PC	265
234	MATERNAL AND CHILD HEALTH	Admin	200
2590	MCO TAX REVENUE TO SUPPORT MEDI-CAL	Regular PC	456
2558	MCP NETWORK ADEQUACY & TIMELY ACCESS SANCTIONS	Regular PC	405
2570	MEASLES, MUMPS, RUBELLA, VARICELLA (MMRV) VACCINES	Regular PC	426
1982	MEDCOMPASS SOLUTION	Admin	110
1797	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	Base PC	56
1837	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	Base PC	50
2029	MEDI-CAL COUNTY INMATE REIMBURSEMENT	Regular PC	26
2124	MEDI-CAL DRUG REBATE FUND	Regular PC	75
1441	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	Admin	136
2117	MEDICAL FI BO & IT CHANGE ORDERS	Admin	160
2115	MEDICAL FI BO & IT COST REIMBURSEMENT	Admin	156
2113	MEDICAL FI BO HOURLY REIMBURSEMENT	Admin	176
2114	MEDICAL FI BO MISCELLANEOUS EXPENSES	Admin	178
2112	MEDICAL FI BO OTHER ESTIMATED COSTS	Admin	168
2116	MEDICAL FI BO TELEPHONE SERVICE CENTER	Admin	171
2111	MEDICAL FI BUSINESS OPERATIONS	Admin	173
2119	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	Admin	164
2118	MEDICAL INFRASTRUCTURE & DATA MGT SVCS	Admin	166
1665	MEDI-CAL INPATIENT SERVICES FOR INMATES	Admin	221
2504	MEDI-CAL MANAGED CARE QUALITY WITHHOLD RELEASE	Regular PC	158
2097	MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG	Regular PC	337
2503	MEDICAL PROVIDER INTERIM PAYMENT LOAN	Regular PC	385
1551	MEDI-CAL RECOVERY CONTRACTS	Admin	68
1038	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	Regular PC	288
1039	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	Regular PC	290
2167	MEDI-CAL RX - ADMINISTRATIVE COSTS	Admin	37
2579	MEDI-CAL RX FRAUD, WASTE, & ABUSE PREVENTION	Regular PC	441
1569	MEDI-CAL STATE INMATE PROGRAMS	Regular PC	7
1181	MEDICAL SUPPLY REBATES	Regular PC	96
27	MEDI-CAL TCM PROGRAM	Base PC	79
2321	MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM	Admin	128
1019	MEDICARE PAYMENTS - PART D PHASED-DOWN	Base PC	65
76	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	Base PC	58
263	MERIT SYSTEM SERVICES FOR COUNTIES	Admin	228
2392	MFP/CCT SUPPLEMENTAL FUNDING	Admin	130
2062	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	Regular PC	153
1957	MHP COSTS FOR CONTINUUM OF CARE REFORM	Regular PC	124
2252	MHP COSTS FOR FFPSA	Regular PC	118
1975	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	Regular PC	344
2502	MISC. ONE-TIME PAYMENTS	Regular PC	357
1137	MITA	Admin	78
266	MMA - DSH ANNUAL INDEPENDENT AUDIT	Admin	142
2467	MOBILE VISION SERVICES	Admin	108
28	MULTIPURPOSE SENIOR SERVICES PROGRAM	Regular PC	54

Fiscal Reference Number	PC Name	Estimate Section	Page
1600	NDPH IGT SUPPLEMENTAL PAYMENTS	Regular PC	275
1076	NDPH SUPPLEMENTAL PAYMENT	Regular PC	281
1824	NEWBORN HEARING SCREENING PROGRAM	Admin	112
13	NON-OTLICP CHIP	Regular PC	18
2181	NURSING FACILITY RATE ADJUSTMENTS	Regular PC	191
1748	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	Admin	74
2268	OUT OF STATE YOUTH - SMHS	Regular PC	127
2582	OVERPAYMENTS FOR REPRODUCTIVE HEALTH	Regular PC	445
62	PACE (OTHER M/C)	Base PC	35
1972	PACES	Admin	119
1720	PASRR	Admin	91
1932	PAVE SYSTEM	Admin	87
236	PERSONAL CARE SERVICES	Admin	192
22	PERSONAL CARE SERVICES (MISC. SVCS.)	Base PC	61
2557	PHARMACY PAYMENT METHODOLOGY - USUAL AND CUSTOMARY	Regular PC	415
2194	PHARMACY RETROACTIVE ADJUSTMENTS	Regular PC	72
2526	PHARMACY UTILIZATION MANAGEMENT	Regular PC	90
1114	PIA EYEWEAR COURIER SERVICE	Admin	229
231	POSTAGE & PRINTING	Admin	52
2267	PP-GEMT IGT PROGRAM	Regular PC	182
2529	PREMIUMS FOR ADULTS WITH UNSATIS. IMMIG. STAT.	Regular PC	9
2518	PRIOR AUTH. FOR CONTINUATION OF DRUG THERAPY	Regular PC	94
1071	PRIVATE HOSPITAL DSH REPLACEMENT	Regular PC	243
1085	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	Regular PC	250
2509	PROP 35 - PROVIDER PAYMENT INCREASE FUNDING	Regular PC	215
2458	PROP 35 - PROVIDER PAYMENT INCREASES	Regular PC	419
2049	PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS	Regular PC	278
2130	PROP 56 - MEDI-CAL FAMILY PLANNING	Regular PC	255
2044	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	Regular PC	295
2593	PROPOSITION 35 FUNDING – CYBHI & BH-CONNECT	Admin	241
2549	PROPOSITION 36 FUNDING	Regular PC	339
2102	PROPOSITION 56 FUNDING	Regular PC	300
1452	PROTECTION OF PHI DATA	Admin	103
1370	PUBLIC HEALTH REGISTRIES SUPPORT	Admin	93
2092	QAF WITHHOLD TRANSFER	Regular PC	326
2329	QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES	Regular PC	323
2497	QUALITY SANCTIONS	Regular PC	394
88	RATE INCREASE FOR FQHCS/RHCS/CBRCS	Regular PC	179
2592	RECONCILIATION - ADMIN	Admin	240
2278	RECOVERY INCENTIVES CONTINGENCY MANAGEMENT	Regular PC	105
2362	RECOVERY INCENTIVES CONTINGENCY MANAGEMENT ADMIN	Admin	140
1505	REDUCTION TO RADIOLOGY RATES	Regular PC	224
2237	REFUGEE MEDICAL ASSISTANCE	Regular PC	24
1842	REGIONAL MODEL	Base PC	41
2535	REINSTATEMENT OF ASSET LIMIT	Regular PC	31
2531	RESIDENCY VERIFICATION IMPROVEMENTS	Regular PC	392
1788	RETRO MC RATE ADJUSTMENTS	Regular PC	177

May 2026 Medi-Cal Estimate
Alphabetic List of Policy Changes

Fiscal Reference Number	PC Name	Estimate Section	Page
2574	RETRO PAYMENTS TO COUNTIES FOR STATE-ONLY BH SVCS	Regular PC	433
215	SAVE	Admin	14
214	SAWS	Admin	6
2500	SB 525 MINIMUM WAGE - CASELOAD IMPACT	Regular PC	29
1007	SCHIP FUNDING FOR PRENATAL CARE	Regular PC	20
235	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	Admin	43
1732	SDMC SYSTEM M&O SUPPORT	Admin	95
2208	SELF-DETERMINATION PROGRAM - CDDS	Regular PC	321
61	SENIOR CARE ACTION NETWORK (OTHER M/C)	Base PC	48
1722	SMH MAA	Admin	58
1780	SMHS FOR ADULTS	Base PC	12
1779	SMHS FOR CHILDREN	Base PC	16
237	SSA COSTS FOR HEALTH COVERAGE INFO.	Admin	134
2559	STATE ONLY CLAIMING ADJUSTMENTS - ADMIN.	Admin	233
54	STATE SUPPLEMENTAL DRUG REBATES	Regular PC	100
1616	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	Regular PC	285
2415	STATE-ONLY CLAIMING ADJUSTMENTS - RETRO ADJ.	Regular PC	314
2358	STATEWIDE VERIFICATION HUB	Admin	123
2527	STEP THERAPY	Regular PC	98
26	TARGETED CASE MGMT. SVCS. - CDDS (MISC. SVCS.)	Base PC	72
1768	T-MSIS	Admin	132
2552	TRANSFORMING MATERNAL HEALTH PROVIDER INFR PYMT	Admin	235
56	TWO PLAN MODEL	Base PC	20
2577	UIS MEMBER TRANSITION TO FFS	Regular PC	443
2594	UIS MEMBER TRANSITION TO FFS SYSTEMS COSTS	Admin	243
1769	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	Regular PC	144
2519	UPDATES TO OTC COVID-19 TESTS AND OTC PRODUCTS	Regular PC	87
2528	UTILIZATION MANAGEMENT FOR HOSPICE	Regular PC	67
232	VETERANS BENEFITS	Admin	223
1774	VITAL RECORDS	Admin	224
32	WAIVER PERSONAL CARE SERVICES (MISC. SVCS.)	Base PC	70
2388	WORKFORCE & QUALITY INCENTIVE PROGRAM	Regular PC	156
1866	WPCS WORKERS' COMPENSATION	Regular PC	367

MAY 2026 MEDI-CAL ESTIMATE
GUIDE TO KEY FEATURES OF REGULAR POLICY CHANGES

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

PROP 56 – DENTAL SERVICES SUPPLEMENTAL PAYMENTS

FISCAL REFERENCE NUMBER:2049

Permanent reference number does not change between Estimate cycles.

Typically, this represents the cash amount, before accounting for percent reflected in base.

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$927,239,000**	**$98,205,000**
FEDERAL FUNDS	$579,031,550	$61,384,750
GENERAL FUND	$348,207,450	$36,820,250
OTHER FUNDS	$0	$0

This represents other non-General Fund, State Funds.

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.

	FY 2025-26	FY 2026-27
% REFLECTED IN BASE	95.1400%	96.0500%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$45,063,800**	**$3,879,100**
FEDERAL FUNDS	$28,140,930	$2,424,700
GENERAL FUND	$16,922,880	$1,454,400
OTHER FUNDS	$0	$0

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 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

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

Background:
The California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56, 2016),

TABLE OF CONTENTS

MANAGEMENT SUMMARY

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

CURRENT YEAR VS NOVEMBER 2025 CURRENT YEAR 1

CURRENT YEAR VS APPROPRIATION 2

BUDGET YEAR VS CURRENT YEAR 3

BUDGET YEAR VS NOVEMBER 2025 BUDGET YEAR 4

OVERVIEW OF MEDI-CAL ESTIMATE 5

SUMMARY OF EXPENDITURES BY FUND .... FS 1-15

- CURRENT YEAR VS PRIOR ESTIMATE CURRENT YEAR .... FS 1-3
- CURRENT YEAR VS APPROPRIATION .... FS 4-6
- BUDGET YEAR VS CURRENT YEAR .... FS 7-9
- BUDGET YEAR VS PRIOR ESTIMATE BUDGET YEAR .... FS 10-12
- BREAKDOWN BY APPROPRIATION YEAR .... FS 13-15

NOTE: FOR THE MAY 2026 ESTIMATE:

- CURRENT YEAR = FY 2025-26
- BUDGET YEAR = FY 2026-27
- APPROPRIATION = MAY 2025 ESTIMATE + BUDGET ACT CHANGES, FY 2025-26
- PRIOR ESTIMATE = NOVEMBER 2025 ESTIMATE

May 2026 Medi-Cal Estimate

Current Year (FY 2025-26) Projected Expenditures Compared to the November 2025 Estimate

(Dollars in Millions)

Medical Care Services	Nov 2025 Estimate	May 2026 Estimate	Change	
			Amount	Percent
Total Funds	$188,683.6	$186,910.8	($1,772.8)	-0.9%
Federal Funds	$113,895.0	$112,185.8	($1,709.2)	-1.5%
General Fund	**$44,056.7**	**$46,041.0**	**$1,984.3**	**4.5%**
Other Non-Federal Funds	$30,731.9	$28,684.0	($2,047.9)	-6.7%

Administration	Nov 2025 Estimate	May 2026 Estimate	Change	
			Amount	Percent
Total Funds	$8,008.5	$7,475.1	($533.4)	-6.7%
Federal Funds	$5,552.6	$4,775.5	($777.1)	-14.0%
General Fund	**$2,318.6**	**$2,579.6**	**$261.0**	**11.3%**
Other Non-Federal Funds	$137.3	$120.0	($17.3)	-12.6%

Total Expenditures	Nov 2025 Estimate	May 2026 Estimate	Change	
			Amount	Percent
Total Funds	$196,692.1	$194,385.8	($2,306.3)	-1.2%
Federal Funds	$119,447.6	$116,961.3	($2,486.3)	-2.1%
General Fund	**$46,375.3**	**$48,620.6**	**$2,245.3**	**4.8%**
Other Non-Federal Funds	$30,869.2	$28,804.0	($2,065.2)	-6.7%

Note: Totals may not add due to rounding.

May 2026 Medi-Cal Estimate

Current Year (FY 2025-26) Projected Expenditures Compared to the Appropriation

(Dollars in Millions)

Medical Care Services	FY 2025-26 Appropriation	May 2026 Estimate	Change	
			Amount	Percent
Total Funds	$187,568.6	$186,910.8	($657.8)	-0.4%
Federal Funds	$113,667.8	$112,185.8	($1,482.0)	-1.3%
General Fund	**$41,922.6**	**$46,041.0**	**$4,118.4**	**9.8%**
Other Non-Federal Funds	$31,978.2	$28,684.0	($3,294.2)	-10.3%

Administration	FY 2025-26 Appropriation	May 2026 Estimate	Change	
			Amount	Percent
Total Funds	$8,427.2	$7,475.1	($952.1)	-11.3%
Federal Funds	$6,020.7	$4,775.5	($1,245.2)	-20.7%
General Fund	**$2,283.5**	**$2,579.6**	**$296.1**	**13.0%**
Other Non-Federal Funds	$123.0	$120.0	($3.0)	-2.4%

Total Expenditures	FY 2025-26 Appropriation	May 2026 Estimate	Change	
			Amount	Percent
Total Funds	$195,995.8	$194,385.8	($1,610.0)	-0.8%
Federal Funds	$119,688.5	$116,961.3	($2,727.2)	-2.3%
General Fund	**$44,206.0**	**$48,620.6**	**$4,414.6**	**10.0%**
Other Non-Federal Funds	$32,101.2	$28,804.0	($3,297.2)	-10.3%

Note: Totals may not add due to rounding.

May 2026 Medi-Cal Estimate

Budget Year (FY 2026-27) Projected Expenditures Compared to Current Year (FY 2025-26)

(Dollars in Millions)

Medical Care Services	FY 2025-26 Estimate	FY 2026-27 Estimate	Change	
			Amount	Percent
Total Funds	$186,910.8	$208,154.6	$21,243.8	11.4%
Federal Funds	$112,185.8	$126,036.9	$13,851.1	12.3%
General Fund	**$46,041.0**	**$43,105.2**	**($2,935.8)**	**-6.4%**
Other Non-Federal Funds	$28,684.0	$39,012.5	$10,328.5	36.0%

Administration	FY 2025-26 Estimate	FY 2026-27 Estimate	Change	
			Amount	Percent
Total Funds	$7,475.1	$8,533.0	$1,057.9	14.2%
Federal Funds	$4,775.5	$6,455.6	$1,680.1	35.2%
General Fund	**$2,579.6**	**$1,838.0**	**($741.6)**	**-28.7%**
Other Non-Federal Funds	$120.0	$239.4	$119.4	99.5%

Total Expenditures	FY 2025-26 Estimate	FY 2026-27 Estimate	Change	
			Amount	Percent
Total Funds	$194,385.8	$216,687.6	$22,301.7	11.5%
Federal Funds	$116,961.3	$132,492.5	$15,531.1	13.3%
General Fund	**$48,620.6**	**$44,943.2**	**($3,677.4)**	**-7.6%**
Other Non-Federal Funds	$28,804.0	$39,251.9	$10,447.9	36.3%

Note: Totals may not add due to rounding.

May 2026 Medi-Cal Estimate

Budget Year (FY 2026-27) Projected Expenditures Compared to the November 2025 Estimate

(Dollars in Millions)

Medical Care Services	Nov 2025 Estimate	May 2026 Estimate	Change Amount	Change Percent
Total Funds	$214,739.5	$208,154.6	($6,584.9)	-3.1%
Federal Funds	$131,674.3	$126,036.9	($5,637.4)	-4.3%
General Fund	**$46,981.3**	**$43,105.2**	**($3,876.1)**	**-8.3%**
Other Non-Federal Funds	$36,083.9	$39,012.5	$2,928.6	8.1%

Administration	Nov 2025 Estimate	May 2026 Estimate	Change Amount	Change Percent
Total Funds	$7,697.7	$8,533.0	$835.3	10.9%
Federal Funds	$5,802.8	$6,455.6	$652.8	11.2%
General Fund	**$1,812.2**	**$1,838.0**	**$25.8**	**1.4%**
Other Non-Federal Funds	$82.7	$239.4	$156.7	189.5%

Total Expenditures	Nov 2025 Estimate	May 2026 Estimate	Change Amount	Change Percent
Total Funds	$222,437.2	$216,687.6	($5,749.7)	-2.6%
Federal Funds	$137,477.1	$132,492.5	($4,984.6)	-3.6%
General Fund	**$48,793.5**	**$44,943.2**	**($3,850.3)**	**-7.9%**
Other Non-Federal Funds	$36,166.6	$39,251.9	$3,085.3	8.5%

Note: Totals may not add due to rounding.

Medi-Cal Funding Summary
May 2026 Estimate Compared to November 2025 Estimate
Fiscal Year 2025 - 2026

TOTAL FUNDS

Benefits:	**Nov 2025 Estimate**	**May 2026 Estimate**	**Difference Incr./(Decr.)**
4260-101-0001/0890 Medi-Cal General and Federal Funds	$157,591,934,000	$157,815,797,000	$223,863,000
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$48,640,000	$48,640,000	$0
4260-101-0233 Prop 99 Physician Srvc. Acct	$13,894,000	$13,894,000	$0
4260-101-0236 Prop 99 Unallocated Account	$24,851,000	$24,851,000	$0
4260-101-3085 Behavioral Health Service (100% SF)	$47,000,000	$47,000,000	$0
4260-101-3305 Healthcare Treatment Fund	$469,703,000	$473,209,000	$3,506,000
4260-101-3311 Healthcare Plan Fines Penalties Fund	$20,400,000	$20,400,000	$0
4260-101-3428 MCO Tax 2023	$3,942,986,000	$3,942,987,000	$1,000
4260-101-3451 BH Schoolsite Fee Schedule Admi Fund	$69,300,000	$0	($69,300,000)
4260-102-0001/0890 Capital Debt	$85,136,000	$89,609,000	$4,473,000
4260-601-3375 Prop 56 Loan Repayment Program 601	$52,389,000	$44,217,000	($8,172,000)
4260-104-0001 NDPH Hosp Supp (GF)*	$1,900,000	$1,900,000	$0
4260-601-3096 NDPH Suppl	$8,956,000	$8,928,000	($28,000)
4260-698-3096 NDPH Hosp Suppl (Less funded GF)	($1,900,000)	($1,900,000)	$0
4260-105-0001 Private Hosp Supp Fund (GF)*	$118,400,000	$118,400,000	$0
4260-601-3097 Private Hosp Suppl	$244,029,000	$237,593,000	($6,436,000)
4260-698-3097 Private Hosp Supp (less funded GF)	($118,400,000)	($118,400,000)	$0
4260-106-0890 Money Follows Person Federal Grant	$91,488,000	$87,709,000	($3,779,000)
4260-601-3420 (3) Behavioral Health IGT Fund	$2,793,900,000	$3,796,525,000	$1,002,625,000
4260-601-3443 Healthcare Oversight & Acct. Subfund	$6,902,017,000	$6,833,379,000	($68,638,000)
4260-601-0942142 Local Trauma Centers	$61,282,000	$60,328,000	($954,000)
4260-601-0995 Reimbursement	$3,191,422,000	$3,314,645,000	$123,223,000
4260-601-3213 LTC QA Fund	$657,269,000	$688,731,000	$31,462,000
4260-601-3323 Medi-Cal Emergency Transport Fund	$49,981,000	$47,660,000	($2,321,000)
4260-601-3331 Medi-Cal Drug Rebates Fund	$2,334,506,000	$2,386,754,000	$52,248,000
4260-601-7502 Demonstration DSH Fund	$62,305,000	$113,031,000	$50,726,000
4260-601-7503 Health Care Support Fund	$599,000	$336,000	($263,000)
4260-601-8107 Whole Person Care Pilot Special Fund	$17,637,000	$11,033,000	($6,604,000)
4260-601-8108 Global Payment Program Special Fund	$1,495,914,000	$1,490,809,000	($5,105,000)
4260-601-8113 DPH GME Special Fund	$569,827,000	$518,074,000	($51,753,000)
4260-606-0834 SB 1100 DSH	$276,666,000	$222,352,000	($54,314,000)
4260-611-3158/0890 Hospital Quality Assurance	$5,018,238,000	$2,030,938,000	($2,987,300,000)
4260-601-0201 Medical Provider Interim Pmt Loan	$2,541,324,000	$2,541,324,000	$0
Total Benefits	**$188,683,593,000**	**$186,910,753,000**	**($1,772,840,000)**
Administration:			
4260-101-0001/0890 Medi-Cal General and Federal Funds	$7,665,725,000	$7,149,361,000	($516,364,000)
4260-101-3085 Behavioral Health Service (100% SF)	$58,708,000	$58,708,000	$0
4260-101-8140 (1) Vision Services CHIP HSI	$2,427,000	$740,000	($1,687,000)
4260-106-0890 Money Follow Person Fed. Grant	$2,480,000	$2,235,000	($245,000)
4260-117-0001/0890 HIPAA	$24,695,000	$25,310,000	$615,000
4260-601-0995 Reimbursement	$63,602,000	$36,001,000	($27,601,000)
4260-601-3420 Behavioral Health IGT Fund	$12,500,000	$24,312,000	$11,812,000
4260-601-7503 Health Care Support Fund	$178,255,000	$178,255,000	$0
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	$150,000	$150,000	$0
Total Administration	**$8,008,542,000**	**$7,475,072,000**	**($533,470,000)**
Grand Total - Total Funds	**$196,692,135,000**	**$194,385,825,000**	**($2,306,310,000)**

Medi-Cal Funding Summary
May 2026 Estimate Compared to November 2025 Estimate
Fiscal Year 2025 - 2026

STATE FUNDS

Benefits:	Nov 2025 Estimate	May 2026 Estimate	Difference Incr./(Decr.)
4260-101-0001 Medi-Cal General Fund*	$43,901,840,000	$45,889,496,000	$1,987,656,000
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$48,640,000	$48,640,000	$0
4260-101-0233 Prop 99 Physician Srvc. Acct	$13,894,000	$13,894,000	$0
4260-101-0236 Prop 99 Unallocated Account	$24,851,000	$24,851,000	$0
4260-101-3085 Behavioral Health Service (100% SF)	$47,000,000	$47,000,000	$0
4260-101-3305 Healthcare Treatment Fund	$469,703,000	$473,209,000	$3,506,000
4260-101-3311 Healthcare Plan Fines Penalties Fund	$20,400,000	$20,400,000	$0
4260-101-3428 MCO Tax 2023	$3,942,986,000	$3,942,987,000	$1,000
4260-101-3451 BH Schoolsite Fee Schedule Admi Fund	$69,300,000	$0	($69,300,000)
4260-102-0001 Capital Debt State*	$34,578,000	$31,179,000	($3,399,000)
4260-601-3375 Prop 56 Loan Repayment Program 601	$52,389,000	$44,217,000	($8,172,000)
4260-104-0001 NDPH Hosp Supp (GF)*	$1,900,000	$1,900,000	$0
4260-601-3096 NDPH Suppl	$8,956,000	$8,928,000	($28,000)
4260-698-3096 NDPH Hosp Suppl (Less funded GF)	($1,900,000)	($1,900,000)	$0
4260-105-0001 Private Hosp Supp Fund (GF)*	$118,400,000	$118,400,000	$0
4260-601-3097 Private Hosp Suppl	$244,029,000	$237,593,000	($6,436,000)
4260-698-3097 Private Hosp Supp (less funded GF)	($118,400,000)	($118,400,000)	$0
4260-601-3420 (3) Behavioral Health IGT Fund	$2,793,900,000	$3,796,525,000	$1,002,625,000
4260-601-3443 Healthcare Oversight & Acct. Subfund	$6,902,017,000	$6,833,379,000	($68,638,000)
4260-601-0942142 Local Trauma Centers	$61,282,000	$60,328,000	($954,000)
4260-601-0995 Reimbursement	$3,191,422,000	$3,314,645,000	$123,223,000
4260-601-3213 LTC QA Fund	$657,269,000	$688,731,000	$31,462,000
4260-601-3323 Medi-Cal Emergency Transport Fund	$49,981,000	$47,660,000	($2,321,000)
4260-601-3331 Medi-Cal Drug Rebates Fund	$2,334,506,000	$2,386,754,000	$52,248,000
4260-601-8107 Whole Person Care Pilot Special Fund	$17,637,000	$11,033,000	($6,604,000)
4260-601-8108 Global Payment Program Special Fund	$1,495,914,000	$1,490,809,000	($5,105,000)
4260-601-8113 DPH GME Special Fund	$569,827,000	$518,074,000	($51,753,000)
4260-606-0834 SB 1100 DSH	$276,666,000	$222,352,000	($54,314,000)
4260-611-3158 Hospital Quality Assurance Revenue	$5,018,238,000	$2,030,938,000	($2,987,300,000)
4260-601-0201 Medical Provider Interim Pmt Loan	$2,541,324,000	$2,541,324,000	$0
Total Benefits	**$74,788,549,000**	**$74,724,946,000**	**($63,603,000)**
Total Benefits General Fund *	**$44,056,718,000**	**$46,040,975,000**	**$1,984,257,000**
Administration:			
4260-101-0001 Medi-Cal General Fund *	$2,312,197,000	$2,573,115,000	$260,918,000
4260-101-3085 Behavioral Health Service (100% SF)	$58,708,000	$58,708,000	$0
4260-101-8140 (1) Vision Services CHIP HSI	$2,427,000	$740,000	($1,687,000)
4260-117-0001 HIPAA *	$6,359,000	$6,516,000	$157,000
4260-601-0995 Reimbursement	$63,602,000	$36,001,000	($27,601,000)
4260-601-3420 Behavioral Health IGT Fund	$12,500,000	$24,312,000	$11,812,000
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	$150,000	$150,000	$0
Total Administration	**$2,455,943,000**	**$2,699,542,000**	**$243,599,000**
Total Administration General Fund *	**$2,318,556,000**	**$2,579,631,000**	**$261,075,000**
Grand Total - State Funds	**$77,244,492,000**	**$77,424,488,000**	**$179,996,000**
Grand Total - General Fund*	**$46,375,274,000**	**$48,620,606,000**	**$2,245,332,000**

Medi-Cal Funding Summary
May 2026 Estimate Compared to November 2025 Estimate
Fiscal Year 2025 - 2026

FEDERAL FUNDS

Benefits:	**Nov 2025 Estimate**	**May 2026 Estimate**	**Difference Incr./(Decr.)**
4260-101-0890 Federal Funds	$113,690,094,000	$111,926,301,000	($1,763,793,000)
4260-102-0890 Capital Debt	$50,558,000	$58,430,000	$7,872,000
4260-106-0890 Money Follows Person Federal Grant	$91,488,000	$87,709,000	($3,779,000)
4260-601-7502 Demonstration DSH Fund	$62,305,000	$113,031,000	$50,726,000
4260-601-7503 Health Care Support Fund	$599,000	$336,000	($263,000)
Total Benefits	**$113,895,044,000**	**$112,185,807,000**	**($1,709,237,000)**
Administration:			
4260-101-0890 Federal Funds	$5,353,528,000	$4,576,246,000	($777,282,000)
4260-106-0890 Money Follows Person Fed. Grant	$2,480,000	$2,235,000	($245,000)
4260-117-0890 HIPAA	$18,336,000	$18,794,000	$458,000
4260-601-7503 Health Care Support Fund	$178,255,000	$178,255,000	$0
Total Administration	**$5,552,599,000**	**$4,775,530,000**	**($777,069,000)**
Grand Total - Federal Funds	**$119,447,643,000**	**$116,961,337,000**	**($2,486,306,000)**

Medi-Cal Funding Summary
May 2026 Estimate Compared to Appropriation
Fiscal Year 2025 - 2026

TOTAL FUNDS

Benefits:	Total Appropriation	May 2026 Estimate	Difference Incr./(Decr.)
4260-101-0001/0890 Medi-Cal General and Federal Funds	$155,105,574,000	$157,815,797,000	$2,710,223,000
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$48,640,000	$48,640,000	$0
4260-101-0233 Prop 99 Physician Srvc. Acct	$13,894,000	$13,894,000	$0
4260-101-0236 Prop 99 Unallocated Account	$24,682,000	$24,851,000	$169,000
4260-101-3085 Behavioral Health Service (100% SF)	$90,000,000	$47,000,000	($43,000,000)
4260-101-3305 Healthcare Treatment Fund	$765,536,000	$473,209,000	($292,327,000)
4260-101-3311 Healthcare Plan Fines Penalties Fund	$20,400,000	$20,400,000	$0
4260-101-3428 MCO Tax 2023	$3,942,986,000	$3,942,987,000	$1,000
4260-101-3451 BH Schoolsite Fee Schedule Admi Fund	$69,300,000	$0	($69,300,000)
4260-102-0001/0890 Capital Debt	$76,165,000	$89,609,000	$13,444,000
4260-601-3375 Prop 56 Loan Repayment Program 601	$22,885,000	$44,217,000	$21,332,000
4260-104-0001 NDPH Hosp Supp (GF)*	$1,900,000	$1,900,000	$0
4260-601-3096 NDPH Suppl	$8,882,000	$8,928,000	$46,000
4260-698-3096 NDPH Hosp Suppl (Less funded GF)	($1,900,000)	($1,900,000)	$0
4260-105-0001 Private Hosp Supp Fund (GF)*	$118,400,000	$118,400,000	$0
4260-601-3097 Private Hosp Suppl	$237,263,000	$237,593,000	$330,000
4260-698-3097 Private Hosp Supp (less funded GF)	($118,400,000)	($118,400,000)	$0
4260-106-0890 Money Follows Person Federal Grant	$115,933,000	$87,709,000	($28,224,000)
4260-601-3420 (3) Behavioral Health IGT Fund	$2,792,353,000	$3,796,525,000	$1,004,172,000
4260-601-3443 Healthcare Oversight & Acct. Subfund	$8,517,891,000	$6,833,379,000	($1,684,512,000)
4260-601-0942142 Local Trauma Centers	$84,010,000	$60,328,000	($23,682,000)
4260-601-0995 Reimbursement	$2,994,825,000	$3,314,645,000	$319,820,000
4260-601-3213 LTC QA Fund	$624,928,000	$688,731,000	$63,803,000
4260-601-3323 Medi-Cal Emergency Transport Fund	$51,234,000	$47,660,000	($3,574,000)
4260-601-3331 Medi-Cal Drug Rebates Fund	$2,202,503,000	$2,386,754,000	$184,251,000
4260-601-7502 Demonstration DSH Fund	$171,777,000	$113,031,000	($58,746,000)
4260-601-7503 Health Care Support Fund	$635,000	$336,000	($299,000)
4260-601-8107 Whole Person Care Pilot Special Fund	$13,023,000	$11,033,000	($1,990,000)
4260-601-8108 Global Payment Program Special Fund	$1,486,190,000	$1,490,809,000	$4,619,000
4260-601-8113 DPH GME Special Fund	$507,565,000	$518,074,000	$10,509,000
4260-605-3167 SNF Quality & Accountability	$756,000	$0	($756,000)
4260-606-0834 SB 1100 DSH	$168,436,000	$222,352,000	$53,916,000
4260-611-3158/0890 Hospital Quality Assurance	$5,119,049,000	$2,030,938,000	($3,088,111,000)
4260-601-0201 Medical Provider Interim Pmt Loan	$2,291,260,000	$2,541,324,000	$250,064,000
Total Benefits	**$187,568,575,000**	**$186,910,753,000**	**($657,822,000)**
Administration:			
4260-101-0001/0890 Medi-Cal General and Federal Funds	$8,098,933,000	$7,149,361,000	($949,572,000)
4260-101-3085 Behavioral Health Service (100% SF)	$58,708,000	$58,708,000	$0
4260-101-8140 (1) Vision Services CHIP HSI	$2,427,000	$740,000	($1,687,000)
4260-106-0890 Money Follow Person Fed. Grant	$2,872,000	$2,235,000	($637,000)
4260-117-0001/0890 HIPAA	$24,080,000	$25,310,000	$1,230,000
4260-601-0995 Reimbursement	$49,311,000	$36,001,000	($13,310,000)
4260-601-3420 Behavioral Health IGT Fund	$12,500,000	$24,312,000	$11,812,000
4260-601-7503 Health Care Support Fund	$178,255,000	$178,255,000	$0
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	$150,000	$150,000	$0
Total Administration	**$8,427,236,000**	**$7,475,072,000**	**($952,164,000)**
Grand Total - Total Funds	**$195,995,811,000**	**$194,385,825,000**	**($1,609,986,000)**

Medi-Cal Funding Summary
May 2026 Estimate Compared to Appropriation
Fiscal Year 2025 - 2026

STATE FUNDS

Benefits:	State Funds Appropriation	May 2026 Estimate	Difference Incr./(Decr.)
4260-101-0001 Medi-Cal General Fund*[1]	$41,777,596,000	$45,889,496,000	$4,111,900,000
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$48,640,000	$48,640,000	$0
4260-101-0233 Prop 99 Physician Srvc. Acct	$13,894,000	$13,894,000	$0
4260-101-0236 Prop 99 Unallocated Account	$24,682,000	$24,851,000	$169,000
4260-101-3085 Behavioral Health Service (100% SF)	$90,000,000	$47,000,000	($43,000,000)
4260-101-3305 Healthcare Treatment Fund	$765,536,000	$473,209,000	($292,327,000)
4260-101-3311 Healthcare Plan Fines Penalties Fund	$20,400,000	$20,400,000	$0
4260-101-3428 MCO Tax 2023	$3,942,986,000	$3,942,987,000	$1,000
4260-101-3451 BH Schoolsite Fee Schedule Admi Fund	$69,300,000	$0	($69,300,000)
4260-102-0001 Capital Debt State*	$24,668,000	$31,179,000	$6,511,000
4260-601-3375 Prop 56 Loan Repayment Program 601	$22,885,000	$44,217,000	$21,332,000
4260-104-0001 NDPH Hosp Supp (GF)*	$1,900,000	$1,900,000	$0
4260-601-3096 NDPH Suppl	$8,882,000	$8,928,000	$46,000
4260-698-3096 NDPH Hosp Suppl (Less funded GF)	($1,900,000)	($1,900,000)	$0
4260-105-0001 Private Hosp Supp Fund (GF)*	$118,400,000	$118,400,000	$0
4260-601-3097 Private Hosp Suppl	$237,263,000	$237,593,000	$330,000
4260-698-3097 Private Hosp Supp (less funded GF)	($118,400,000)	($118,400,000)	$0
4260-601-3420 (3) Behavioral Health IGT Fund	$2,792,353,000	$3,796,525,000	$1,004,172,000
4260-601-3443 Healthcare Oversight & Acct. Subfund	$8,517,891,000	$6,833,379,000	($1,684,512,000)
4260-601-0942142 Local Trauma Centers	$84,010,000	$60,328,000	($23,682,000)
4260-601-0995 Reimbursement	$2,994,825,000	$3,314,645,000	$319,820,000
4260-601-3213 LTC QA Fund	$624,928,000	$688,731,000	$63,803,000
4260-601-3323 Medi-Cal Emergency Transport Fund	$51,234,000	$47,660,000	($3,574,000)
4260-601-3331 Medi-Cal Drug Rebates Fund	$2,202,503,000	$2,386,754,000	$184,251,000
4260-601-8107 Whole Person Care Pilot Special Fund	$13,023,000	$11,033,000	($1,990,000)
4260-601-8108 Global Payment Program Special Fund	$1,486,190,000	$1,490,809,000	$4,619,000
4260-601-8113 DPH GME Special Fund	$507,565,000	$518,074,000	$10,509,000
4260-605-3167 SNF Quality & Accountability	$756,000	$0	($756,000)
4260-606-0834 SB 1100 DSH	$168,436,000	$222,352,000	$53,916,000
4260-611-3158 Hospital Quality Assurance Revenue	$5,119,049,000	$2,030,938,000	($3,088,111,000)
4260-601-0201 Medical Provider Interim Pmt Loan	$2,291,260,000	$2,541,324,000	$250,064,000
Total Benefits	**$73,900,755,000**	**$74,724,946,000**	**$824,191,000**
Total Benefits General Fund *	**$41,922,564,000**	**$46,040,975,000**	**$4,118,411,000**
Administration:			
4260-101-0001 Medi-Cal General Fund *	$2,277,208,000	$2,573,115,000	$295,907,000
4260-101-3085 Behavioral Health Service (100% SF)	$58,708,000	$58,708,000	$0
4260-101-8140 (1) Vision Services CHIP HSI	$2,427,000	$740,000	($1,687,000)
4260-117-0001 HIPAA *	$6,246,000	$6,516,000	$270,000
4260-601-0995 Reimbursement	$49,311,000	$36,001,000	($13,310,000)
4260-601-3420 Behavioral Health IGT Fund	$12,500,000	$24,312,000	$11,812,000
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	$150,000	$150,000	$0
Total Administration	**$2,406,550,000**	**$2,699,542,000**	**$292,992,000**
Total Administration General Fund *	**$2,283,454,000**	**$2,579,631,000**	**$296,177,000**
Grand Total - State Funds	**$76,307,305,000**	**$77,424,488,000**	**$1,117,183,000**
Grand Total - General Fund*	**$44,206,018,000**	**$48,620,606,000**	**$4,414,588,000**

[1] Reflects mid-year adjustments to the Appropriation

Medi-Cal Funding Summary
May 2026 Estimate Compared to Appropriation
Fiscal Year 2025 - 2026

FEDERAL FUNDS

	Federal Funds Appropriation	May 2026 Estimate	Difference Incr./(Decr.)
Benefits:			
4260-101-0890 Federal Funds	$113,327,978,000	$111,926,301,000	($1,401,677,000)
4260-102-0890 Capital Debt	$51,497,000	$58,430,000	$6,933,000
4260-106-0890 Money Follows Person Federal Grant	$115,933,000	$87,709,000	($28,224,000)
4260-601-7502 Demonstration DSH Fund	$171,777,000	$113,031,000	($58,746,000)
4260-601-7503 Health Care Support Fund	$635,000	$336,000	($299,000)
Total Benefits	**$113,667,820,000**	**$112,185,807,000**	**($1,482,013,000)**
Administration:			
4260-101-0890 Federal Funds	$5,821,725,000	$4,576,246,000	($1,245,479,000)
4260-106-0890 Money Follows Person Fed. Grant	$2,872,000	$2,235,000	($637,000)
4260-117-0890 HIPAA	$17,834,000	$18,794,000	$960,000
4260-601-7503 Health Care Support Fund	$178,255,000	$178,255,000	$0
Total Administration	**$6,020,686,000**	**$4,775,530,000**	**($1,245,156,000)**
Grand Total - Federal Funds	**$119,688,506,000**	**$116,961,337,000**	**($2,727,169,000)**

[1] Reflects mid-year adjustments to the Appropriation

Medi-Cal Funding Summary
May 2026 Estimate Comparison of
FY 2025-26 to FY 2026-27

TOTAL FUNDS

Benefits:	FY 2025-26 Estimate	FY 2026-27 Estimate	Difference Incr./(Decr.)
4260-101-0001/0890 Medi-Cal General and Federal Funds	$157,815,797,000	$168,492,560,000	$10,676,763,000
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$48,640,000	$52,996,000	$4,356,000
4260-101-0233 Prop 99 Physician Srvc. Acct	$13,894,000	$15,144,000	$1,250,000
4260-101-0236 Prop 99 Unallocated Account	$24,851,000	$24,421,000	($430,000)
4260-101-3085 Behavioral Health Service (100% SF)	$47,000,000	$163,128,000	$116,128,000
4260-101-3156 MCO Tax Direct Appropriation	$0	$154,506,000	$154,506,000
4260-101-3305 Healthcare Treatment Fund	$473,209,000	$461,274,000	($11,935,000)
4260-101-3311 Healthcare Plan Fines Penalties Fund	$20,400,000	$12,502,000	($7,898,000)
4260-101-3397 Opioid Settlements Fund	$0	$35,400,000	$35,400,000
4260-101-3428 MCO Tax 2023	$3,942,987,000	$2,827,156,000	($1,115,831,000)
4260-101-3451 BH Schoolsite Fee Schedule Admi Fund	$0	$50,900,000	$50,900,000
4260-102-0001/0890 Capital Debt	$89,609,000	$82,759,000	($6,850,000)
4260-601-3375 Prop 56 Loan Repayment Program 601	$44,217,000	$36,143,000	($8,074,000)
4260-104-0001 NDPH Hosp Supp (GF)*	$1,900,000	$0	($1,900,000)
4260-601-3096 NDPH Suppl	$8,928,000	$62,000	($8,866,000)
4260-698-3096 NDPH Hosp Suppl (Less funded GF)	($1,900,000)	$0	$1,900,000
4260-105-0001 Private Hosp Supp Fund (GF)*	$118,400,000	$118,400,000	$0
4260-601-3097 Private Hosp Suppl	$237,593,000	$208,360,000	($29,233,000)
4260-698-3097 Private Hosp Supp (less funded GF)	($118,400,000)	($118,400,000)	$0
4260-106-0890 Money Follows Person Federal Grant	$87,709,000	$100,298,000	$12,589,000
4260-601-3420 (3) Behavioral Health IGT Fund	$3,796,525,000	$3,559,155,000	($237,370,000)
4260-601-3442 Protect Access to Health Care Fund	$0	$1,881,637,000	$1,881,637,000
4260-601-3443 Healthcare Oversight & Acct. Subfund	$6,833,379,000	$5,919,286,000	($914,093,000)
4260-601-3492 2027 MCO Tax Fund	$0	$707,750,000	$707,750,000
4260-601-0942142 Local Trauma Centers	$60,328,000	$84,950,000	$24,622,000
4260-601-0995 Reimbursement	$3,314,645,000	$6,935,587,000	$3,620,942,000
4260-601-3213 LTC QA Fund	$688,731,000	$753,912,000	$65,181,000
4260-601-3323 Medi-Cal Emergency Transport Fund	$47,660,000	$43,775,000	($3,885,000)
4260-601-3331 Medi-Cal Drug Rebates Fund	$2,386,754,000	$2,846,543,000	$459,789,000
4260-601-7502 Demonstration DSH Fund	$113,031,000	$127,089,000	$14,058,000
4260-601-7503 Health Care Support Fund	$336,000	$623,000	$287,000
4260-601-8107 Whole Person Care Pilot Special Fund	$11,033,000	$0	($11,033,000)
4260-601-8108 Global Payment Program Special Fund	$1,490,809,000	$1,506,551,000	$15,742,000
4260-601-8113 DPH GME Special Fund	$518,074,000	$758,340,000	$240,266,000
4260-601-8144 DMPH GME IGT Fund	$0	$12,685,000	$12,685,000
4260-603-0001 Children's Hospital Directed Payment*	$0	$220,416,000	$220,416,000
4260-606-0834 SB 1100 DSH	$222,352,000	$225,667,000	$3,315,000
4260-611-3158/0890 Hospital Quality Assurance	$2,030,938,000	$9,853,027,000	$7,822,089,000
4260-601-0201 Medical Provider Interim Pmt Loan	$2,541,324,000	$0	($2,541,324,000)
Total Benefits	**$186,910,753,000**	**$208,154,602,000**	**$21,243,849,000**
Administration:			
4260-101-0001/0890 Medi-Cal General and Federal Funds	$7,149,361,000	$7,918,852,000	$769,491,000
4260-101-3085 Behavioral Health Service (100% SF)	$58,708,000	$10,000,000	($48,708,000)
4260-101-8140 (1) Vision Services CHIP HSI	$740,000	$773,000	$33,000
4260-106-0890 Money Follow Person Fed. Grant	$2,235,000	$2,316,000	$81,000
4260-117-0001/0890 HIPAA	$25,310,000	$25,539,000	$229,000
4260-601-0995 Reimbursement	$36,001,000	$148,631,000	$112,630,000
4260-601-3420 Behavioral Health IGT Fund	$24,312,000	$80,000,000	$55,688,000
4260-601-7503 Health Care Support Fund	$178,255,000	$346,856,000	$168,601,000
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	$150,000	$0	($150,000)
Total Administration	**$7,475,072,000**	**$8,532,967,000**	**$1,057,895,000**
Grand Total - Total Funds	**$194,385,825,000**	**$216,687,569,000**	**$22,301,744,000**

Medi-Cal Funding Summary
May 2026 Estimate Comparison of
FY 2025-26 to FY 2026-27

STATE FUNDS

Benefits:	FY 2025-26 Estimate	FY 2026-27 Estimate	Difference Incr./(Decr.)
4260-101-0001 Medi-Cal General Fund*	$45,889,496,000	$42,738,809,000	($3,150,687,000)
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$48,640,000	$52,996,000	$4,356,000
4260-101-0233 Prop 99 Physician Srvc. Acct	$13,894,000	$15,144,000	$1,250,000
4260-101-0236 Prop 99 Unallocated Account	$24,851,000	$24,421,000	($430,000)
4260-101-3085 Behavioral Health Service (100% SF)	$47,000,000	$163,128,000	$116,128,000
4260-101-3156 MCO Tax Direct Appropriation	$0	$154,506,000	$154,506,000
4260-101-3305 Healthcare Treatment Fund	$473,209,000	$461,274,000	($11,935,000)
4260-101-3311 Healthcare Plan Fines Penalties Fund	$20,400,000	$12,502,000	($7,898,000)
4260-101-3397 Opioid Settlements Fund	$0	$35,400,000	$35,400,000
4260-101-3428 MCO Tax 2023	$3,942,987,000	$2,827,156,000	($1,115,831,000)
4260-101-3451 BH Schoolsite Fee Schedule Admi Fund	$0	$50,900,000	$50,900,000
4260-102-0001 Capital Debt State*	$31,179,000	$27,610,000	($3,569,000)
4260-601-3375 Prop 56 Loan Repayment Program 601	$44,217,000	$36,143,000	($8,074,000)
4260-104-0001 NDPH Hosp Supp (GF)*	$1,900,000	$0	($1,900,000)
4260-601-3096 NDPH Suppl	$8,928,000	$62,000	($8,866,000)
4260-698-3096 NDPH Hosp Suppl (Less funded GF)	($1,900,000)	$0	$1,900,000
4260-105-0001 Private Hosp Supp Fund (GF)*	$118,400,000	$118,400,000	$0
4260-601-3097 Private Hosp Suppl	$237,593,000	$208,360,000	($29,233,000)
4260-698-3097 Private Hosp Supp (less funded GF)	($118,400,000)	($118,400,000)	$0
4260-601-3420 (3) Behavioral Health IGT Fund	$3,796,525,000	$3,559,155,000	($237,370,000)
4260-601-3442 Protect Access to Health Care Fund	$0	$1,881,637,000	$1,881,637,000
4260-601-3443 Healthcare Oversight & Acct. Subfund	$6,833,379,000	$5,919,286,000	($914,093,000)
4260-601-3492 2027 MCO Tax Fund	$0	$707,750,000	$707,750,000
4260-601-0942142 Local Trauma Centers	$60,328,000	$84,950,000	$24,622,000
4260-601-0995 Reimbursement	$3,314,645,000	$6,935,587,000	$3,620,942,000
4260-601-3213 LTC QA Fund	$688,731,000	$753,912,000	$65,181,000
4260-601-3323 Medi-Cal Emergency Transport Fund	$47,660,000	$43,775,000	($3,885,000)
4260-601-3331 Medi-Cal Drug Rebates Fund	$2,386,754,000	$2,846,543,000	$459,789,000
4260-601-8107 Whole Person Care Pilot Special Fund	$11,033,000	$0	($11,033,000)
4260-601-8108 Global Payment Program Special Fund	$1,490,809,000	$1,506,551,000	$15,742,000
4260-601-8113 DPH GME Special Fund	$518,074,000	$758,340,000	$240,266,000
4260-601-8144 DMPH GME IGT Fund	$0	$12,685,000	$12,685,000
4260-603-0001 Children's Hospital Directed Payment*	$0	$220,416,000	$220,416,000
4260-606-0834 SB 1100 DSH	$222,352,000	$225,667,000	$3,315,000
4260-611-3158 Hospital Quality Assurance Revenue	$2,030,938,000	$9,853,027,000	$7,822,089,000
4260-601-0201 Medical Provider Interim Pmt Loan	$2,541,324,000	$0	($2,541,324,000)
Total Benefits	**$74,724,946,000**	**$82,117,692,000**	**$7,392,746,000**
Total Benefits General Fund *	**$46,040,975,000**	**$43,105,235,000**	**($2,935,740,000)**
Administration:			
4260-101-0001 Medi-Cal General Fund *	$2,573,115,000	$1,831,306,000	($741,809,000)
4260-101-3085 Behavioral Health Service (100% SF)	$58,708,000	$10,000,000	($48,708,000)
4260-101-8140 (1) Vision Services CHIP HSI	$740,000	$773,000	$33,000
4260-117-0001 HIPAA *	$6,516,000	$6,694,000	$178,000
4260-601-0995 Reimbursement	$36,001,000	$148,631,000	$112,630,000
4260-601-3420 Behavioral Health IGT Fund	$24,312,000	$80,000,000	$55,688,000
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	$150,000	$0	($150,000)
Total Administration	**$2,699,542,000**	**$2,077,404,000**	**($622,138,000)**
Total Administration General Fund *	**$2,579,631,000**	**$1,838,000,000**	**($741,631,000)**
Grand Total - State Funds	**$77,424,488,000**	**$84,195,096,000**	**$6,770,608,000**
Grand Total - General Fund*	**$48,620,606,000**	**$44,943,235,000**	**($3,677,371,000)**

Medi-Cal Funding Summary

May 2026 Estimate Comparison of FY 2025-26 to FY 2026-27

FEDERAL FUNDS

Benefits:	FY 2025-26 Estimate	FY 2026-27 Estimate	Difference Incr./(Decr.)
4260-101-0890 Federal Funds	$111,926,301,000	$125,753,751,000	$13,827,450,000
4260-102-0890 Capital Debt	$58,430,000	$55,149,000	($3,281,000)
4260-106-0890 Money Follows Person Federal Grant	$87,709,000	$100,298,000	$12,589,000
4260-601-7502 Demonstration DSH Fund	$113,031,000	$127,089,000	$14,058,000
4260-601-7503 Health Care Support Fund	$336,000	$623,000	$287,000
Total Benefits	**$112,185,807,000**	**$126,036,910,000**	**$13,851,103,000**

Administration:	FY 2025-26 Estimate	FY 2026-27 Estimate	Difference Incr./(Decr.)
4260-101-0890 Federal Funds	$4,576,246,000	$6,087,546,000	$1,511,300,000
4260-106-0890 Money Follows Person Fed. Grant	$2,235,000	$2,316,000	$81,000
4260-117-0890 HIPAA	$18,794,000	$18,845,000	$51,000
4260-601-7503 Health Care Support Fund	$178,255,000	$346,856,000	$168,601,000
Total Administration	**$4,775,530,000**	**$6,455,563,000**	**$1,680,033,000**
Grand Total - Federal Funds	**$116,961,337,000**	**$132,492,473,000**	**$15,531,136,000**

Medi-Cal Funding Summary
May 2026 Estimate Compared to November 2025 Estimate
Fiscal Year 2026 - 2027

TOTAL FUNDS

Benefits:	**Nov 2025 Estimate**	**May 2026 Estimate**	**Difference Incr./(Decr.)**
4260-101-0001/0890 Medi-Cal General and Federal Funds	$178,009,550,000	$168,492,560,000	($9,516,990,000)
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$52,916,000	$52,996,000	$80,000
4260-101-0233 Prop 99 Physician Srvc. Acct	$15,122,000	$15,144,000	$22,000
4260-101-0236 Prop 99 Unallocated Account	$22,265,000	$24,421,000	$2,156,000
4260-101-3085 Behavioral Health Service (100% SF)	$43,000,000	$163,128,000	$120,128,000
4260-101-3156 MCO Tax Direct Appropriation	$149,702,000	$154,506,000	$4,804,000
4260-101-3305 Healthcare Treatment Fund	$461,817,000	$461,274,000	($543,000)
4260-101-3311 Healthcare Plan Fines Penalties Fund	$0	$12,502,000	$12,502,000
4260-101-3397 Opioid Settlements Fund	$0	$35,400,000	$35,400,000
4260-101-3414 988 State Suicide and BH Crisis	$28,208,000	$0	($28,208,000)
4260-101-3428 MCO Tax 2023	$2,827,155,000	$2,827,156,000	$1,000
4260-101-3451 BH Schoolsite Fee Schedule Admi Fund	$69,300,000	$50,900,000	($18,400,000)
4260-102-0001/0890 Capital Debt	$65,900,000	$82,759,000	$16,859,000
4260-601-3375 Prop 56 Loan Repayment Program 601	$48,351,000	$36,143,000	($12,208,000)
4260-601-3096 NDPH Suppl	$0	$62,000	$62,000
4260-105-0001 Private Hosp Supp Fund (GF)*	$118,400,000	$118,400,000	$0
4260-601-3097 Private Hosp Suppl	$198,008,000	$208,360,000	$10,352,000
4260-698-3097 Private Hosp Supp (less funded GF)	($118,400,000)	($118,400,000)	$0
4260-106-0890 Money Follows Person Federal Grant	$101,857,000	$100,298,000	($1,559,000)
4260-601-3420 (3) Behavioral Health IGT Fund	$3,132,995,000	$3,559,155,000	$426,160,000
4260-601-3442 Protect Access to Health Care Fund	$0	$1,881,637,000	$1,881,637,000
4260-601-3443 Healthcare Oversight & Acct. Subfund	$6,324,627,000	$5,919,286,000	($405,341,000)
4260-601-3492 2027 MCO Tax Fund	$0	$707,750,000	$707,750,000
4260-601-0942142 Local Trauma Centers	$83,063,000	$84,950,000	$1,887,000
4260-601-0995 Reimbursement	$6,437,400,000	$6,935,587,000	$498,187,000
4260-601-3213 LTC QA Fund	$618,750,000	$753,912,000	$135,162,000
4260-601-3323 Medi-Cal Emergency Transport Fund	$50,965,000	$43,775,000	($7,190,000)
4260-601-3331 Medi-Cal Drug Rebates Fund	$2,350,812,000	$2,846,543,000	$495,731,000
4260-601-7502 Demonstration DSH Fund	$138,849,000	$127,089,000	($11,760,000)
4260-601-7503 Health Care Support Fund	$650,000	$623,000	($27,000)
4260-601-8108 Global Payment Program Special Fund	$1,511,049,000	$1,506,551,000	($4,498,000)
4260-601-8113 DPH GME Special Fund	$627,342,000	$758,340,000	$130,998,000
4260-601-8144 DMPH GME IGT Fund	$0	$12,685,000	$12,685,000
4260-603-0001 Children’s Hospital Directed Payment*	$220,416,000	$220,416,000	$0
4260-606-0834 SB 1100 DSH	$213,982,000	$225,667,000	$11,685,000
4260-611-3158/0890 Hospital Quality Assurance	$10,935,432,000	$9,853,027,000	($1,082,405,000)
Total Benefits	**$214,739,483,000**	**$208,154,602,000**	**($6,584,881,000)**
Administration:			
4260-101-0001/0890 Medi-Cal General and Federal Funds	$7,241,222,000	$7,918,852,000	$677,630,000
4260-101-3085 Behavioral Health Service (100% SF)	$10,000,000	$10,000,000	$0
4260-101-8140 (1) Vision Services CHIP HSI	$2,427,000	$773,000	($1,654,000)
4260-106-0890 Money Follow Person Fed. Grant	$2,480,000	$2,316,000	($164,000)
4260-117-0001/0890 HIPAA	$24,400,000	$25,539,000	$1,139,000
4260-601-0995 Reimbursement	$57,706,000	$148,631,000	$90,925,000
4260-601-3420 Behavioral Health IGT Fund	$12,500,000	$80,000,000	$67,500,000
4260-601-7503 Health Care Support Fund	$346,856,000	$346,856,000	$0
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	$150,000	$0	($150,000)
Total Administration	**$7,697,741,000**	**$8,532,967,000**	**$835,226,000**
Grand Total - Total Funds	**$222,437,224,000**	**$216,687,569,000**	**($5,749,655,000)**

Medi-Cal Funding Summary
May 2026 Estimate Compared to November 2025 Estimate
Fiscal Year 2026 - 2027

STATE FUNDS

Benefits:	Nov 2025 Estimate	May-26 Estimate	Difference Incr./(Decr.)
4260-101-0001 Medi-Cal General Fund*	$46,622,839,000	$42,738,809,000	($3,884,030,000)
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$52,916,000	$52,996,000	$80,000
4260-101-0233 Prop 99 Physician Srvc. Acct	$15,122,000	$15,144,000	$22,000
4260-101-0236 Prop 99 Unallocated Account	$22,265,000	$24,421,000	$2,156,000
4260-101-3085 Behavioral Health Service (100% SF)	$43,000,000	$163,128,000	$120,128,000
4260-101-3156 MCO Tax Direct Appropriation	$149,702,000	$154,506,000	$4,804,000
4260-101-3305 Healthcare Treatment Fund	$461,817,000	$461,274,000	($543,000)
4260-101-3311 Healthcare Plan Fines Penalties Fund	$0	$12,502,000	$12,502,000
4260-101-3397 Opioid Settlements Fund	$0	$35,400,000	$35,400,000
4260-101-3414 988 State Suicide and BH Crisis	$28,208,000	$0	($28,208,000)
4260-101-3428 MCO Tax 2023	$2,827,155,000	$2,827,156,000	$1,000
4260-101-3451 BH Schoolsite Fee Schedule Admi Fund	$69,300,000	$50,900,000	($18,400,000)
4260-102-0001 Capital Debt State*	$19,670,000	$27,610,000	$7,940,000
4260-601-3375 Prop 56 Loan Repayment Program 601	$48,351,000	$36,143,000	($12,208,000)
4260-601-3096 NDPH Suppl	$0	$62,000	$62,000
4260-105-0001 Private Hosp Supp Fund (GF)*	$118,400,000	$118,400,000	$0
4260-601-3097 Private Hosp Suppl	$198,008,000	$208,360,000	$10,352,000
4260-698-3097 Private Hosp Supp (less funded GF)	($118,400,000)	($118,400,000)	$0
4260-601-3420 (3) Behavioral Health IGT Fund	$3,132,995,000	$3,559,155,000	$426,160,000
4260-601-3442 Protect Access to Health Care Fund	$0	$1,881,637,000	$1,881,637,000
4260-601-3443 Healthcare Oversight & Acct. Subfund	$6,324,627,000	$5,919,286,000	($405,341,000)
4260-601-3492 2027 MCO Tax Fund	$0	$707,750,000	$707,750,000
4260-601-0942142 Local Trauma Centers	$83,063,000	$84,950,000	$1,887,000
4260-601-0995 Reimbursement	$6,437,400,000	$6,935,587,000	$498,187,000
4260-601-3213 LTC QA Fund	$618,750,000	$753,912,000	$135,162,000
4260-601-3323 Medi-Cal Emergency Transport Fund	$50,965,000	$43,775,000	($7,190,000)
4260-601-3331 Medi-Cal Drug Rebates Fund	$2,350,812,000	$2,846,543,000	$495,731,000
4260-601-8108 Global Payment Program Special Fund	$1,511,049,000	$1,506,551,000	($4,498,000)
4260-601-8113 DPH GME Special Fund	$627,342,000	$758,340,000	$130,998,000
4260-601-8144 DMPH GME IGT Fund	$0	$12,685,000	$12,685,000
4260-603-0001 Children's Hospital Directed Payment*	$220,416,000	$220,416,000	$0
4260-606-0834 SB 1100 DSH	$213,982,000	$225,667,000	$11,685,000
4260-611-3158 Hospital Quality Assurance Revenue	$10,935,432,000	$9,853,027,000	($1,082,405,000)
Total Benefits	**$83,065,186,000**	**$82,117,692,000**	**($947,494,000)**
Total Benefits General Fund *	**$46,981,325,000**	**$43,105,235,000**	**($3,876,090,000)**
Administration:			
4260-101-0001 Medi-Cal General Fund *	$1,805,765,000	$1,831,306,000	$25,541,000
4260-101-3085 Behavioral Health Service (100% SF)	$10,000,000	$10,000,000	$0
4260-101-8140 (1) Vision Services CHIP HSI	$2,427,000	$773,000	($1,654,000)
4260-117-0001 HIPAA *	$6,401,000	$6,694,000	$293,000
4260-601-0995 Reimbursement	$57,706,000	$148,631,000	$90,925,000
4260-601-3420 Behavioral Health IGT Fund	$12,500,000	$80,000,000	$67,500,000
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	$150,000	$0	($150,000)
Total Administration	**$1,894,949,000**	**$2,077,404,000**	**$182,455,000**
Total Administration General Fund *	**$1,812,166,000**	**$1,838,000,000**	**$25,834,000**
Grand Total - State Funds	**$84,960,135,000**	**$84,195,096,000**	**($765,039,000)**
Grand Total - General Fund*	**$48,793,491,000**	**$44,943,235,000**	**($3,850,256,000)**

Medi-Cal Funding Summary
May 2026 Estimate Compared to November 2025 Estimate
Fiscal Year 2026 - 2027

FEDERAL FUNDS

Benefits:	Nov 2025 Estimate	FY 2025-26 Appropriation	Difference Incr./(Decr.)
4260-101-0890 Federal Funds	$131,386,711,000	$125,753,751,000	($5,632,960,000)
4260-102-0890 Capital Debt	$46,230,000	$55,149,000	$8,919,000
4260-106-0890 Money Follows Person Federal Grant	$101,857,000	$100,298,000	($1,559,000)
4260-601-7502 Demonstration DSH Fund	$138,849,000	$127,089,000	($11,760,000)
4260-601-7503 Health Care Support Fund	$650,000	$623,000	($27,000)
Total Benefits	**$131,674,297,000**	**$126,036,910,000**	**($5,637,387,000)**
Administration:			
4260-101-0890 Federal Funds	$5,435,457,000	$6,087,546,000	$652,089,000
4260-106-0890 Money Follows Person Fed. Grant	$2,480,000	$2,316,000	($164,000)
4260-117-0890 HIPAA	$17,999,000	$18,845,000	$846,000
4260-601-7503 Health Care Support Fund	$346,856,000	$346,856,000	$0
Total Administration	**$5,802,792,000**	**$6,455,563,000**	**$652,771,000**
Grand Total - Federal Funds	**$137,477,089,000**	**$132,492,473,000**	**($4,984,616,000)**

Medi-Cal Funding Summary

May 2026 FY 2025-26 and FY 2026-27 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 2026-27

Benefits:	FY 2025-26 Estimate	FY 2026-27 Estimate
4260-101-0001 Medi-Cal General Funds	$0	$42,729,729,000
4260-101-0890 Medi-Cal Federal Funds	$0	$125,753,751,000
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$0	$52,996,000
4260-101-0233 Prop 99 Physician Srvc. Acct	$0	$15,144,000
4260-101-0236 Prop 99 Unallocated Account	$0	$24,421,000
4260-101-3085 Mental Health Services	$0	$163,128,000
4260-101-3156 MCO Tax Direct Appropriation	$0	$154,506,000
4260-101-3305 Healthcare Treatment Fund	$0	$461,274,000
4260-101-3311 Healthcare Plan Fines Penalties Fund	$0	$12,502,000
4260-101-3397 Opioid Settlements Fund	$0	$35,400,000
4260-101-3428 MCO Tax 2023	$0	$2,827,156,000
4260-101-3451 BH Schoolsite Fee Schedule Admi Fund	$0	$50,900,000
4260-102-0001 Capital Debt General Funds	$0	$27,610,000
4260-102-0890 Capital Debt Federal Funds	$0	$55,149,000
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	$100,298,000
4260-601-0995 Reimbursements	$0	$6,935,587,000
Total Benefits	**$0**	**$179,399,551,000**

County and Other Local Assistance Administration:	FY 2025-26 Estimate	FY 2026-27 Estimate
4260-101-0001 Medi-Cal General Funds	$0	$1,831,306,000
4260-101-0890 Medi-Cal Federal Funds	$0	$6,087,546,000
4260-101-3085 Mental Health Services	$0	$10,000,000
4260-101-8140 Vision Services CHIP HSI	$0	$773,000
4260-106-0890 Money Follow Person Fed. Grant	$0	$2,316,000
4260-117-0001 HIPAA General Funds	$0	$6,694,000
4260-117-0890 HIPAA Federal Funds	$0	$18,845,000
4260-601-0995 Reimbursements	$0	$148,631,000
Total County and Other Local Assistance Administration	**$0**	**$8,106,111,000**

Appropriation Year 2026-27 - Total Funds	**$0**	**$187,505,662,000**

Medi-Cal Funding Summary
May 2026 FY 2025-26 and FY 2026-27 Breakdown by Appropriation Year

TOTAL FUNDS

Appropriation Year 2025-26

Benefits:	FY 2025-26 Estimate	FY 2026-27 Estimate
4260-101-0001 Medi-Cal General Funds	$45,678,234,950	$0
4260-101-0890 Medi-Cal Federal Funds	$111,926,301,000	$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$48,640,000	$0
4260-101-0233 Prop 99 Physician Srvc. Acct	$13,894,000	$0
4260-101-0236 Prop 99 Unallocated Account	$24,851,000	$0
4260-101-3085 Mental Health Services	$47,000,000	$0
4260-101-3305 Healthcare Treatment Fund	$473,209,000	$0
4260-101-3311 Healthcare Plan Fines Penalties Fund	$20,400,000	$0
4260-101-3428 MCO Tax 2023	$3,942,987,000	$0
4260-102-0001 Capital Debt General Funds	$31,179,000	$0
4260-102-0890 Capital Debt Federal Funds	$58,430,000	$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	$87,709,000	$0
4260-601-0995 Reimbursements	$3,314,645,000	$0
Total Benefits	**$165,667,479,950**	**$0**
County and Other Local Assistance Administration:		
4260-101-0001 Medi-Cal General Funds	$2,573,115,000	$0
4260-101-0890 Medi-Cal Federal Funds	$4,576,246,000	$0
4260-101-3085 Mental Health Services	$58,708,000	$0
4260-101-8140 Vision Services CHIP HSI	$740,000	$0
4260-106-0890 Money Follow Person Fed. Grant	$2,235,000	$0
4260-117-0001 HIPAA General Funds	$6,516,000	$0
4260-117-0890 HIPAA Federal Funds	$18,794,000	$0
4260-601-0995 Reimbursements	$36,001,000	$0
Total County and Other Local Assistance Administration	**$7,272,355,000**	**$0**
Appropriation Year 2025-26 - Total Funds	**$172,939,834,950**	**$0**

Medi-Cal Funding Summary
May 2026 FY 2025-26 and FY 2026-27 Breakdown by Appropriation Year

TOTAL FUNDS

Appropriation Year 2022-23

Benefits:	FY 2025-26 Estimate	FY 2026-27 Estimate
4260-101-0001 Medi-Cal General Funds	$211,261,050	$9,080,000
Total Benefits	**$211,261,050**	**$9,080,000**
Appropriation Year 2022-23 - Total Funds	**$211,261,050**	**$9,080,000**

Non-Budget Act Items

Benefits:	FY 2025-26 Estimate	FY 2026-27 Estimate
4260-601-3375 Medi-Cal Loan Repayment Program 601	$44,217,000	$36,143,000
4260-601-3096 NDPH Suppl	$8,928,000	$62,000
4260-601-3097 Private Hosp Suppl	$237,593,000	$208,360,000
4260-601-3420 Behavioral Health IGT Fund	$3,796,525,000	$3,559,155,000
4260-601-0942142 Local Trauma Centers	$60,328,000	$84,950,000
4260-601-3213 LTC QA Fund	$688,731,000	$753,912,000
4260-601-3323 Medi-Cal Emergency Transport Fund	$47,660,000	$43,775,000
4260-601-3331 Medi-Cal Drug Rebates Fund	$2,386,754,000	$2,846,543,000
4260-601-3442 Protect Access to Health Care Fund	$0	$1,881,637,000
4260-601-3443 Healthcare Oversight & Acct. Subfund	$6,833,379,000	$5,919,286,000
4260-601-3492 2027 MCO Tax Fund	$0	$707,750,000
4260-601-7502 Demonstration DSH Fund	$113,031,000	$127,089,000
4260-601-7503 Health Care Support Fund	$336,000	$623,000
4260-601-8107 Whole Person Care Pilot Special Fund	$11,033,000	$0
4260-601-8108 Global Payment Program Fund	$1,490,809,000	$1,506,551,000
4260-601-8113 DPH GME Special Fund	$518,074,000	$758,340,000
4260-601-8144 DMPH GME IGT Fund	$0	$12,685,000
4260-603-0001 Children’s Hospital Directed Payment*	$0	$220,416,000
4260-606-0834 SB 1100 DSH	$222,352,000	$225,667,000
4260-611-3158 Hospital Quality Assurance Revenue	$2,030,938,000	$9,853,027,000
4260-601-0201 Medical Provider Interim Pmt Loan	$2,541,324,000	$0
Total Benefits	**$21,032,012,000**	**$28,745,971,000**
County and Other Local Assistance Administration:		
4260-601-3420 Behavioral Health IGT Fund	$24,312,000	$80,000,000
4260-601-7503 Health Care Support Fund	$178,255,000	$346,856,000
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	$150,000	$0
Total County and Other Local Assistance Administration	**$202,717,000**	**$426,856,000**
Non-Budget Act Items - Total Funds	**$21,234,729,000**	**$29,172,827,000**
Grand Total - Total Funds	**$194,385,825,000**	**$216,687,569,000**

TABLE OF CONTENTS

CURRENT YEAR

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

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

SUMMARY OF BASE POLICY CHANGES 2-3

SUMMARY OF REGULAR POLICY CHANGES 4-9

SUMMARY OF COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION POLICY CHANGES...10-13

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY AND FUND TYPE 14

MEDI-CAL TOTAL FUND EXPENDITURES BY SERVICE CATEGORY, CURRENT YEAR ESTIMATE COMPARISON...15-16

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES, CURRENT YEAR ESTIMATE COMPARISON...17-18

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES, CURRENT YEAR ESTIMATE COMPARISON...19-27

COMPARISON OF FISCAL IMPACTS OF COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION POLICY CHANGES, CURRENT YEAR ESTIMATE COMPARISON 28-32

COST PER ELIGIBLE BY SERVICE CATEGORY 33-38

MEDI-CAL PROGRAM ESTIMATE SUMMARY
FISCAL YEAR 2025-26

	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER FUNDS
I. BASE ESTIMATES				
A. C/Y BASE POLICY CHANGES	$139,688,217,270	$81,008,998,260	$54,924,044,020	$3,755,175,000
B. BASE ADJUSTMENTS	($285,532,000)	($244,763,150)	($40,768,850)	$0
C. ADJUSTED BASE	**$139,402,685,270**	**$80,764,235,110**	**$54,883,275,170**	**$3,755,175,000**
II. REGULAR POLICY CHANGES				
A. ELIGIBILITY	($122,205,650)	$320,300,500	($444,989,150)	$2,483,000
B. AFFORDABLE CARE ACT	$11,424,226,000	$11,466,405,600	($42,179,600)	$0
C. BENEFITS	$1,264,408,770	$1,176,479,070	$87,929,700	$0
D. PHARMACY	($8,347,953,160)	($8,213,139,480)	($2,521,567,680)	$2,386,754,000
E. DRUG MEDI-CAL	$33,378,170	$21,859,620	$8,927,070	$2,591,480
F. MENTAL HEALTH	$158,368,000	$74,305,700	$45,103,300	$38,959,000
G. WAIVER--MH/UCD & BTR	$5,397,149,000	$2,892,935,700	$1,013,404,300	$1,490,809,000
H. MANAGED CARE	$23,738,095,000	$15,186,114,900	($3,763,884,900)	$12,315,865,000
I. PROVIDER RATES	$1,369,966,010	$823,732,170	($1,905,498,400)	$2,451,732,240
J. SUPPLEMENTAL PMNTS.	$10,429,837,480	$6,771,841,240	$254,452,140	$3,403,544,100
K. COVID-19	($190,617,670)	($118,640,390)	($71,977,280)	$0
L. STATE-ONLY CLAIMING	$0	($326,604,680)	$326,604,680	$0
M. OTHER DEPARTMENTS	$1,235,310,000	$1,235,310,000	$0	$0
N. OTHER	$1,118,103,880	$110,671,500	($1,828,624,610)	$2,836,057,000
O. TOTAL CHANGES	**$47,508,065,840**	**$31,421,571,440**	**($8,842,300,430)**	**$24,928,794,830**
III. SUBTOTAL BENEFITS	**$186,910,751,110**	**$112,185,806,550**	**$46,040,974,730**	**$28,683,969,830**
IV. COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION	**$7,475,070,000**	**$4,775,528,550**	**$2,579,630,450**	**$119,911,000**
V. TOTAL MEDI-CAL ESTIMATE	**$194,385,821,110**	**$116,961,335,100**	**$48,620,605,180**	**$28,803,880,830**

* Rounded to nearest 10

SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2025-26

FRN	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER FUNDS
	DRUG MEDI-CAL				
2012	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	$2,125,136,000	$1,636,833,550	$322,603,450	$165,699,000
2320	DRUG MEDI-CAL STATE PLAN SERVICES	$49,221,000	$35,459,300	$3,394,700	$10,367,000
	DRUG MEDI-CAL SUBTOTAL	**$2,174,357,000**	**$1,672,292,850**	**$325,998,150**	**$176,066,000**
	MENTAL HEALTH				
1780	SMHS FOR ADULTS	$5,958,142,000	$4,048,887,300	$504,458,700	$1,404,796,000
1779	SMHS FOR CHILDREN	$4,861,069,000	$2,593,767,700	$92,988,300	$2,174,313,000
	MENTAL HEALTH SUBTOTAL	**$10,819,211,000**	**$6,642,655,000**	**$597,447,000**	**$3,579,109,000**
	MANAGED CARE				
56	TWO PLAN MODEL	$35,773,534,000	$20,342,731,500	$15,430,802,500	$0
57	COUNTY ORGANIZED HEALTH SYSTEMS & SINGLE PLAN	$19,965,233,000	$11,510,441,400	$8,454,791,600	$0
58	GEOGRAPHIC MANAGED CARE	$6,238,879,000	$3,728,428,950	$2,510,450,050	$0
62	PACE (Other M/C)	$2,474,328,000	$1,159,411,600	$1,314,916,400	$0
1842	REGIONAL MODEL	$226,218,000	$143,439,300	$82,778,700	$0
1029	DENTAL MANAGED CARE (Other M/C)	$175,042,000	$96,180,200	$78,861,800	$0
61	SENIOR CARE ACTION NETWORK (Other M/C)	$109,154,000	$54,097,000	$55,057,000	$0
1837	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	$59,467,000	$37,533,000	$21,934,000	$0
1823	COUNTY CHILDREN’S HEALTH INITIATIVE PROGRAM	$16,267,000	$10,573,550	$5,693,450	$0
63	AIDS HEALTHCARE CENTERS (Other M/C)	$12,536,000	$7,616,000	$4,920,000	$0
1797	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	$3,051,000	$1,983,150	$1,067,850	$0
	MANAGED CARE SUBTOTAL	**$65,053,709,000**	**$37,092,435,650**	**$27,961,273,350**	**$0**
	FEE-FOR-SERVICE BASE				
2540	FFS - PHARMACY	$24,051,152,000	$13,802,458,000	$10,248,694,000	$0
2539	FFS - OTHER MEDICAL	$7,999,778,000	$4,072,097,950	$3,927,680,050	$0
2543	FFS - COMMUNITY INPATIENT	$3,206,229,000	$2,064,920,600	$1,141,308,400	$0
2547	FFS - OTHER SERVICES	$1,841,281,000	$942,687,750	$898,593,250	$0
2544	FFS - NURSING FACILITIES	$737,897,000	$405,665,300	$332,231,700	$0
2542	FFS - COUNTY INPATIENT	$615,158,000	$606,812,950	$8,345,050	$0
2541	FFS - CO. & COMM. OUTPATIENT	$619,973,000	$342,256,950	$277,716,050	$0
2538	FFS - PHYSICIANS	$521,854,000	$291,207,650	$230,646,350	$0
2548	FFS - HOME HEALTH	$132,896,000	$68,688,200	$64,207,800	$0
2546	FFS - MEDICAL TRANSPORTATION	$75,851,000	$50,839,100	$25,011,900	$0
2545	FFS - ICF-DD	$8,148,000	$4,147,400	$4,000,600	$0
	FEE-FOR-SERVICE BASE SUBTOTAL	**$39,810,217,000**	**$22,651,781,850**	**$17,158,435,150**	**$0**
	OTHER				
76	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$5,975,627,000	$2,527,028,000	$3,448,599,000	$0

SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2025-26

FRN	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER FUNDS
	OTHER				
22	PERSONAL CARE SERVICES (Misc. Svcs.)	$4,224,145,000	$4,224,145,000	$0	$0
23	HOME & COMMUNITY-BASED SVCS.- CDDS (Misc.)	$4,605,030,000	$4,605,030,000	$0	$0
1019	MEDICARE PAYMENTS - PART D PHASED-DOWN	$4,024,294,000	$0	$4,024,294,000	$0
135	DENTAL SERVICES	$2,701,106,000	$1,426,627,100	$1,274,478,900	$0
32	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$525,081,000	$260,280,000	$264,801,000	$0
26	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$502,052,000	$502,052,000	$0	$0
2080	LAWSUITS/CLAIMS	$208,519,000	$104,259,500	$104,259,500	$0
77	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$18,877,000	$18,877,000	$0	$0
27	MEDI-CAL TCM PROGRAM	$12,304,000	$12,304,000	$0	$0
91	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$243,000	$121,500	$121,500	$0
127	BASE RECOVERIES	($966,554,000)	($730,890,700)	($235,663,300)	$0
	OTHER SUBTOTAL	**$21,830,724,000**	**$12,949,833,400**	**$8,880,890,600**	**$0**
	GRAND TOTAL	**$139,688,218,000**	**$81,008,998,750**	**$54,924,044,250**	**$3,755,175,000**

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2025-26

FRN	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER FUNDS
	ELIGIBILITY				
1569	MEDI-CAL STATE INMATE PROGRAMS	$47,616,000	$47,616,000	$0	$0
2332	CALAIM - INMATE PRE-RELEASE PROGRAM	$9,293,740	$7,981,640	$1,312,100	$0
3	BREAST AND CERVICAL CANCER TREATMENT	$12,399,000	$6,337,650	$6,061,350	$0
2422	HEALTH ENROLLMENT NAVIGATORS FOR CLINICS	$8,244,000	$4,122,000	$4,122,000	$0
13	NON-OTLICP CHIP	$0	$126,430,800	($126,430,800)	$0
1007	SCHIP FUNDING FOR PRENATAL CARE	$0	$80,347,150	($80,347,150)	$0
2155	CS3 PROXY ADJUSTMENT	$0	$113,512,600	($113,512,600)	$0
2237	REFUGEE MEDICAL ASSISTANCE	$0	$0	($47,000)	$47,000
2029	MEDI-CAL COUNTY INMATE REIMBURSEMENT	$0	$0	($2,436,000)	$2,436,000
2500	SB 525 MINIMUM WAGE - CASELOAD IMPACT	($4,883,080)	($2,929,850)	($1,953,230)	$0
2535	REINSTATEMENT OF ASSET LIMIT	($104,689,690)	($52,344,850)	($52,344,850)	$0
2530	FULL-SCOPE MEDI-CAL EXPANSION ENROLLMENT FREEZE	($90,185,610)	($10,772,640)	($79,412,970)	$0
	ELIGIBILITY SUBTOTAL	**($122,205,650)**	**$320,300,500**	**($444,989,150)**	**$2,483,000**
	AFFORDABLE CARE ACT				
1595	COMMUNITY FIRST CHOICE OPTION	$11,410,654,000	$11,410,654,000	$0	$0
1967	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	$13,572,000	$13,572,000	$0	$0
1791	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	$6,154,000	($6,154,000)	$0
1821	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	$0	$36,025,600	($36,025,600)	$0
	AFFORDABLE CARE ACT SUBTOTAL	**$11,424,226,000**	**$11,466,405,600**	**($42,179,600)**	**$0**
	BENEFITS				
25	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$976,828,000	$976,828,000	$0	$0
1	FAMILY PACT PROGRAM	$105,766,000	$78,983,600	$26,782,400	$0
1228	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$111,759,000	$86,973,000	$24,786,000	$0
28	MULTIPURPOSE SENIOR SERVICES PROGRAM	$63,951,000	$31,736,500	$32,214,500	$0
2457	CYBHI WELLNESS COACH BENEFIT	$99,000	$56,000	$43,000	$0
1855	BEHAVIORAL HEALTH TREATMENT	$7,792,000	$3,896,000	$3,896,000	$0
2189	HEARING AID COVERAGE FOR CHILDREN PROGRAM	$1,401,770	$0	$1,401,770	$0
1562	CCT FUND TRANSFER TO CDSS	$736,000	$736,000	$0	$0
2528	UTILIZATION MANAGEMENT FOR HOSPICE	($7,000,000)	($4,321,130)	($2,678,870)	$0
2570	MEASLES, MUMPS, RUBELLA, VARICELLA (MMRV) VACCINES	$3,076,000	$1,591,100	$1,484,900	$0
	BENEFITS SUBTOTAL	**$1,264,408,770**	**$1,176,479,070**	**$87,929,700**	**$0**

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2025-26

FRN	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER FUNDS
	PHARMACY				
2512	CELL AND GENE THERAPY ACCESS MODEL	$18,110,000	$9,055,000	$9,055,000	$0
2194	PHARMACY RETROACTIVE ADJUSTMENTS	$800,000	($30,949,250)	$31,749,250	$0
2124	MEDI-CAL DRUG REBATE FUND	$0	$0	($2,386,754,000)	$2,386,754,000
1449	LITIGATION SETTLEMENTS	($6,000)	$0	($6,000)	$0
1433	BCCTP DRUG REBATES	($1,320,000)	($1,320,000)	$0	$0
51	FAMILY PACT DRUG REBATES	($2,477,000)	($2,477,000)	$0	$0
2519	UPDATES TO OTC COVID-19 TESTS AND OTC PRODUCTS	($4,360,000)	($2,531,100)	($1,828,900)	$0
2526	PHARMACY UTILIZATION MANAGEMENT	($16,011,490)	($9,295,940)	($6,715,550)	$0
2520	ELIMINATE GLP-1 COVERAGE FOR WEIGHT LOSS	($77,607,320)	($190,060)	($77,417,260)	$0
2518	PRIOR AUTH. FOR CONTINUATION OF DRUG THERAPY	($100,071,810)	($58,095,980)	($41,975,830)	$0
1181	MEDICAL SUPPLY REBATES	($153,000,000)	($76,500,000)	($76,500,000)	$0
2527	STEP THERAPY	($140,100,540)	($81,334,250)	($58,766,290)	$0
54	STATE SUPPLEMENTAL DRUG REBATES	($637,806,000)	($637,806,000)	$0	$0
55	FEDERAL DRUG REBATES	($7,210,876,000)	($7,210,876,000)	$0	$0
2557	PHARMACY PAYMENT METHODOLOGY - USUAL AND CUSTOMARY	($8,641,000)	($102,351,100)	$93,710,100	$0
2579	MEDI-CAL RX FRAUD, WASTE, & ABUSE PREVENTION	($14,586,000)	($8,467,800)	($6,118,200)	$0
	PHARMACY SUBTOTAL	**($8,347,953,160)**	**($8,213,139,480)**	**($2,521,567,680)**	**$2,386,754,000**
	DRUG MEDI-CAL				
2278	RECOVERY INCENTIVES CONTINGENCY MANAGEMENT	$13,299,000	$10,751,000	$0	$2,548,000
1723	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	$19,878,000	$10,964,000	$8,914,000	$0
1724	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	$201,170	$144,620	$13,070	$43,480
	DRUG MEDI-CAL SUBTOTAL	**$33,378,170**	**$21,859,620**	**$8,927,070**	**$2,591,480**
	MENTAL HEALTH				
2394	CALAIM - BH - CONNECT DEMONSTRATION	$113,933,000	$71,998,000	$11,908,000	$30,027,000
2252	MHP COSTS FOR FFPSA	$34,932,000	$17,468,000	$8,732,000	$8,732,000
1957	MHP COSTS FOR CONTINUUM OF CARE REFORM	$2,024,000	$112,700	$1,911,300	$0
2268	OUT OF STATE YOUTH - SMHS	$930,000	$465,000	$465,000	$0
1660	IMPERIAL AND SISKIYOU COUNTY MHP OVERPAYMENT	$0	$0	($200,000)	$200,000
1713	INTERIM AND FINAL COST SETTLEMENTS - SMHS	($13,451,000)	($15,738,000)	$2,287,000	$0
2574	RETRO PAYMENTS TO COUNTIES FOR STATE-ONLY BH SVCS	$20,000,000	$0	$20,000,000	$0
	MENTAL HEALTH SUBTOTAL	**$158,368,000**	**$74,305,700**	**$45,103,300**	**$38,959,000**

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2025-26

FRN	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER FUNDS
	WAIVER--MH/UCD & BTR				
1951	GLOBAL PAYMENT PROGRAM	$2,981,620,000	$1,490,811,000	$0	$1,490,809,000
2245	CALAIM ECM-COMMUNITY SUPPORTS-TRANSITIONAL RENT	$2,415,193,000	$1,401,788,700	$1,013,404,300	$0
1769	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	$336,000	$336,000	$0	$0
	WAIVER--MH/UCD & BTR SUBTOTAL	**$5,397,149,000**	**$2,892,935,700**	**$1,013,404,300**	**$1,490,809,000**
	MANAGED CARE				
2408	2023 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	$15,208,141,000	$9,659,035,700	$5,549,105,300	$0
2061	MANAGED CARE HEALTH CARE FINANCING PROGRAM	$2,990,968,000	$1,871,447,850	$1,119,520,150	$0
2060	MANAGED CARE PUBLIC HOSPITAL EPP	$2,362,740,000	$1,513,186,800	$849,553,200	$0
2062	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	$2,204,499,000	$1,541,776,900	$662,722,100	$0
2388	WORKFORCE & QUALITY INCENTIVE PROGRAM	$310,868,000	$145,021,950	$165,846,050	$0
2504	MEDI-CAL MANAGED CARE QUALITY WITHHOLD RELEASE	$252,096,000	$148,457,400	$103,638,600	$0
2437	MANAGED CARE DISTRICT HOSPITAL DIRECTED PAYMENTS	$204,032,000	$133,580,000	$0	$70,452,000
2448	MANAGED CARE PUBLIC DP-NF PASS-THROUGH PYMT PROG	$76,397,000	$36,623,100	$39,773,900	$0
2031	CCI-QUALITY WITHHOLD REPAYMENTS	$15,837,000	$7,918,500	$7,918,500	$0
2406	2023 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	$0	$0	($4,712,883,000)	$4,712,883,000
2407	2023 MCO ENROLLMENT TAX MANAGED CARE PLANS	$0	$0	($4,478,050,000)	$4,478,050,000
2063	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	$0	$0	($3,054,480,000)	$3,054,480,000
1788	RETRO MC RATE ADJUSTMENTS	$154,235,000	$156,864,200	($2,629,200)	$0
2576	MANAGED CARE RISK CORRIDORS	($41,718,000)	($27,797,500)	($13,920,500)	$0
	MANAGED CARE SUBTOTAL	**$23,738,095,000**	**$15,186,114,900**	**($3,763,884,900)**	**$12,315,865,000**
	PROVIDER RATES				
88	RATE INCREASE FOR FQHCS/RHCS/CBRCS	$430,063,010	$190,890,180	$239,172,830	$0
2267	PP-GEMT IGT PROGRAM	$410,737,630	$271,871,410	$8,957,520	$129,908,700
2081	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	$140,605,370	$98,353,450	($5,407,620)	$47,659,540
1152	DPH INTERIM & FINAL RECONS	$130,113,000	$130,113,000	$0	$0
2181	NURSING FACILITY RATE ADJUSTMENTS	$85,652,380	$45,532,810	$40,119,570	$0
1329	FQHC/RHC/CBRC RECONCILIATION PROCESS	$108,847,000	$48,313,350	$60,533,650	$0
2184	GDSP NBS & PNS FEE ADJUSTMENTS	$44,550,000	$27,185,050	$17,364,950	$0
1046	LTC RATE ADJUSTMENT	$9,241,320	$4,838,830	$4,402,490	$0
96	HOSPICE RATE INCREASES	$10,156,300	$6,634,100	$3,522,200	$0
1784	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	$0	$0	($688,731,000)	$688,731,000

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2025-26

FRN	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER FUNDS
	PROVIDER RATES				
2509	PROP 35 - PROVIDER PAYMENT INCREASE FUNDING	$0	$0	($1,585,433,000)	$1,585,433,000
	PROVIDER RATES SUBTOTAL	**$1,369,966,010**	**$823,732,170**	**($1,905,498,400)**	**$2,451,732,240**
	SUPPLEMENTAL PMNTS.				
2055	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	$6,291,696,000	$3,996,900,400	$0	$2,294,795,600
1475	HOSPITAL QAF - FFS PAYMENTS	($199,543,000)	$149,013,000	$0	($348,556,000)
2024	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	$1,110,346,000	$613,787,000	$0	$496,559,000
1071	PRIVATE HOSPITAL DSH REPLACEMENT	$769,852,000	$384,926,000	$384,926,000	$0
1073	DSH PAYMENT	$604,637,000	$358,834,000	$43,553,000	$202,250,000
1085	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	$505,332,000	$267,739,000	$118,400,000	$119,193,000
2130	PROP 56 - MEDI-CAL FAMILY PLANNING	$442,849,000	$296,694,900	$146,154,100	$0
78	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$231,553,000	$231,553,000	$0	$0
1078	DPH PHYSICIAN & NON-PHYS. COST	$181,065,000	$181,065,000	$0	$0
1899	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	$134,080,000	$78,347,000	($1,388,000)	$57,121,000
104	FFP FOR LOCAL TRAUMA CENTERS	$131,325,000	$70,997,000	$0	$60,328,000
82	CAPITAL PROJECT DEBT REIMBURSEMENT	$81,745,000	$58,430,000	$23,315,000	$0
1600	NDPH IGT SUPPLEMENTAL PAYMENTS	$43,685,000	$24,980,500	($1,397,000)	$20,101,500
2049	PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS	$43,837,480	$27,350,440	$16,487,040	$0
1076	NDPH SUPPLEMENTAL PAYMENT	$18,234,000	$9,306,000	$1,900,000	$7,028,000
1616	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	$15,425,000	$15,425,000	$0	$0
1038	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	$10,000,000	$5,000,000	$5,000,000	$0
1039	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	$8,000,000	$4,000,000	$4,000,000	$0
86	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	$7,087,000	$7,087,000	$0	$0
2044	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	$6,226,000	$0	$6,226,000	$0
2303	FREE CLINICS AUGMENTATION	$2,000,000	$0	$2,000,000	$0
2102	PROPOSITION 56 FUNDING	$0	$0	($473,209,000)	$473,209,000
1601	IGT ADMIN. & PROCESSING FEE	$0	$0	($21,515,000)	$21,515,000
1661	GEMT SUPPLEMENTAL PAYMENT PROGRAM	($9,594,000)	($9,594,000)	$0	$0
	SUPPLEMENTAL PMNTS. SUBTOTAL	**$10,429,837,480**	**$6,771,841,240**	**$254,452,140**	**$3,403,544,100**

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2025-26

FRN	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER FUNDS
	COVID-19				
2363	COVID-19 VACCINE FUNDING ADJUSTMENT	$0	$11,893,000	($11,893,000)	$0
2218	COVID-19 END OF UNWINDING FLEXIBILITIES	($190,617,670)	($130,533,390)	($60,084,280)	$0
	COVID-19 SUBTOTAL	**($190,617,670)**	**($118,640,390)**	**($71,977,280)**	**$0**
	STATE-ONLY CLAIMING				
2415	STATE-ONLY CLAIMING ADJUSTMENTS - RETRO ADJ.	$0	($326,604,680)	$326,604,680	$0
	STATE-ONLY CLAIMING SUBTOTAL	**$0**	**($326,604,680)**	**$326,604,680**	**$0**
	OTHER DEPARTMENTS				
1476	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$1,235,310,000	$1,235,310,000	$0	$0
	OTHER DEPARTMENTS SUBTOTAL	**$1,235,310,000**	**$1,235,310,000**	**$0**	**$0**
	OTHER				
2354	BEHAVIORAL HEALTH BRIDGE HOUSING	$281,087,000	$0	$239,087,000	$42,000,000
2208	SELF-DETERMINATION PROGRAM - CDDS	$345,739,000	$345,739,000	$0	$0
2329	QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES	$155,373,000	$132,067,000	$23,306,000	$0
2092	QAF WITHHOLD TRANSFER	$9,624,000	$4,812,000	$4,812,000	$0
2424	CYBHI - FEE SCHEDULE THIRD PARTY ADMINISTRATOR	$39,500,000	$0	$39,500,000	$0
1232	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	$94,506,000	$94,506,000	$0	$0
2346	EQUITY & PRACTICE TRANSFORMATION PAYMENTS	$59,200,000	$39,525,950	$19,674,050	$0
2097	MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG	$44,217,000	$0	$0	$44,217,000
2549	PROPOSITION 36 FUNDING	$50,000,000	$0	$50,000,000	$0
2439	CALAIM - PATH WPC	$21,627,000	$10,594,000	$0	$11,033,000
1975	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	$11,755,750	$5,713,360	$6,042,390	$0
2396	CARE ACT	$13,804,000	$0	$13,804,000	$0
111	INDIAN HEALTH SERVICES	$3,693,980	$2,462,690	$1,231,290	$0
2009	INFANT DEVELOPMENT PROGRAM	$34,868,000	$34,868,000	$0	$0
2550	BACKFILL LOST TITLE X FAMILY PLANNING FUNDING	$15,000,000	$0	$15,000,000	$0
1526	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	$15,559,000	$8,439,000	$7,120,000	$0
2502	MISC. ONE-TIME PAYMENTS	$12,550,000	$0	$12,550,000	$0
2375	CYBHI - URGENT NEEDS AND EMERGENT ISSUES	$10,100,000	$0	$10,100,000	$0
2355	CALHOPE	$5,000,000	$0	$0	$5,000,000
2443	ASSET LIMIT INCREASE & ELIM. - CNTY BH FUNDING	$5,688,000	$0	$5,688,000	$0
1866	WPCS WORKERS' COMPENSATION	$620,000	$310,000	$310,000	$0
35	IMD ANCILLARY SERVICES	$0	($57,766,000)	$57,766,000	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2025-26

FRN	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER FUNDS
	OTHER				
1087	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	$0	($87,385,000)	$87,385,000
1760	HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	$0	($84,698,000)	$84,698,000
2034	CMS DEFERRED CLAIMS	$0	($477,700,000)	$477,700,000	$0
2156	INDIAN HEALTH SERVICES FUNDING SHIFT	$0	$28,729,000	($28,729,000)	$0
2503	MEDICAL PROVIDER INTERIM PAYMENT LOAN	$0	$0	($2,541,324,000)	$2,541,324,000
2484	HEALTH CARE SVCS. FINES AND PENALTIES	$0	$0	($20,400,000)	$20,400,000
2497	QUALITY SANCTIONS	($1,460,000)	($730,000)	($730,000)	$0
2054	ASSISTED LIVING WAIVER EXPANSION	($657,190)	($315,840)	($341,350)	$0
2010	HCBA WAIVER EXPANSION	($6,744,660)	($3,343,670)	($3,400,990)	$0
1906	COUNTY SHARE OF OTLICP-CCS COSTS	($17,000,000)	$0	($17,000,000)	$0
2343	COUNTY BH RECOUPMENTS	($85,546,000)	$0	($85,546,000)	$0
110	AUDIT SETTLEMENTS	$0	($57,239,000)	$57,239,000	$0
	OTHER SUBTOTAL	**$1,118,103,880**	**$110,671,500**	**($1,828,624,610)**	**$2,836,057,000**
	GRAND TOTAL	**$47,508,065,840**	**$31,421,571,440**	**($8,842,300,430)**	**$24,928,794,820**

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

SUMMARY OF COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION POLICY CHANGES FISCAL YEAR 2025-26

FRN.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER FUNDS
	COUNTY ADMIN				
1704	COUNTY ADMINISTRATION ALLOCATION	$2,377,805,000	$1,188,902,500	$1,188,902,500	$0
214	SAWS	$200,841,000	$200,435,500	$405,500	$0
217	CALWORKS APPLICATIONS	$99,964,000	$49,982,000	$49,982,000	$0
1598	CASE MANAGEMENT FOR OTLICP	$44,763,000	$22,381,500	$22,381,500	$0
213	LOS ANGELES COUNTY HOSPITAL INTAKES	$20,166,000	$17,430,000	$2,736,000	$0
215	SAVE	$0	$4,000,000	($4,000,000)	$0
1835	ENHANCED FEDERAL FUNDING	$0	$608,380,250	($608,380,250)	$0
	COUNTY ADMIN SUBTOTAL	**$2,743,539,000**	**$2,091,511,750**	**$652,027,250**	**$0**
	DHCS-OTHER				
2389	CALAIM - PATH	$473,522,000	$236,761,000	$214,535,000	$22,226,000
1721	COUNTY SPECIALTY MENTAL HEALTH ADMIN	$284,592,000	$273,949,000	$10,643,000	$0
1757	INTERIM AND FINAL COST SETTLEMENTS-SMHS	$186,894,000	$186,894,000	$0	$0
230	CCS PROGRAM COUNTY ADMINISTRATIVE BUDGET	$204,223,000	$131,628,950	$72,594,050	$0
2289	CYBHI - BH SERVICES AND SUPPORTS PLATFORM	$175,900,000	$0	$175,900,000	$0
2167	MEDI-CAL RX - ADMINISTRATIVE COSTS	$158,298,000	$116,796,750	$41,501,250	$0
1963	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	$167,907,000	$167,907,000	$0	$0
235	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	$153,579,000	$153,579,000	$0	$0
1813	DRUG MEDI-CAL COUNTY ADMINISTRATION	$119,212,000	$118,580,000	$632,000	$0
2517	CALAIM-BH-CONNECT WORKFORCE INITIATIVE	$95,095,000	$95,095,000	$0	$0
2491	BH TRANSFORMATION FUNDING FOR COUNTY BH DEPTS.	$93,508,000	$38,508,000	$0	$55,000,000
231	POSTAGE & PRINTING	$71,362,000	$35,552,500	$35,809,500	$0
2288	CALAIM - POPULATION HEALTH MANAGEMENT	$71,365,000	$68,566,000	$2,799,000	$0
1722	SMH MAA	$52,327,000	$52,327,000	$0	$0
2398	CALAIM - BH - CONNECT DEMONSTRATION ADMIN	$65,490,000	$32,745,000	$8,433,000	$24,312,000
1937	ACTUARIAL COSTS FOR RATE DEVELOPMENT	$41,000,000	$20,500,000	$20,350,000	$150,000
1551	MEDI-CAL RECOVERY CONTRACTS	$41,445,000	$31,083,750	$10,361,250	$0
252	ENTERPRISE DATA ENVIRONMENT	$29,978,000	$21,924,400	$8,053,600	$0
1748	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	$29,494,000	$14,475,700	$15,018,300	$0
1137	MITA	$33,594,000	$29,327,700	$4,266,300	$0
2505	ELECTRONIC VISIT VERIFICATION M&O COSTS	$37,762,000	$37,762,000	$0	$0
2402	EMSA - CALIFORNIA POISON CONTROL SYSTEM SVCS.	$16,289,000	$16,289,000	$0	$0
2152	HCBA WAIVER ADMINISTRATIVE COST	$22,026,000	$10,918,000	$11,108,000	$0
1932	PAVE SYSTEM	$16,316,000	$11,789,300	$4,526,700	$0

SUMMARY OF COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION POLICY CHANGES FISCAL YEAR 2025-26

FRN.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER FUNDS
	DHCS-OTHER				
1318	CAPMAN	$19,788,000	$14,674,550	$5,113,450	$0
1720	PASRR	$11,373,000	$8,529,750	$2,843,250	$0
1732	SDMC SYSTEM M&O SUPPORT	$2,689,000	$1,344,500	$1,344,500	$0
2002	ELECTRONIC ASSET VERIFICATION PROGRAM	$8,632,000	$4,316,000	$4,316,000	$0
1452	PROTECTION OF PHI DATA	$5,538,000	$2,769,000	$2,769,000	$0
2414	BHSF - PROVIDER ACES TRAININGS	$7,415,000	$3,707,000	$0	$3,708,000
2467	MOBILE VISION SERVICES	$2,114,000	$1,374,000	$0	$740,000
1982	MEDCOMPASS SOLUTION	$7,036,000	$5,186,200	$1,849,800	$0
1824	NEWBORN HEARING SCREENING PROGRAM	$6,220,000	$3,110,000	$3,110,000	$0
2206	DRUG MEDI-CAL PARITY RULE ADMINISTRATION	$5,875,000	$3,917,000	$1,958,000	$0
1972	PACES	$3,761,000	$2,772,450	$988,550	$0
2413	CALAIM - INMATE PRE-RELEASE PROGRAM ADMIN	$2,746,000	$1,373,000	$1,373,000	$0
2358	STATEWIDE VERIFICATION HUB	$112,000	$100,800	$11,200	$0
1902	DATA ANALYTICS	$3,357,000	$2,427,000	$930,000	$0
2321	MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM	$2,200,000	$1,100,000	$1,100,000	$0
2392	MFP/CCT SUPPLEMENTAL FUNDING	$1,871,000	$1,871,000	$0	$0
1768	T-MSIS	$1,849,000	$1,403,950	$445,050	$0
237	SSA COSTS FOR HEALTH COVERAGE INFO.	$1,800,000	$900,000	$900,000	$0
1441	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$1,022,000	$729,000	$293,000	$0
1675	FAMILY PACT PROGRAM ADMIN.	$1,568,000	$784,000	$784,000	$0
2362	RECOVERY INCENTIVES CONTINGENCY MANAGEMENT ADMIN	$1,046,000	$1,046,000	$0	$0
266	MMA - DSH ANNUAL INDEPENDENT AUDIT	$444,000	$222,000	$222,000	$0
2159	HEALTH INFORMATION EXCHANGE INTEROPERABILITY	$250,000	$218,300	$31,700	$0
1556	CCT OUTREACH - ADMINISTRATIVE COSTS	$364,000	$364,000	$0	$0
2438	HEALTH PLAN OF SAN MATEO DENTAL INTEGRATION EVAL	$186,000	$93,000	$0	$93,000
2123	CMS DEFERRED CLAIMS - OTHER ADMIN	$0	($582,438,000)	$582,438,000	$0
2459	DESIGNATED STATE HEALTH PROGRAMS	$0	$178,255,000	($178,255,000)	$0
2562	EPTP - STATEWIDE LEARNING COLLABORATIVE	$6,900,000	$3,450,000	$3,450,000	$0
2559	STATE ONLY CLAIMING ADJUSTMENTS - ADMIN.	$0	($622,631,000)	$622,631,000	$0
	DHCS-OTHER SUBTOTAL	**$2,747,334,000**	**$943,927,550**	**$1,697,177,450**	**$106,229,000**
	DHCS-MEDICAL FI				
2115	MEDICAL FI BO & IT COST REIMBURSEMENT	$63,944,000	$46,226,150	$17,717,850	$0
2117	MEDICAL FI BO & IT CHANGE ORDERS	$41,156,000	$30,333,850	$10,822,150	$0
2119	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	$45,487,000	$33,527,100	$11,959,900	$0

SUMMARY OF COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION POLICY CHANGES FISCAL YEAR 2025-26

FRN.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER FUNDS
	DHCS-MEDICAL FI				
2118	MEDICAL INFRASTRUCTURE & DATA MGT SVCS	$44,894,000	$33,092,050	$11,801,950	$0
2112	MEDICAL FI BO OTHER ESTIMATED COSTS	$26,475,000	$18,521,150	$7,953,850	$0
2116	MEDICAL FI BO TELEPHONE SERVICE CENTER	$19,370,000	$13,571,000	$5,799,000	$0
2111	MEDICAL FI BUSINESS OPERATIONS	$17,655,000	$13,005,450	$4,638,550	$11,000
2113	MEDICAL FI BO HOURLY REIMBURSEMENT	$12,768,000	$9,411,150	$3,356,850	$0
2114	MEDICAL FI BO MISCELLANEOUS EXPENSES	$1,199,000	$869,900	$329,100	$0
2564	HR 1 - PROHIBITED ENTITIES SYSTEMS COSTS	$547,000	$0	$547,000	$0
	DHCS-MEDICAL FI SUBTOTAL	**$273,495,000**	**$198,557,800**	**$74,926,200**	**$11,000**
	DHCS-HEALTH CARE OPT				
2051	HCO OPERATIONS	$36,760,000	$18,655,700	$18,104,300	$0
2052	HCO COST REIMBURSEMENT	$34,987,000	$17,749,250	$17,237,750	$0
2053	HCO ESR HOURLY REIMBURSEMENT	$15,590,000	$7,912,000	$7,678,000	$0
	DHCS-HEALTH CARE OPT SUBTOTAL	**$87,337,000**	**$44,316,950**	**$43,020,050**	**$0**
	DHCS-DENTAL FI				
2380	DENTAL FI-DBO ADMIN 2022 CONTRACT	$162,882,000	$119,318,500	$43,563,500	$0
2006	DENTAL FI ADMINISTRATION 2016 CONTRACT	$18,474,000	$13,838,500	$4,635,500	$0
	DHCS-DENTAL FI SUBTOTAL	**$181,356,000**	**$133,157,000**	**$48,199,000**	**$0**
	OTHER DEPARTMENTS				
236	PERSONAL CARE SERVICES	$598,333,000	$598,333,000	$0	$0
233	HEALTH-RELATED ACTIVITIES - CDSS	$241,720,000	$241,720,000	$0	$0
1679	CALHEERS DEVELOPMENT	$173,104,000	$126,973,500	$46,130,500	$0
234	MATERNAL AND CHILD HEALTH	$90,793,000	$90,793,000	$0	$0
243	CDDS ADMINISTRATIVE COSTS	$143,008,000	$143,008,000	$0	$0
256	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$57,744,000	$57,744,000	$0	$0
246	HCPCFC CASE MANAGEMENT	$74,400,000	$55,800,000	$4,929,000	$13,671,000
2455	HCPCFC ADMIN COSTS	$23,757,000	$11,878,500	$11,878,500	$0
1192	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	$8,761,000	$8,761,000	$0	$0
253	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$7,570,000	$7,570,000	$0	$0
2244	FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG	$8,052,000	$8,052,000	$0	$0
239	CLPP CASE MANAGEMENT SERVICES	$6,502,000	$6,502,000	$0	$0
1680	CALIFORNIA SMOKERS' HELPLINE	$2,353,000	$2,353,000	$0	$0
257	CALHHS AGENCY HIPAA FUNDING	$1,749,000	$874,500	$874,500	$0
1665	MEDI-CAL INPATIENT SERVICES FOR INMATES	$1,144,000	$1,144,000	$0	$0
232	VETERANS BENEFITS	$1,100,000	$1,100,000	$0	$0

SUMMARY OF COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION POLICY CHANGES FISCAL YEAR 2025-26

FRN.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER FUNDS
	OTHER DEPARTMENTS				
1774	VITAL RECORDS	$883,000	$879,000	$4,000	$0
249	KIT FOR NEW PARENTS	$108,000	$108,000	$0	$0
263	MERIT SYSTEM SERVICES FOR COUNTIES	$202,000	$101,000	$101,000	$0
1114	PIA EYEWEAR COURIER SERVICE	$726,000	$363,000	$363,000	$0
	OTHER DEPARTMENTS SUBTOTAL	**$1,442,009,000**	**$1,364,057,500**	**$64,280,500**	**$13,671,000**
	GRAND TOTAL	**$7,475,070,000**	**$4,775,528,550**	**$2,579,630,450**	**$119,911,000**

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

SERVICE CATEGORY	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER FUNDS
PROFESSIONAL	$10,311,572,840	$5,522,531,620	$4,535,090,090	$253,951,120
PHYSICIANS	$680,453,600	$451,322,510	$187,381,790	$41,749,300
OTHER MEDICAL	$8,627,143,100	$4,411,462,030	$4,155,953,620	$59,727,440
CO. & COMM. OUTPATIENT	$1,003,976,140	$659,747,080	$191,754,680	$152,474,370
PHARMACY	$15,843,851,930	$5,741,732,400	$7,715,365,540	$2,386,754,000
HOSPITAL INPATIENT	$10,073,510,640	$6,357,009,610	$1,641,386,100	$2,075,114,940
COUNTY INPATIENT	$3,720,152,230	$2,228,811,510	($15,914,320)	$1,507,255,040
COMMUNITY INPATIENT	$6,353,358,410	$4,128,198,100	$1,657,300,420	$567,859,900
LONG TERM CARE	$892,049,450	$497,546,130	$386,296,130	$8,207,190
NURSING FACILITIES	$867,788,820	$484,681,810	$374,992,890	$8,114,130
ICF-DD	$24,260,630	$12,864,330	$11,303,250	$93,060
OTHER SERVICES	$3,001,064,950	$2,054,792,240	$932,319,440	$13,953,270
MEDICAL TRANSPORTATION	$72,291,420	$45,296,070	$25,010,670	$1,984,680
OTHER SERVICES	$2,796,152,460	$1,940,289,260	$844,030,950	$11,832,260
HOME HEALTH	$132,621,060	$69,206,910	$63,277,820	$136,330
TOTAL FEE-FOR-SERVICE	**$40,122,049,810**	**$20,173,612,000**	**$15,210,457,300**	**$4,737,980,510**
MANAGED CARE	$98,158,234,880	$58,174,302,050	$22,485,549,540	$17,498,383,290
TWO PLAN MODEL	$54,622,447,780	$32,353,958,450	$12,132,780,370	$10,135,708,970
COUNTY ORGANIZED HEALTH SYSTEMS	$29,881,349,310	$17,828,193,640	$6,680,332,200	$5,372,823,460
GEOGRAPHIC MANAGED CARE	$10,204,866,970	$6,243,951,920	$2,142,375,880	$1,818,539,170
PHP & OTHER MANAG. CARE	$2,865,118,510	$1,377,372,510	$1,470,206,550	$17,539,450
REGIONAL MODEL	$584,452,310	$370,825,540	$59,854,540	$153,772,240
DENTAL	$2,715,106,910	$1,447,986,810	$1,239,698,340	$27,421,760
MENTAL HEALTH	$11,056,545,960	$6,892,368,970	$531,421,210	$3,632,755,780
AUDITS/ LAWSUITS	$208,513,000	($430,679,500)	$639,192,500	$0
EPSDT SCREENS	$0	$0	$0	$0
MEDICARE PAYMENTS	$9,977,064,260	$2,515,599,630	$7,461,464,630	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$18,877,000	$18,877,000	$0	$0
MISC. SERVICES	$23,411,680,000	$22,431,178,500	($1,628,269,500)	$2,608,771,000
RECOVERIES	($966,554,000)	($730,890,700)	($235,663,300)	$0
DRUG MEDI-CAL	$2,209,233,280	$1,693,451,780	$337,124,010	$178,657,480
GRAND TOTAL MEDI-CAL BENEFITS	**$186,910,751,110**	**$112,185,806,550**	**$46,040,974,730**	**$28,683,969,830**

MEDI-CAL BENEFITS EXPENDITURES BY SERVICE CATEGORY
MAY 2026 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2025-26

SERVICE CATEGORY	2025-26 APPROPRIATION	MAY 2026 EST. FOR 2025-26	DOLLAR DIFFERENCE	% CHANGE
PROFESSIONAL	$10,912,619,070	$10,311,572,840	($601,046,230)	-5.51%
PHYSICIANS	$711,308,800	$680,453,600	($30,855,200)	-4.34%
OTHER MEDICAL	$8,208,525,080	$8,627,143,100	$418,618,020	5.10%
CO. & COMM. OUTPATIENT	$1,992,785,190	$1,003,976,140	($988,809,050)	-49.62%
PHARMACY	$17,785,471,550	$15,843,851,930	($1,941,619,620)	-10.92%
HOSPITAL INPATIENT	$12,874,802,880	$10,073,510,640	($2,801,292,240)	-21.76%
COUNTY INPATIENT	$4,087,802,950	$3,720,152,230	($367,650,720)	-8.99%
COMMUNITY INPATIENT	$8,786,999,930	$6,353,358,410	($2,433,641,520)	-27.70%
LONG TERM CARE	$1,065,094,670	$892,049,450	($173,045,220)	-16.25%
NURSING FACILITIES	$1,033,709,780	$867,788,820	($165,920,960)	-16.05%
ICF-DD	$31,384,890	$24,260,630	($7,124,260)	-22.70%
OTHER SERVICES	$2,966,520,690	$3,001,064,950	$34,544,260	1.16%
MEDICAL TRANSPORTATION	$73,275,160	$72,291,420	($983,740)	-1.34%
OTHER SERVICES	$2,762,197,470	$2,796,152,460	$33,954,990	1.23%
HOME HEALTH	$131,048,060	$132,621,060	$1,573,000	1.20%
TOTAL FEE-FOR-SERVICE	**$45,604,508,860**	**$40,122,049,810**	**($5,482,459,050)**	**-12.02%**
MANAGED CARE	$100,382,161,180	$98,158,234,880	($2,223,926,300)	-2.22%
TWO PLAN MODEL	$56,448,799,160	$54,622,447,780	($1,826,351,380)	-3.24%
COUNTY ORGANIZED HEALTH SYSTEMS	$29,385,533,050	$29,881,349,310	$495,816,260	1.69%
GEOGRAPHIC MANAGED CARE	$11,030,481,710	$10,204,866,970	($825,614,740)	-7.48%
PHP & OTHER MANAG. CARE	$2,682,610,190	$2,865,118,510	$182,508,320	6.80%
REGIONAL MODEL	$834,737,070	$584,452,310	($250,284,760)	-29.98%
DENTAL	$2,972,008,790	$2,715,106,910	($256,901,880)	-8.64%
MENTAL HEALTH	$8,000,567,710	$11,056,545,960	$3,055,978,250	38.20%
AUDITS/ LAWSUITS	$1,350,000	$208,513,000	$207,163,000	15,345.41%
MEDICARE PAYMENTS	$9,584,456,470	$9,977,064,260	$392,607,790	4.10%
STATE HOSP./DEVELOPMENTAL CNTRS.	$20,771,330	$18,877,000	($1,894,330)	-9.12%
MISC. SERVICES	$22,631,235,880	$23,411,680,000	$780,444,120	3.45%
RECOVERIES	($1,041,812,850)	($966,554,000)	$75,258,850	-7.22%
DRUG MEDI-CAL	$1,118,014,820	$2,209,233,280	$1,091,218,460	97.60%
GRAND TOTAL MEDI-CAL	**$189,273,262,200**	**$186,910,751,110**	**($2,362,511,090)**	**-1.25%**
GENERAL FUNDS	**$43,627,253,180**	**$46,040,974,730**	**$2,413,721,550**	**5.53%**
OTHER FUNDS	**$31,978,191,260**	**$28,683,969,830**	**($3,294,221,430)**	**-10.30%**

MEDI-CAL BENEFITS EXPENDITURES BY SERVICE CATEGORY
MAY 2026 ESTIMATE COMPARED TO NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2025-26

SERVICE CATEGORY	NOV. 2025 EST. FOR 2025-26	MAY 2026 EST. FOR 2025-26	DOLLAR DIFFERENCE	% CHANGE
PROFESSIONAL	$11,628,309,100	$10,311,572,840	($1,316,736,260)	-11.32%
PHYSICIANS	$704,248,520	$680,453,600	($23,794,920)	-3.38%
OTHER MEDICAL	$8,498,532,870	$8,627,143,100	$128,610,230	1.51%
CO. & COMM. OUTPATIENT	$2,425,527,710	$1,003,976,140	($1,421,551,570)	-58.61%
PHARMACY	$17,162,585,730	$15,843,851,930	($1,318,733,790)	-7.68%
HOSPITAL INPATIENT	$11,833,837,790	$10,073,510,640	($1,760,327,150)	-14.88%
COUNTY INPATIENT	$3,840,169,250	$3,720,152,230	($120,017,020)	-3.13%
COMMUNITY INPATIENT	$7,993,668,540	$6,353,358,410	($1,640,310,130)	-20.52%
LONG TERM CARE	$1,054,486,070	$892,049,450	($162,436,620)	-15.40%
NURSING FACILITIES	$1,027,500,310	$867,788,820	($159,711,490)	-15.54%
ICF-DD	$26,985,760	$24,260,630	($2,725,130)	-10.10%
OTHER SERVICES	$3,168,827,120	$3,001,064,950	($167,762,180)	-5.29%
MEDICAL TRANSPORTATION	$85,867,610	$72,291,420	($13,576,190)	-15.81%
OTHER SERVICES	$2,951,693,590	$2,796,152,460	($155,541,130)	-5.27%
HOME HEALTH	$131,265,920	$132,621,060	$1,355,140	1.03%
TOTAL FEE-FOR-SERVICE	**$44,848,045,810**	**$40,122,049,810**	**($4,725,996,000)**	**-10.54%**
MANAGED CARE	$99,004,024,230	$98,158,234,880	($845,789,350)	-0.85%
TWO PLAN MODEL	$55,130,957,010	$54,622,447,780	($508,509,230)	-0.92%
COUNTY ORGANIZED HEALTH SYSTEMS	$29,993,414,480	$29,881,349,310	($112,065,170)	-0.37%
GEOGRAPHIC MANAGED CARE	$10,425,423,460	$10,204,866,970	($220,556,490)	-2.12%
PHP & OTHER MANAG. CARE	$2,766,512,260	$2,865,118,510	$98,606,260	3.56%
REGIONAL MODEL	$687,717,030	$584,452,310	($103,264,720)	-15.02%
DENTAL	$2,928,977,290	$2,715,106,910	($213,870,380)	-7.30%
MENTAL HEALTH	$8,310,822,090	$11,056,545,960	$2,745,723,880	33.04%
AUDITS/ LAWSUITS	$162,778,000	$208,513,000	$45,735,000	28.10%
MEDICARE PAYMENTS	$10,077,701,910	$9,977,064,260	($100,637,640)	-1.00%
STATE HOSP./DEVELOPMENTAL CNTRS.	$22,721,000	$18,877,000	($3,844,000)	-16.92%
MISC. SERVICES	$22,829,730,000	$23,411,680,000	$581,950,000	2.55%
RECOVERIES	($971,793,000)	($966,554,000)	$5,239,000	-0.54%
DRUG MEDI-CAL	$1,470,587,970	$2,209,233,280	$738,645,310	50.23%
GRAND TOTAL MEDI-CAL	**$188,683,595,290**	**$186,910,751,110**	**($1,772,844,180)**	**-0.94%**
GENERAL FUNDS	**$44,056,718,760**	**$46,040,974,730**	**$1,984,255,970**	**4.50%**
OTHER FUNDS	**$30,731,831,520**	**$28,683,969,830**	**($2,047,861,690)**	**-6.66%**

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2025-26

.		2025-26 APPROPRIATION		NOV. 2025 EST. FOR 2025-26		MAY 2026 EST. FOR 2025-26		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
FRN.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	DRUG MEDI-CAL										
2012	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	$1,022,470,000	$163,775,950	$1,398,459,000	$221,591,900	$2,125,136,000	$322,603,450	$1,102,666,000	$158,827,500	$726,677,000	$101,011,550
2320	DRUG MEDI-CAL STATE PLAN SERVICES	$45,854,000	$3,195,800	$56,343,000	$1,980,400	$49,221,000	$3,394,700	$3,367,000	$198,900	($7,122,000)	$1,414,300
	DRUG MEDI-CAL SUBTOTAL	**$1,068,324,000**	**$166,971,750**	**$1,454,802,000**	**$223,572,300**	**$2,174,357,000**	**$325,998,150**	**$1,106,033,000**	**$159,026,400**	**$719,555,000**	**$102,425,850**
	MENTAL HEALTH										
1780	SMHS FOR ADULTS	$4,209,264,000	$372,484,300	$4,431,118,000	$392,473,700	$5,958,142,000	$504,458,700	$1,748,878,000	$131,974,400	$1,527,024,000	$111,985,000
1779	SMHS FOR CHILDREN	$3,609,169,000	$66,586,100	$3,597,595,000	$74,679,200	$4,861,069,000	$92,988,300	$1,251,900,000	$26,402,200	$1,263,474,000	$18,309,100
	MENTAL HEALTH SUBTOTAL	**$7,818,433,000**	**$439,070,400**	**$8,028,713,000**	**$467,152,900**	**$10,819,211,000**	**$597,447,000**	**$3,000,778,000**	**$158,376,600**	**$2,790,498,000**	**$130,294,100**
	MANAGED CARE										
56	TWO PLAN MODEL	$35,143,222,000	$14,870,113,350	$35,957,888,000	$15,162,039,700	$35,773,534,000	$15,430,802,500	$630,312,000	$560,689,150	($184,354,000)	$268,762,800
57	COUNTY ORGANIZED HEALTH SYSTEMS & SINGLE PLAN	$19,183,176,000	$7,876,879,600	$20,275,413,000	$8,460,911,250	$19,965,233,000	$8,454,791,600	$782,057,000	$577,912,000	($310,180,000)	($6,119,650)
58	GEOGRAPHIC MANAGED CARE	$6,422,948,000	$2,530,491,500	$6,374,711,000	$2,511,905,300	$6,238,879,000	$2,510,450,050	($184,069,000)	($20,041,450)	($135,832,000)	($1,455,250)
62	PACE (Other M/C)	$2,345,211,000	$1,199,185,000	$2,413,325,000	$1,252,167,600	$2,474,328,000	$1,314,916,400	$129,117,000	$115,731,400	$61,003,000	$62,748,800
1842	REGIONAL MODEL	$218,446,000	$73,538,950	$228,587,000	$82,956,800	$226,218,000	$82,778,700	$7,772,000	$9,239,750	($2,369,000)	($178,100)
1029	DENTAL MANAGED CARE (Other M/C)	$173,936,000	$75,206,900	$179,734,000	$75,690,650	$175,042,000	$78,861,800	$1,106,000	$3,654,900	($4,692,000)	$3,171,150
61	SENIOR CARE ACTION NETWORK (Other M/C)	$106,157,000	$53,344,500	$109,398,000	$54,983,000	$109,154,000	$55,057,000	$2,997,000	$1,712,500	($244,000)	$74,000
1837	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	$47,435,000	$19,703,000	$48,570,000	$20,179,000	$59,467,000	$21,934,000	$12,032,000	$2,231,000	$10,897,000	$1,755,000
1823	COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM	$11,322,000	$3,962,700	$15,632,000	$5,471,200	$16,267,000	$5,693,450	$4,945,000	$1,730,750	$635,000	$222,250
63	AIDS HEALTHCARE CENTERS (Other M/C)	$13,595,000	$7,872,500	$13,674,000	$5,793,300	$12,536,000	$4,920,000	($1,059,000)	($2,952,500)	($1,138,000)	($873,300)
1797	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	$1,879,000	$657,650	$2,191,000	$766,850	$3,051,000	$1,067,850	$1,172,000	$410,200	$860,000	$301,000
	MANAGED CARE SUBTOTAL	**$63,667,327,000**	**$26,710,955,650**	**$65,619,123,000**	**$27,632,864,650**	**$65,053,709,000**	**$27,961,273,350**	**$1,386,382,000**	**$1,250,317,700**	**($565,414,000)**	**$328,408,700**
	FEE-FOR-SERVICE BASE										
2540	FFS - PHARMACY	$24,432,873,000	$12,216,436,550	$23,807,971,000	$9,986,432,300	$24,051,152,000	$10,248,694,000	($381,721,000)	($1,967,742,550)	$243,181,000	$262,261,700
2539	FFS - OTHER MEDICAL	$7,341,596,000	$3,670,797,750	$7,627,546,000	$3,945,884,200	$7,999,778,000	$3,927,680,050	$658,182,000	$256,882,300	$372,232,000	($18,204,150)
2543	FFS - COMMUNITY INPATIENT	$3,640,051,000	$1,820,025,550	$3,330,895,000	$1,171,804,750	$3,206,229,000	$1,141,308,400	($433,822,000)	($678,717,150)	($124,666,000)	($30,496,350)

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2025-26

.		2025-26 APPROPRIATION		NOV. 2025 EST. FOR 2025-26		MAY 2026 EST. FOR 2025-26		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
FRN.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	FEE-FOR-SERVICE BASE										
2547	FFS - OTHER SERVICES	$2,017,561,000	$1,008,780,250	$2,019,845,000	$982,124,700	$1,841,281,000	$898,593,250	($176,280,000)	($110,187,000)	($178,564,000)	($83,531,450)
2544	FFS - NURSING FACILITIES	$840,474,000	$420,237,050	$850,029,000	$437,036,800	$737,897,000	$332,231,700	($102,577,000)	($88,005,350)	($112,132,000)	($104,805,100)
2542	FFS - COUNTY INPATIENT	$857,137,000	$428,568,550	$651,492,000	$38,859,750	$615,158,000	$8,345,050	($241,979,000)	($420,223,500)	($36,334,000)	($30,514,700)
2541	FFS - CO. & COMM. OUTPATIENT	$586,634,000	$293,316,750	$639,032,000	$297,173,700	$619,973,000	$277,716,050	$33,339,000	($15,600,700)	($19,059,000)	($19,457,650)
2538	FFS - PHYSICIANS	$635,977,000	$317,988,400	$599,116,000	$263,581,950	$521,854,000	$230,646,350	($114,123,000)	($87,342,050)	($77,262,000)	($32,935,600)
2548	FFS - HOME HEALTH	$132,427,000	$66,213,700	$132,869,000	$63,691,000	$132,896,000	$64,207,800	$469,000	($2,005,900)	$27,000	$516,800
2546	FFS - MEDICAL TRANSPORTATION	$77,084,000	$38,542,200	$81,291,000	$26,882,000	$75,851,000	$25,011,900	($1,233,000)	($13,530,300)	($5,440,000)	($1,870,100)
2545	FFS - ICF-DD	$15,563,000	$7,781,550	$11,778,000	$5,968,300	$8,148,000	$4,000,600	($7,415,000)	($3,780,950)	($3,630,000)	($1,967,700)
	FEE-FOR-SERVICE BASE SUBTOTAL	**$40,577,377,000**	**$20,288,688,300**	**$39,751,864,000**	**$17,219,439,450**	**$39,810,217,000**	**$17,158,435,150**	**($767,160,000)**	**($3,130,253,150)**	**$58,353,000**	**($61,004,300)**
	OTHER										
76	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$5,013,282,000	$2,944,983,000	$6,020,143,000	$3,476,118,000	$5,975,627,000	$3,448,599,000	$962,345,000	$503,616,000	($44,516,000)	($27,519,000)
22	PERSONAL CARE SERVICES (Misc. Svcs.)	$4,607,519,000	$0	$4,437,012,000	$0	$4,224,145,000	$0	($383,374,000)	$0	($212,867,000)	$0
23	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	$4,121,414,000	$0	$4,381,416,000	$0	$4,605,030,000	$0	$483,616,000	$0	$223,614,000	$0
1019	MEDICARE PAYMENTS - PART D PHASED-DOWN	$3,934,181,000	$3,934,181,000	$4,041,788,000	$4,041,788,000	$4,024,294,000	$4,024,294,000	$90,113,000	$90,113,000	($17,494,000)	($17,494,000)
135	DENTAL SERVICES	$3,001,881,000	$1,403,796,700	$2,964,455,000	$1,135,580,700	$2,701,106,000	$1,274,478,900	($300,775,000)	($129,317,800)	($263,349,000)	$138,898,200
32	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$557,468,000	$279,864,000	$637,905,000	$321,813,500	$525,081,000	$264,801,000	($32,387,000)	($15,063,000)	($112,824,000)	($57,012,500)
26	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$420,908,000	$0	$461,001,000	$0	$502,052,000	$0	$81,144,000	$0	$41,051,000	$0
2080	LAWSUITS/CLAIMS	$1,350,000	$675,000	$162,784,000	$81,392,000	$208,519,000	$104,259,500	$207,169,000	$103,584,500	$45,735,000	$22,867,500
77	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$20,816,000	$0	$22,721,000	$0	$18,877,000	$0	($1,939,000)	$0	($3,844,000)	$0
27	MEDI-CAL TCM PROGRAM	$11,809,000	$0	$7,266,000	$0	$12,304,000	$0	$495,000	$0	$5,038,000	$0
91	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$307,000	$153,500	$306,000	$153,000	$243,000	$121,500	($64,000)	($32,000)	($63,000)	($31,500)
127	BASE RECOVERIES	($1,043,525,000)	($420,569,250)	($971,793,000)	($236,940,700)	($966,554,000)	($235,663,300)	$76,971,000	$184,905,950	$5,239,000	$1,277,400
	OTHER SUBTOTAL	**$20,647,410,000**	**$8,143,083,950**	**$22,165,004,000**	**$8,819,904,500**	**$21,830,724,000**	**$8,880,890,600**	**$1,183,314,000**	**$737,806,650**	**($334,280,000)**	**$60,986,100**
	GRAND TOTAL	**$133,778,871,000**	**$55,748,770,050**	**$137,019,506,000**	**$54,362,933,800**	**$139,688,218,000**	**$54,924,044,250**	**$5,909,347,000**	**($824,725,800)**	**$2,668,712,000**	**$561,110,450**

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2025-26

.		2025-26 APPROPRIATION		NOV. 2025 EST. FOR 2025-26		MAY 2026 EST. FOR 2025-26		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
FRN.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	ELIGIBILITY										
1569	MEDI-CAL STATE INMATE PROGRAMS	$38,834,000	$0	$42,390,000	$0	$47,616,000	$0	$8,782,000	$0	$5,226,000	$0
2332	CALAIM - INMATE PRE-RELEASE PROGRAM	$146,073,000	$35,937,000	$36,971,000	$5,437,000	$39,297,000	$5,548,000	($106,776,000)	($30,389,000)	$2,326,000	$111,000
3	BREAST AND CERVICAL CANCER TREATMENT	$15,009,000	$7,250,800	$15,814,000	$7,798,850	$12,399,000	$6,061,350	($2,610,000)	($1,189,450)	($3,415,000)	($1,737,500)
2422	HEALTH ENROLLMENT NAVIGATORS FOR CLINICS	$5,877,000	$2,938,500	$8,548,000	$4,274,000	$8,244,000	$4,122,000	$2,367,000	$1,183,500	($304,000)	($152,000)
13	NON-OTLICP CHIP	$0	($106,138,800)	$0	($114,213,600)	$0	($126,430,800)	$0	($20,292,000)	$0	($12,217,200)
1007	SCHIP FUNDING FOR PRENATAL CARE	$0	($73,845,200)	$0	($79,810,250)	$0	($80,347,150)	$0	($6,501,950)	$0	($536,900)
2155	CS3 PROXY ADJUSTMENT	$0	($70,306,100)	$0	($102,427,900)	$0	($113,512,600)	$0	($43,206,500)	$0	($11,084,700)
2237	REFUGEE MEDICAL ASSISTANCE	$0	($120,000)	$0	($112,000)	$0	($47,000)	$0	$73,000	$0	$65,000
2029	MEDI-CAL COUNTY INMATE REIMBURSEMENT	$0	($2,081,000)	$0	($2,361,000)	$0	($2,436,000)	$0	($355,000)	$0	($75,000)
2500	SB 525 MINIMUM WAGE - CASELOAD IMPACT	($188,536,000)	($75,414,400)	($188,536,000)	($75,414,400)	($188,536,000)	($75,414,400)	$0	$0	$0	$0
2535	REINSTATEMENT OF ASSET LIMIT	($93,108,000)	($46,554,000)	($94,206,000)	($47,103,000)	($113,411,000)	($56,705,500)	($20,303,000)	($10,151,500)	($19,205,000)	($9,602,500)
2530	FULL-SCOPE MEDI-CAL EXPANSION ENROLLMENT FREEZE	($89,242,000)	($77,930,700)	($94,693,000)	($83,381,950)	($94,693,000)	($83,381,950)	($5,451,000)	($5,451,250)	$0	$0
2529	PREMIUMS FOR ADULTS WITH UNSATIS. IMMIG. STAT.	$0	$0	$28,000,000	$28,000,000	$0	$0	$0	$0	($28,000,000)	($28,000,000)
15	NON-EMERGENCY FUNDING ADJUSTMENT	$0	$4,495,172,900	$0	$0	$0	$0	$0	($4,495,172,900)	$0	$0
	ELIGIBILITY SUBTOTAL	**($165,093,000)**	**$4,088,909,000**	**($245,712,000)**	**($459,314,250)**	**($289,084,000)**	**($522,544,050)**	**($123,991,000)**	**($4,611,453,050)**	**($43,372,000)**	**($63,229,800)**
	AFFORDABLE CARE ACT										
1595	COMMUNITY FIRST CHOICE OPTION	$10,667,855,000	$0	$10,890,947,000	$0	$11,410,654,000	$0	$742,799,000	$0	$519,707,000	$0
1967	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	$18,460,000	$0	$17,844,000	$0	$13,572,000	$0	($4,888,000)	$0	($4,272,000)	$0
1791	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	($5,426,000)	$0	($5,939,000)	$0	($6,154,000)	$0	($728,000)	$0	($215,000)
1821	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	$0	($34,899,600)	$0	($33,839,200)	$0	($36,025,600)	$0	($1,126,000)	$0	($2,186,400)
	AFFORDABLE CARE ACT SUBTOTAL	**$10,686,315,000**	**($40,325,600)**	**$10,908,791,000**	**($39,778,200)**	**$11,424,226,000**	**($42,179,600)**	**$737,911,000**	**($1,854,000)**	**$515,435,000**	**($2,401,400)**
	BENEFITS										
25	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$768,342,000	$0	$961,315,000	$0	$976,828,000	$0	$208,486,000	$0	$15,513,000	$0

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2025-26

.		2025-26 APPROPRIATION		NOV. 2025 EST. FOR 2025-26		MAY 2026 EST. FOR 2025-26		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
FRN.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	BENEFITS										
1	FAMILY PACT PROGRAM	$156,842,000	$38,382,100	$142,408,000	$35,850,200	$105,766,000	$26,782,400	($51,076,000)	($11,599,700)	($36,642,000)	($9,067,800)
1228	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$165,940,000	$50,036,000	$116,922,000	$25,472,000	$111,759,000	$24,786,000	($54,181,000)	($25,250,000)	($5,163,000)	($686,000)
28	MULTIPURPOSE SENIOR SERVICES PROGRAM	$63,951,000	$31,975,500	$63,951,000	$32,212,500	$63,951,000	$32,214,500	$0	$239,000	$0	$2,000
2457	CYBHI WELLNESS COACH BENEFIT	$43,142,000	$18,707,200	$43,303,000	$18,776,950	$99,000	$43,000	($43,043,000)	($18,664,200)	($43,204,000)	($18,733,950)
1855	BEHAVIORAL HEALTH TREATMENT	$7,283,000	$3,641,500	$7,620,000	$3,810,000	$7,792,000	$3,896,000	$509,000	$254,500	$172,000	$86,000
2189	HEARING AID COVERAGE FOR CHILDREN PROGRAM	$1,552,000	$1,552,000	$1,552,000	$1,552,000	$1,552,000	$1,552,000	$0	$0	$0	$0
1562	CCT FUND TRANSFER TO CDSS	$29,000	$0	$38,000	$0	$736,000	$0	$707,000	$0	$698,000	$0
2528	UTILIZATION MANAGEMENT FOR HOSPICE	$0	$0	$0	$0	($100,000,000)	($38,269,550)	($100,000,000)	($38,269,550)	($100,000,000)	($38,269,550)
2570	MEASLES, MUMPS, RUBELLA, VARICELLA (MMRV) VACCINES	$0	$0	$0	$0	$3,076,000	$1,484,900	$3,076,000	$1,484,900	$3,076,000	$1,484,900
	BENEFITS SUBTOTAL	**$1,207,081,000**	**$144,294,300**	**$1,337,109,000**	**$117,673,650**	**$1,171,559,000**	**$52,489,250**	**($35,522,000)**	**($91,805,050)**	**($165,550,000)**	**($65,184,400)**
	PHARMACY										
2512	CELL AND GENE THERAPY ACCESS MODEL	$19,321,000	$9,660,500	$18,110,000	$9,055,000	$18,110,000	$9,055,000	($1,211,000)	($605,500)	$0	$0
2194	PHARMACY RETROACTIVE ADJUSTMENTS	$0	$31,463,000	$800,000	$31,749,250	$800,000	$31,749,250	$800,000	$286,250	$0	$0
2124	MEDI-CAL DRUG REBATE FUND	$0	($2,202,503,000)	$0	($2,334,506,000)	$0	($2,386,754,000)	$0	($184,251,000)	$0	($52,248,000)
1449	LITIGATION SETTLEMENTS	$0	$0	($6,000)	($6,000)	($6,000)	($6,000)	($6,000)	($6,000)	$0	$0
1433	BCCTP DRUG REBATES	($2,237,000)	$0	($1,177,000)	$0	($1,320,000)	$0	$917,000	$0	($143,000)	$0
51	FAMILY PACT DRUG REBATES	($1,712,000)	$0	($2,459,000)	$0	($2,477,000)	$0	($765,000)	$0	($18,000)	$0
2519	UPDATES TO OTC COVID-19 TESTS AND OTC PRODUCTS	($6,000,000)	($3,000,000)	($5,358,000)	($2,247,300)	($4,360,000)	($1,828,900)	$1,640,000	$1,171,100	$998,000	$418,400
2526	PHARMACY UTILIZATION MANAGEMENT	($50,000,000)	($25,000,000)	($44,650,000)	($18,728,550)	($17,860,000)	($7,490,850)	$32,140,000	$17,509,150	$26,790,000	$11,237,700
2520	ELIMINATE GLP-1 COVERAGE FOR WEIGHT LOSS	($85,200,000)	($85,000,000)	($86,567,000)	($86,355,000)	($86,567,000)	($86,355,000)	($1,367,000)	($1,355,000)	$0	$0
2518	PRIOR AUTH. FOR CONTINUATION OF DRUG THERAPY	($125,000,000)	($62,500,000)	($111,625,000)	($46,821,900)	($111,625,000)	($46,821,900)	$13,375,000	$15,678,100	$0	$0
1181	MEDICAL SUPPLY REBATES	($141,000,000)	($52,606,700)	($145,800,000)	($72,900,000)	($153,000,000)	($76,500,000)	($12,000,000)	($23,893,300)	($7,200,000)	($3,600,000)
2527	STEP THERAPY	($175,000,000)	($87,500,000)	($156,275,000)	($65,550,800)	($156,275,000)	($65,550,800)	$18,725,000	$21,949,200	$0	$0
54	STATE SUPPLEMENTAL DRUG REBATES	($401,666,000)	$0	($580,093,000)	$0	($637,806,000)	$0	($236,140,000)	$0	($57,713,000)	$0
55	FEDERAL DRUG REBATES	($5,192,053,000)	$0	($5,133,883,000)	$0	($7,210,876,000)	$0	($2,018,823,000)	$0	($2,076,993,000)	$0

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2025-26

.		2025-26 APPROPRIATION		NOV. 2025 EST. FOR 2025-26		MAY 2026 EST. FOR 2025-26		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
FRN.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	PHARMACY										
2557	PHARMACY PAYMENT METHODOLOGY - USUAL AND CUSTOMARY	$0	$0	($53,040,000)	$54,649,700	($8,641,000)	$93,710,100	($8,641,000)	$93,710,100	$44,399,000	$39,060,400
2579	MEDI-CAL RX FRAUD, WASTE, & ABUSE PREVENTION	$0	$0	$0	$0	($14,586,000)	($6,118,200)	($14,586,000)	($6,118,200)	($14,586,000)	($6,118,200)
2525	MEDI-CAL RX REBATE AGGREGATOR	($370,000,000)	($370,000,000)	($123,333,000)	($123,333,000)	$0	$0	$370,000,000	$370,000,000	$123,333,000	$123,333,000
2454	RESPIRATORY SYNCYTIAL VIRUS VACCINES	$227,228,000	$101,063,100	$0	$0	$0	$0	($227,228,000)	($101,063,100)	$0	$0
2524	HIV/AIDS AND CANCER DRUG REBATES	($150,000,000)	($75,000,000)	$0	$0	$0	$0	$150,000,000	$75,000,000	$0	$0
	PHARMACY SUBTOTAL	**($6,453,319,000)**	**($2,820,923,100)**	**($6,425,356,000)**	**($2,654,994,600)**	**($8,386,489,000)**	**($2,542,911,300)**	**($1,933,170,000)**	**$278,011,800**	**($1,961,133,000)**	**$112,083,300**
	DRUG MEDI-CAL										
2278	RECOVERY INCENTIVES CONTINGENCY MANAGEMENT	$17,816,000	$0	$13,299,000	$0	$13,299,000	$0	($4,517,000)	$0	$0	$0
1723	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	$4,330,000	$438,000	$3,877,000	$362,000	$19,878,000	$8,914,000	$15,548,000	$8,476,000	$16,001,000	$8,552,000
1724	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	$21,416,000	$1,352,200	$650,000	$40,300	$657,000	$42,700	($20,759,000)	($1,309,500)	$7,000	$2,400
	DRUG MEDI-CAL SUBTOTAL	**$43,562,000**	**$1,790,200**	**$17,826,000**	**$402,300**	**$33,834,000**	**$8,956,700**	**($9,728,000)**	**$7,166,500**	**$16,008,000**	**$8,554,400**
	MENTAL HEALTH										
2394	CALAIM - BH - CONNECT DEMONSTRATION	$415,361,000	$18,188,000	$129,592,000	$11,908,000	$113,933,000	$11,908,000	($301,428,000)	($6,280,000)	($15,659,000)	$0
2252	MHP COSTS FOR FFPSA	$36,494,000	$9,123,000	$34,927,000	$8,731,000	$34,932,000	$8,732,000	($1,562,000)	($391,000)	$5,000	$1,000
1957	MHP COSTS FOR CONTINUUM OF CARE REFORM	$5,062,000	$3,416,150	$4,840,000	$3,301,650	$2,024,000	$1,911,300	($3,038,000)	($1,504,850)	($2,816,000)	($1,390,350)
2268	OUT OF STATE YOUTH - SMHS	$986,000	$493,000	$682,000	$341,000	$930,000	$465,000	($56,000)	($28,000)	$248,000	$124,000
1660	IMPERIAL AND SISKIYOU COUNTY MHP OVERPAYMENT	$0	($200,000)	$0	($200,000)	$0	($200,000)	$0	$0	$0	$0
1713	INTERIM AND FINAL COST SETTLEMENTS - SMHS	($453,082,000)	$2,406,000	($19,409,000)	$3,434,000	($13,451,000)	$2,287,000	$439,631,000	($119,000)	$5,958,000	($1,147,000)
2574	RETRO PAYMENTS TO COUNTIES FOR STATE-ONLY BH SVCS	$0	$0	$0	$0	$20,000,000	$20,000,000	$20,000,000	$20,000,000	$20,000,000	$20,000,000
2247	SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS	$0	$142,000	$0	$23,000	$0	$0	$0	($142,000)	$0	($23,000)
2262	BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE	$530,090,000	$530,090,000	$0	$0	$0	$0	($530,090,000)	($530,090,000)	$0	$0
	MENTAL HEALTH SUBTOTAL	**$534,911,000**	**$563,658,150**	**$150,632,000**	**$27,538,650**	**$158,368,000**	**$45,103,300**	**($376,543,000)**	**($518,554,850)**	**$7,736,000**	**$17,564,650**

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2025-26

.		2025-26 APPROPRIATION		NOV. 2025 EST. FOR 2025-26		MAY 2026 EST. FOR 2025-26		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
FRN.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	WAIVER--MH/UCD & BTR										
1951	GLOBAL PAYMENT PROGRAM	$2,972,382,000	$0	$2,991,826,000	$0	$2,981,620,000	$0	$9,238,000	$0	($10,206,000)	$0
2245	CALAIM ECM-COMMUNITY SUPPORTS-TRANSITIONAL RENT	$2,402,421,000	$1,027,157,600	$2,336,705,000	$989,877,100	$2,415,193,000	$1,013,404,300	$12,772,000	($13,753,300)	$78,488,000	$23,527,200
1769	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	$635,000	$0	$599,000	$0	$336,000	$0	($299,000)	$0	($263,000)	$0
2452	ENHANCED CARE MANAGEMENT RISK CORRIDOR	$13,384,000	$166,635,000	$0	$0	$0	$0	($13,384,000)	($166,635,000)	$0	$0
	WAIVER--MH/UCD & BTR SUBTOTAL	**$5,388,822,000**	**$1,193,792,600**	**$5,329,130,000**	**$989,877,100**	**$5,397,149,000**	**$1,013,404,300**	**$8,327,000**	**($180,388,300)**	**$68,019,000**	**$23,527,200**
	MANAGED CARE										
2408	2023 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	$14,667,788,000	$6,169,259,150	$15,149,464,000	$5,579,949,550	$15,208,141,000	$5,549,105,300	$540,353,000	($620,153,850)	$58,677,000	($30,844,250)
2061	MANAGED CARE HEALTH CARE FINANCING PROGRAM	$3,197,407,000	$1,136,550,650	$2,984,186,000	$1,117,679,150	$2,990,968,000	$1,119,520,150	($206,439,000)	($17,030,500)	$6,782,000	$1,841,000
2060	MANAGED CARE PUBLIC HOSPITAL EPP	$2,362,044,000	$716,987,750	$2,362,127,000	$849,038,750	$2,362,740,000	$849,553,200	$696,000	$132,565,450	$613,000	$514,450
2062	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	$2,209,565,000	$645,769,400	$2,209,570,000	$662,139,750	$2,204,499,000	$662,722,100	($5,066,000)	$16,952,700	($5,071,000)	$582,350
2388	WORKFORCE & QUALITY INCENTIVE PROGRAM	$265,590,000	$124,668,900	$280,831,000	$140,899,600	$310,868,000	$165,846,050	$45,278,000	$41,177,150	$30,037,000	$24,946,450
2504	MEDI-CAL MANAGED CARE QUALITY WITHHOLD RELEASE	$250,577,000	$103,096,300	$252,056,000	$103,601,650	$252,096,000	$103,638,600	$1,519,000	$542,300	$40,000	$36,950
2437	MANAGED CARE DISTRICT HOSPITAL DIRECTED PAYMENTS	$203,645,000	$0	$204,032,000	$0	$204,032,000	$0	$387,000	$0	$0	$0
2448	MANAGED CARE PUBLIC DP-NF PASS-THROUGH PYMT PROG	$67,497,000	$34,681,800	$75,622,000	$39,143,700	$76,397,000	$39,773,900	$8,900,000	$5,092,100	$775,000	$630,200
2031	CCI-QUALITY WITHHOLD REPAYMENTS	$15,837,000	$7,918,500	$15,837,000	$7,918,500	$15,837,000	$7,918,500	$0	$0	$0	$0
2406	2023 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	$0	($5,746,824,000)	$0	($4,745,218,000)	$0	($4,712,883,000)	$0	$1,033,941,000	$0	$32,335,000
2407	2023 MCO ENROLLMENT TAX MANAGED CARE PLANS	$0	($4,161,019,000)	$0	($4,444,952,000)	$0	($4,478,050,000)	$0	($317,031,000)	$0	($33,098,000)
2063	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	$0	($2,764,955,000)	$0	($2,863,060,000)	$0	($3,054,480,000)	$0	($289,525,000)	$0	($191,420,000)
1788	RETRO MC RATE ADJUSTMENTS	($230,700,000)	($335,709,700)	$72,730,000	($17,514,160)	$154,235,000	($2,629,200)	$384,935,000	$333,080,500	$81,505,000	$14,884,960
2576	MANAGED CARE RISK CORRIDORS	$0	$0	$0	$0	($41,718,000)	($13,920,500)	($41,718,000)	($13,920,500)	($41,718,000)	($13,920,500)
2499	COMMUNITY CLINIC DIRECTED PAYMENT PROGRAM	$148,750,000	$74,375,000	$148,750,000	$51,142,050	$0	$0	($148,750,000)	($74,375,000)	($148,750,000)	($51,142,050)

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2025-26

.		2025-26 APPROPRIATION		NOV. 2025 EST. FOR 2025-26		MAY 2026 EST. FOR 2025-26		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
FRN.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	MANAGED CARE										
2333	PROP 56 - DIRECTED PAYMENT RISK MITIGATION	($26,254,000)	$301,007,290	($64,138,000)	($23,441,250)	$0	$0	$26,254,000	($301,007,290)	$64,138,000	$23,441,250
1338	CAPITATED RATE ADJUSTMENT FOR FY 2025-26	$2,321,521,000	$962,861,650	$0	$0	$0	$0	($2,321,521,000)	($962,861,650)	$0	$0
2135	COORDINATED CARE INITIATIVE RISK MITIGATION	($111,260,000)	($55,630,000)	$0	$0	$0	$0	$111,260,000	$55,630,000	$0	$0
2507	MANAGED CARE DIRECTED PAYMENTS MLK COMM HOSPITAL	$28,905,000	$8,083,000	$0	$0	$0	$0	($28,905,000)	($8,083,000)	$0	$0
2523	ELIM. SNF WORKFORCE AND QUALITY INCENTIVE PROG.	($140,000,000)	($70,000,000)	$0	$0	$0	$0	$140,000,000	$70,000,000	$0	$0
2532	PROP 35 SUPPORT FOR INCREASED BASE PAYMENT RATES	($3,223,300,000)	($1,289,300,000)	$0	$0	$0	$0	$3,223,300,000	$1,289,300,000	$0	$0
	MANAGED CARE SUBTOTAL	**$22,007,612,000**	**($4,138,178,310)**	**$23,691,067,000**	**($3,542,672,710)**	**$23,738,095,000**	**($3,763,884,900)**	**$1,730,483,000**	**$374,293,410**	**$47,028,000**	**($221,212,190)**
	PROVIDER RATES										
88	RATE INCREASE FOR FQHCS/RHCS/CBRCS	$1,071,232,000	$548,711,750	$1,026,772,000	$571,023,150	$1,028,121,000	$571,773,450	($43,111,000)	$23,061,700	$1,349,000	$750,300
2267	PP-GEMT IGT PROGRAM	$366,984,000	$0	$378,201,000	$0	$450,469,000	$9,824,000	$83,485,000	$9,824,000	$72,268,000	$9,824,000
2081	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	$166,237,000	($5,800,000)	$166,095,000	($6,378,000)	$157,594,000	($6,061,000)	($8,643,000)	($261,000)	($8,501,000)	$317,000
1152	DPH INTERIM & FINAL RECONS	$138,163,000	$0	$147,952,000	$0	$130,113,000	$0	($8,050,000)	$0	($17,839,000)	$0
2181	NURSING FACILITY RATE ADJUSTMENTS	$777,850,000	$368,701,000	$772,774,000	$361,658,200	$725,253,000	$339,708,500	($52,597,000)	($28,992,500)	($47,521,000)	($21,949,700)
1329	FQHC/RHC/CBRC RECONCILIATION PROCESS	$131,997,000	$67,611,850	$106,598,000	$59,282,650	$108,847,000	$60,533,650	($23,150,000)	($7,078,200)	$2,249,000	$1,251,000
2184	GDSP NBS & PNS FEE ADJUSTMENTS	$6,188,000	$2,414,000	$44,601,000	$17,392,400	$44,550,000	$17,364,950	$38,362,000	$14,950,950	($51,000)	($27,450)
1046	LTC RATE ADJUSTMENT	$230,061,000	$110,337,150	$225,128,000	$108,220,300	$205,820,000	$98,051,050	($24,241,000)	($12,286,100)	($19,308,000)	($10,169,250)
96	HOSPICE RATE INCREASES	$17,540,000	$6,076,400	$14,327,000	$4,929,400	$14,341,000	$4,973,450	($3,199,000)	($1,102,950)	$14,000	$44,050
1784	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	$0	($624,928,000)	$0	($657,269,000)	$0	($688,731,000)	$0	($63,803,000)	$0	($31,462,000)
2509	PROP 35 - PROVIDER PAYMENT INCREASE FUNDING	$0	($2,553,034,000)	$39,500,000	($1,615,333,000)	$0	($1,585,433,000)	$0	$967,601,000	($39,500,000)	$29,900,000
1162	DPH INTERIM RATE GROWTH	$44,227,000	$13,967,900	$3,343,000	($1,128,200)	$0	$0	($44,227,000)	($13,967,900)	($3,343,000)	$1,128,200
1505	REDUCTION TO RADIOLOGY RATES	($23,369,000)	($9,572,850)	($6,967,000)	($2,848,700)	$0	$0	$23,369,000	$9,572,850	$6,967,000	$2,848,700
1161	DPH INTERIM RATE	$0	($388,157,700)	$0	$0	$0	$0	$0	$388,157,700	$0	$0
1703	LABORATORY RATE METHODOLOGY CHANGE	($9,095,000)	($3,773,350)	$0	$0	$0	$0	$9,095,000	$3,773,350	$0	$0

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2025-26

.		2025-26 APPROPRIATION		NOV. 2025 EST. FOR 2025-26		MAY 2026 EST. FOR 2025-26		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
FRN.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	PROVIDER RATES										
2417	MEDI-CAL PROVIDER PAYMENT INCREASE	$810,000,000	$357,000,000	$0	$0	$0	$0	($810,000,000)	($357,000,000)	$0	$0
2458	MEDI-CAL PROVIDER PAYMENT INCREASES 2025 & LATER	$5,850,085,000	$2,196,034,000	$0	$0	$0	$0	($5,850,085,000)	($2,196,034,000)	$0	$0
	PROVIDER RATES SUBTOTAL	**$9,578,100,000**	**$85,588,150**	**$2,918,324,000**	**($1,160,450,800)**	**$2,865,108,000**	**($1,177,995,950)**	**($6,712,992,000)**	**($1,263,584,100)**	**($53,216,000)**	**($17,545,150)**
	SUPPLEMENTAL PMNTS.										
2055	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	$6,289,557,000	$0	$6,289,994,000	$0	$6,291,696,000	$0	$2,139,000	$0	$1,702,000	$0
1475	HOSPITAL QAF - FFS PAYMENTS	$2,744,188,000	$0	$2,747,639,000	$0	($199,543,000)	$0	($2,943,731,000)	$0	($2,947,182,000)	$0
2024	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	$1,163,178,000	$0	$1,111,444,000	$0	$1,110,346,000	$0	($52,832,000)	$0	($1,098,000)	$0
1071	PRIVATE HOSPITAL DSH REPLACEMENT	$767,056,000	$383,528,000	$767,828,000	$383,914,000	$769,852,000	$384,926,000	$2,796,000	$1,398,000	$2,024,000	$1,012,000
1073	DSH PAYMENT	$525,289,000	$28,771,000	$638,907,000	$34,101,000	$604,637,000	$43,553,000	$79,348,000	$14,782,000	($34,270,000)	$9,452,000
1085	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	$504,097,000	$118,400,000	$504,762,000	$118,400,000	$505,332,000	$118,400,000	$1,235,000	$0	$570,000	$0
2130	PROP 56 - MEDI-CAL FAMILY PLANNING	$472,168,000	$164,563,300	$464,517,000	$216,478,800	$442,849,000	$146,154,100	($29,319,000)	($18,409,200)	($21,668,000)	($70,324,700)
78	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$254,434,000	$0	$201,463,000	$0	$231,553,000	$0	($22,881,000)	$0	$30,090,000	$0
1078	DPH PHYSICIAN & NON-PHYS. COST	$82,830,000	$0	$137,187,000	$0	$181,065,000	$0	$98,235,000	$0	$43,878,000	$0
1899	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	$129,883,000	($733,000)	$135,089,000	($870,000)	$134,080,000	($1,388,000)	$4,197,000	($655,000)	($1,009,000)	($518,000)
104	FFP FOR LOCAL TRAUMA CENTERS	$181,813,000	$0	$129,712,000	$0	$131,325,000	$0	($50,488,000)	$0	$1,613,000	$0
82	CAPITAL PROJECT DEBT REIMBURSEMENT	$89,425,000	$24,668,000	$90,469,000	$26,645,000	$81,745,000	$23,315,000	($7,680,000)	($1,353,000)	($8,724,000)	($3,330,000)
1600	NDPH IGT SUPPLEMENTAL PAYMENTS	$47,245,000	($1,583,000)	$48,592,000	($1,582,000)	$43,685,000	($1,397,000)	($3,560,000)	$186,000	($4,907,000)	$185,000
2049	PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS	$938,953,000	$361,995,600	$927,239,000	$348,207,450	$765,052,000	$287,732,000	($173,901,000)	($74,263,600)	($162,187,000)	($60,475,450)
1076	NDPH SUPPLEMENTAL PAYMENT	$18,143,000	$1,900,000	$18,169,000	$1,900,000	$18,234,000	$1,900,000	$91,000	$0	$65,000	$0
1616	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	$14,856,000	$0	$12,846,000	$0	$15,425,000	$0	$569,000	$0	$2,579,000	$0
1038	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	$10,000,000	$5,000,000	$10,000,000	$5,000,000	$10,000,000	$5,000,000	$0	$0	$0	$0
1039	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	$8,000,000	$4,000,000	$8,000,000	$4,000,000	$8,000,000	$4,000,000	$0	$0	$0	$0

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2025-26

.		2025-26 APPROPRIATION		NOV. 2025 EST. FOR 2025-26		MAY 2026 EST. FOR 2025-26		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
FRN.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	SUPPLEMENTAL PMNTS.										
86	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	$24,419,000	$0	$7,848,000	$0	$7,087,000	$0	($17,332,000)	$0	($761,000)	$0
2044	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	$53,350,000	$23,141,000	$5,935,000	$5,935,000	$6,226,000	$6,226,000	($47,124,000)	($16,915,000)	$291,000	$291,000
2303	FREE CLINICS AUGMENTATION	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$0	$0	$0	$0
2102	PROPOSITION 56 FUNDING	$0	($765,536,000)	$0	($469,703,000)	$0	($473,209,000)	$0	$292,327,000	$0	($3,506,000)
1601	IGT ADMIN. & PROCESSING FEE	$0	($20,982,000)	$0	($21,481,000)	$0	($21,515,000)	$0	($533,000)	$0	($34,000)
1661	GEMT SUPPLEMENTAL PAYMENT PROGRAM	($3,672,000)	$0	($10,913,000)	$0	($9,594,000)	$0	($5,922,000)	$0	$1,319,000	$0
1761	HOSPITAL QAF - MANAGED CARE PAYMENTS	$1,200,000,000	$0	$1,200,000,000	$0	$0	$0	($1,200,000,000)	$0	($1,200,000,000)	$0
1563	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	$1,512,000	$0	$0	$0	$0	$0	($1,512,000)	$0	$0	$0
	SUPPLEMENTAL PMNTS. SUBTOTAL	**$15,518,724,000**	**$329,132,900**	**$15,448,727,000**	**$652,945,250**	**$11,151,052,000**	**$525,697,100**	**($4,367,672,000)**	**$196,564,200**	**($4,297,675,000)**	**($127,248,150)**
	COVID-19										
2363	COVID-19 VACCINE FUNDING ADJUSTMENT	$0	$0	$0	($11,893,000)	$0	($11,893,000)	$0	($11,893,000)	$0	$0
2218	COVID-19 END OF UNWINDING FLEXIBILITIES	($1,314,049,000)	($422,025,900)	($1,417,302,000)	($448,863,400)	($1,437,539,000)	($453,124,300)	($123,490,000)	($31,098,400)	($20,237,000)	($4,260,900)
2301	CONTINUOUS CHIP COVERAGE DURING THE COVID-19 PHE	$0	$54,318,000	$0	$0	$0	$0	$0	($54,318,000)	$0	$0
2456	COVID-19 VACCINES	$75,328,000	$26,876,500	$0	$0	$0	$0	($75,328,000)	($26,876,500)	$0	$0
	COVID-19 SUBTOTAL	**($1,238,721,000)**	**($340,831,400)**	**($1,417,302,000)**	**($460,756,400)**	**($1,437,539,000)**	**($465,017,300)**	**($198,818,000)**	**($124,185,900)**	**($20,237,000)**	**($4,260,900)**
	STATE-ONLY CLAIMING										
2415	STATE-ONLY CLAIMING ADJUSTMENTS - RETRO ADJ.	$0	$178,384,000	$0	$397,679,000	$0	$686,577,000	$0	$508,193,000	$0	$288,898,000
	STATE-ONLY CLAIMING SUBTOTAL	**$0**	**$178,384,000**	**$0**	**$397,679,000**	**$0**	**$686,577,000**	**$0**	**$508,193,000**	**$0**	**$288,898,000**
	OTHER DEPARTMENTS										
1476	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$926,326,000	$0	$1,084,838,000	$0	$1,235,310,000	$0	$308,984,000	$0	$150,472,000	$0
	OTHER DEPARTMENTS SUBTOTAL	**$926,326,000**	**$0**	**$1,084,838,000**	**$0**	**$1,235,310,000**	**$0**	**$308,984,000**	**$0**	**$150,472,000**	**$0**

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2025-26

.		2025-26 APPROPRIATION		NOV. 2025 EST. FOR 2025-26		MAY 2026 EST. FOR 2025-26		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
FRN.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER										
2354	BEHAVIORAL HEALTH BRIDGE HOUSING	$283,587,000	$198,587,000	$281,087,000	$239,087,000	$281,087,000	$239,087,000	($2,500,000)	$40,500,000	$0	$0
2208	SELF-DETERMINATION PROGRAM - CDDS	$299,019,000	$0	$335,534,000	$0	$345,739,000	$0	$46,720,000	$0	$10,205,000	$0
2329	QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES	$272,872,000	$40,931,000	$187,862,000	$28,179,000	$155,373,000	$23,306,000	($117,499,000)	($17,625,000)	($32,489,000)	($4,873,000)
2092	QAF WITHHOLD TRANSFER	$64,060,000	$32,030,000	$71,562,000	$35,781,000	$9,624,000	$4,812,000	($54,436,000)	($27,218,000)	($61,938,000)	($30,969,000)
2424	CYBHI - FEE SCHEDULE THIRD PARTY ADMINISTRATOR	$69,300,000	$0	$69,300,000	$0	$39,500,000	$39,500,000	($29,800,000)	$39,500,000	($29,800,000)	$39,500,000
1232	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	$68,702,000	$0	$84,999,000	$0	$94,506,000	$0	$25,804,000	$0	$9,507,000	$0
2346	EQUITY & PRACTICE TRANSFORMATION PAYMENTS	$40,420,000	$20,210,000	$58,100,000	$20,647,550	$59,200,000	$19,674,050	$18,780,000	($535,950)	$1,100,000	($973,500)
2097	MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG	$22,885,000	$0	$52,389,000	$0	$44,217,000	$0	$21,332,000	$0	($8,172,000)	$0
2549	PROPOSITION 36 FUNDING	$50,000,000	$50,000,000	$50,000,000	$50,000,000	$50,000,000	$50,000,000	$0	$0	$0	$0
2439	CALAIM - PATH WPC	$26,046,000	$0	$35,274,000	$0	$21,627,000	$0	($4,419,000)	$0	($13,647,000)	$0
1975	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	$90,940,000	$54,564,000	$55,290,000	$28,485,500	$52,271,000	$26,867,000	($38,669,000)	($27,697,000)	($3,019,000)	($1,618,500)
2396	CARE ACT	$31,925,000	$31,925,000	$31,806,000	$31,806,000	$13,804,000	$13,804,000	($18,121,000)	($18,121,000)	($18,002,000)	($18,002,000)
111	INDIAN HEALTH SERVICES	$25,015,000	$8,338,500	$25,015,000	$8,338,500	$18,278,000	$6,092,500	($6,737,000)	($2,246,000)	($6,737,000)	($2,246,000)
2009	INFANT DEVELOPMENT PROGRAM	$20,671,000	$0	$30,798,000	$0	$34,868,000	$0	$14,197,000	$0	$4,070,000	$0
2550	BACKFILL LOST TITLE X FAMILY PLANNING FUNDING	$15,000,000	$15,000,000	$15,000,000	$15,000,000	$15,000,000	$15,000,000	$0	$0	$0	$0
1526	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	$13,554,000	$6,199,000	$13,672,000	$6,287,000	$15,559,000	$7,120,000	$2,005,000	$921,000	$1,887,000	$833,000
2502	MISC. ONE-TIME PAYMENTS	$0	$0	$12,550,000	$12,550,000	$12,550,000	$12,550,000	$12,550,000	$12,550,000	$0	$0
2375	CYBHI - URGENT NEEDS AND EMERGENT ISSUES	$15,850,000	$15,850,000	$10,100,000	$10,100,000	$10,100,000	$10,100,000	($5,750,000)	($5,750,000)	$0	$0
2355	CALHOPE	$5,000,000	$0	$5,000,000	$0	$5,000,000	$0	$0	$0	$0	$0
2443	ASSET LIMIT INCREASE & ELIM. - CNTY BH FUNDING	$4,413,000	$4,413,000	$3,994,000	$3,994,000	$5,688,000	$5,688,000	$1,275,000	$1,275,000	$1,694,000	$1,694,000
1866	WPCS WORKERS' COMPENSATION	$620,000	$310,000	$620,000	$310,000	$620,000	$310,000	$0	$0	$0	$0
35	IMD ANCILLARY SERVICES	$0	$54,448,000	$0	$54,739,000	$0	$57,766,000	$0	$3,318,000	$0	$3,027,000
1087	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	($87,216,000)	$0	($87,385,000)	$0	($87,385,000)	$0	($169,000)	$0	$0
1760	HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	($1,373,894,000)	$0	($1,281,900,000)	$0	($84,698,000)	$0	$1,289,196,000	$0	$1,197,202,000
2034	CMS DEFERRED CLAIMS	$0	($2,127,000)	$0	$332,514,000	$0	$477,700,000	$0	$479,827,000	$0	$145,186,000

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2025-26

.		2025-26 APPROPRIATION		NOV. 2025 EST. FOR 2025-26		MAY 2026 EST. FOR 2025-26		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
FRN.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER										
2156	INDIAN HEALTH SERVICES FUNDING SHIFT	$0	($28,533,000)	$0	($29,961,500)	$0	($28,729,000)	$0	($196,000)	$0	$1,232,500
2503	MEDICAL PROVIDER INTERIM PAYMENT LOAN	$0	($2,291,260,000)	$0	($2,541,324,000)	$0	($2,541,324,000)	$0	($250,064,000)	$0	$0
2484	HEALTH CARE SVCS. FINES AND PENALTIES	$0	($20,400,000)	$0	($20,400,000)	$0	($20,400,000)	$0	$0	$0	$0
2497	QUALITY SANCTIONS	($3,500,000)	($1,750,000)	($3,500,000)	($1,750,000)	($1,460,000)	($730,000)	$2,040,000	$1,020,000	$2,040,000	$1,020,000
2054	ASSISTED LIVING WAIVER EXPANSION	($20,382,000)	($12,229,000)	($3,908,000)	($2,030,000)	($953,000)	($495,000)	$19,429,000	$11,734,000	$2,955,000	$1,535,000
2010	HCBA WAIVER EXPANSION	($59,506,000)	($30,000,500)	($14,614,000)	($7,373,000)	($10,118,000)	($5,102,000)	$49,388,000	$24,898,500	$4,496,000	$2,271,000
1906	COUNTY SHARE OF OTLICP-CCS COSTS	($14,145,000)	($14,145,000)	($14,951,000)	($14,951,000)	($17,000,000)	($17,000,000)	($2,855,000)	($2,855,000)	($2,049,000)	($2,049,000)
2343	COUNTY BH RECOUPMENTS	($85,546,000)	($85,546,000)	($86,910,000)	($86,910,000)	($85,546,000)	($85,546,000)	$0	$0	$1,364,000	$1,364,000
110	AUDIT SETTLEMENTS	$0	$0	$0	$0	$0	$57,239,000	$0	$57,239,000	$0	$57,239,000
2356	DENTAL MANAGED CARE MLR RISK CORRIDOR	($1,500,000)	($634,850)	($1,500,000)	($634,850)	$0	$0	$1,500,000	$634,850	$1,500,000	$634,850
2442	MEDICARE PART A BUY-IN PROGRAM	($22,409,000)	($14,912,000)	($14,013,000)	($10,714,000)	$0	$0	$22,409,000	$14,912,000	$14,013,000	$10,714,000
2306	RECONCILIATION - BENEFITS	$0	$0	($1,569,000)	($1,569,000)	$0	$0	$0	$0	$1,569,000	$1,569,000
1915	FUNDING ADJUST.—ACA OPT. EXPANSION	$0	($6,485,144,800)	$0	$0	$0	$0	$0	$6,485,144,800	$0	$0
1926	FUNDING ADJUST.—OTLICP	$0	($150,764,550)	$0	$0	$0	$0	$0	$150,764,550	$0	$0
2531	RESIDENCY VERIFICATION IMPROVEMENTS	($226,500,000)	($90,600,000)	$0	$0	$0	$0	$226,500,000	$90,600,000	$0	$0
	OTHER SUBTOTAL	**$986,391,000**	**($10,156,351,200)**	**$1,288,987,000**	**($3,209,083,800)**	**$1,169,534,000**	**($1,804,793,450)**	**$183,143,000**	**$8,351,557,750**	**($119,453,000)**	**$1,404,290,350**
	GRAND TOTAL	**$59,020,711,000**	**($10,911,060,310)**	**$54,087,061,000**	**($9,340,934,810)**	**$48,231,123,000**	**($7,987,098,900)**	**($10,789,588,000)**	**$2,923,961,410**	**($5,855,938,000)**	**$1,353,835,910**

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

COMPARISON OF FISCAL IMPACTS OF COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2025-26

		2025-26 APPROPRIATION		NOV. 2025 EST. FOR 2025-26		MAY 2026 EST. FOR 2025-26		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
FRN	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	COUNTY ADMIN										
1704	COUNTY ADMINISTRATION ALLOCATION	$2,377,805,000	$1,188,902,500	$2,377,805,000	$1,188,902,500	$2,377,805,000	$1,188,902,500	$0	$0	$0	$0
214	SAWS	$215,536,000	$0	$244,497,000	$4,889,750	$200,841,000	$405,500	($14,695,000)	$405,500	($43,656,000)	($4,484,250)
217	CALWORKS APPLICATIONS	$94,701,000	$47,350,500	$99,217,000	$49,608,500	$99,964,000	$49,982,000	$5,263,000	$2,631,500	$747,000	$373,500
1598	CASE MANAGEMENT FOR OTLICP	$44,591,000	$22,295,500	$44,591,000	$22,295,500	$44,763,000	$22,381,500	$172,000	$86,000	$172,000	$86,000
213	LOS ANGELES COUNTY HOSPITAL INTAKES	$37,336,000	$1,797,500	$34,034,000	$2,735,500	$20,166,000	$2,736,000	($17,170,000)	$938,500	($13,868,000)	$500
215	SAVE	$0	($4,000,000)	$0	($4,000,000)	$0	($4,000,000)	$0	$0	$0	$0
1835	ENHANCED FEDERAL FUNDING	$0	($587,747,750)	$0	($596,032,250)	$0	($608,380,250)	$0	($20,632,500)	$0	($12,348,000)
	COUNTY ADMIN SUBTOTAL	**$2,769,969,000**	**$668,598,250**	**$2,800,144,000**	**$668,399,500**	**$2,743,539,000**	**$652,027,250**	**($26,430,000)**	**($16,571,000)**	**($56,605,000)**	**($16,372,250)**
	DHCS-OTHER										
2389	CALAIM - PATH	$378,816,000	$153,872,000	$563,118,000	$231,732,000	$473,522,000	$214,535,000	$94,706,000	$60,663,000	($89,596,000)	($17,197,000)
1721	COUNTY SPECIALTY MENTAL HEALTH ADMIN	$284,906,000	$10,447,000	$285,065,000	$10,169,000	$284,592,000	$10,643,000	($314,000)	$196,000	($473,000)	$474,000
1757	INTERIM AND FINAL COST SETTLEMENTS-SMHS	$255,646,000	$0	$266,418,000	$0	$186,894,000	$0	($68,752,000)	$0	($79,524,000)	$0
230	CCS PROGRAM COUNTY ADMINISTRATIVE BUDGET	$196,461,000	$69,771,400	$204,221,000	$72,606,800	$204,223,000	$72,594,050	$7,762,000	$2,822,650	$2,000	($12,750)
2289	CYBHI - BH SERVICES AND SUPPORTS PLATFORM	$175,900,000	$175,900,000	$175,900,000	$175,900,000	$175,900,000	$175,900,000	$0	$0	$0	$0
2167	MEDI-CAL RX - ADMINISTRATIVE COSTS	$150,381,000	$39,481,100	$158,298,000	$41,501,250	$158,298,000	$41,501,250	$7,917,000	$2,020,150	$0	$0
1963	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	$131,591,000	$0	$154,201,000	$0	$167,907,000	$0	$36,316,000	$0	$13,706,000	$0
235	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	$117,112,000	$0	$138,123,000	$0	$153,579,000	$0	$36,467,000	$0	$15,456,000	$0
1813	DRUG MEDI-CAL COUNTY ADMINISTRATION	$65,914,000	$89,000	$118,800,000	$220,000	$119,212,000	$632,000	$53,298,000	$543,000	$412,000	$412,000
2517	CALAIM-BH-CONNECT WORKFORCE INITIATIVE	$95,095,000	$0	$95,095,000	$0	$95,095,000	$0	$0	$0	$0	$0
2491	BH TRANSFORMATION FUNDING FOR COUNTY BH DEPTS.	$93,508,000	$0	$93,508,000	$0	$93,508,000	$0	$0	$0	$0	$0
231	POSTAGE & PRINTING	$63,878,000	$32,067,500	$70,815,000	$35,536,000	$71,362,000	$35,809,500	$7,484,000	$3,742,000	$547,000	$273,500
2288	CALAIM - POPULATION HEALTH MANAGEMENT	$78,010,000	$7,801,000	$69,660,000	$2,799,000	$71,365,000	$2,799,000	($6,645,000)	($5,002,000)	$1,705,000	$0
1722	SMH MAA	$53,357,000	$0	$53,303,000	$0	$52,327,000	$0	($1,030,000)	$0	($976,000)	$0
2398	CALAIM - BH - CONNECT DEMONSTRATION ADMIN	$39,866,000	$7,433,000	$41,866,000	$8,433,000	$65,490,000	$8,433,000	$25,624,000	$1,000,000	$23,624,000	$0
1937	ACTUARIAL COSTS FOR RATE DEVELOPMENT	$41,000,000	$20,350,000	$41,000,000	$20,350,000	$41,000,000	$20,350,000	$0	$0	$0	$0

COMPARISON OF FISCAL IMPACTS OF COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2025-26

		2025-26 APPROPRIATION		NOV. 2025 EST. FOR 2025-26		MAY 2026 EST. FOR 2025-26		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
FRN	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	DHCS-OTHER										
1551	MEDI-CAL RECOVERY CONTRACTS	$40,837,000	$10,209,250	$37,781,000	$9,445,250	$41,445,000	$10,361,250	$608,000	$152,000	$3,664,000	$916,000
252	ENTERPRISE DATA ENVIRONMENT	$50,351,000	$13,418,850	$37,761,000	$10,099,850	$29,978,000	$8,053,600	($20,373,000)	($5,365,250)	($7,783,000)	($2,046,250)
1748	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	$27,528,000	$13,756,250	$34,328,000	$17,170,700	$29,494,000	$15,018,300	$1,966,000	$1,262,050	($4,834,000)	($2,152,400)
1137	MITA	$34,030,000	$4,322,350	$31,142,000	$3,955,150	$33,594,000	$4,266,300	($436,000)	($56,050)	$2,452,000	$311,150
2505	ELECTRONIC VISIT VERIFICATION M&O COSTS	$29,763,000	$0	$28,192,000	$0	$37,762,000	$0	$7,999,000	$0	$9,570,000	$0
2402	EMSA - CALIFORNIA POISON CONTROL SYSTEM SVCS.	$17,961,000	$0	$23,357,000	$0	$16,289,000	$0	($1,672,000)	$0	($7,068,000)	$0
2152	HCBA WAIVER ADMINISTRATIVE COST	$23,247,000	$11,720,000	$22,396,000	$11,298,000	$22,026,000	$11,108,000	($1,221,000)	($612,000)	($370,000)	($190,000)
1932	PAVE SYSTEM	$17,371,000	$4,859,750	$21,350,000	$5,824,700	$16,316,000	$4,526,700	($1,055,000)	($333,050)	($5,034,000)	($1,298,000)
1318	CAPMAN	$18,884,000	$4,904,950	$19,188,000	$4,952,750	$19,788,000	$5,113,450	$904,000	$208,500	$600,000	$160,700
1720	PASRR	$9,011,000	$2,252,750	$11,019,000	$2,754,750	$11,373,000	$2,843,250	$2,362,000	$590,500	$354,000	$88,500
1732	SDMC SYSTEM M&O SUPPORT	$2,168,000	$1,084,000	$8,974,000	$4,487,000	$2,689,000	$1,344,500	$521,000	$260,500	($6,285,000)	($3,142,500)
2002	ELECTRONIC ASSET VERIFICATION PROGRAM	$4,613,000	$2,306,500	$8,632,000	$4,316,000	$8,632,000	$4,316,000	$4,019,000	$2,009,500	$0	$0
1452	PROTECTION OF PHI DATA	$7,502,000	$3,751,000	$7,881,000	$3,940,500	$5,538,000	$2,769,000	($1,964,000)	($982,000)	($2,343,000)	($1,171,500)
2414	BHSF - PROVIDER ACES TRAININGS	$7,415,000	$0	$7,415,000	$0	$7,415,000	$0	$0	$0	$0	$0
2467	MOBILE VISION SERVICES	$6,933,000	$0	$6,933,000	$0	$2,114,000	$0	($4,819,000)	$0	($4,819,000)	$0
1982	MEDCOMPASS SOLUTION	$5,412,000	$1,422,750	$6,812,000	$1,791,150	$7,036,000	$1,849,800	$1,624,000	$427,050	$224,000	$58,650
1824	NEWBORN HEARING SCREENING PROGRAM	$6,220,000	$3,110,000	$6,220,000	$3,110,000	$6,220,000	$3,110,000	$0	$0	$0	$0
2206	DRUG MEDI-CAL PARITY RULE ADMINISTRATION	$5,875,000	$1,958,000	$5,875,000	$1,958,000	$5,875,000	$1,958,000	$0	$0	$0	$0
1972	PACES	$3,663,000	$963,150	$3,686,000	$969,200	$3,761,000	$988,550	$98,000	$25,400	$75,000	$19,350
2413	CALAIM - INMATE PRE-RELEASE PROGRAM ADMIN	$2,746,000	$1,373,000	$2,746,000	$1,373,000	$2,746,000	$1,373,000	$0	$0	$0	$0
2358	STATEWIDE VERIFICATION HUB	$1,101,000	$112,100	$2,589,000	$258,900	$112,000	$11,200	($989,000)	($100,900)	($2,477,000)	($247,700)
1902	DATA ANALYTICS	$2,564,000	$353,000	$2,367,000	$337,500	$3,357,000	$930,000	$793,000	$577,000	$990,000	$592,500
2321	MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM	$2,200,000	$1,100,000	$2,200,000	$1,100,000	$2,200,000	$1,100,000	$0	$0	$0	$0
2392	MFP/CCT SUPPLEMENTAL FUNDING	$2,532,000	$0	$2,116,000	$0	$1,871,000	$0	($661,000)	$0	($245,000)	$0
1768	T-MSIS	$2,067,000	$321,300	$1,721,000	$421,300	$1,849,000	$445,050	($218,000)	$123,750	$128,000	$23,750
237	SSA COSTS FOR HEALTH COVERAGE INFO.	$1,618,000	$809,000	$1,704,000	$852,000	$1,800,000	$900,000	$182,000	$91,000	$96,000	$48,000
1441	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$1,278,000	$442,250	$1,333,000	$448,250	$1,022,000	$293,000	($256,000)	($149,250)	($311,000)	($155,250)

COMPARISON OF FISCAL IMPACTS OF COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2025-26

		2025-26 APPROPRIATION		NOV. 2025 EST. FOR 2025-26		MAY 2026 EST. FOR 2025-26		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
FRN	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	DHCS-OTHER										
1675	FAMILY PACT PROGRAM ADMIN.	$1,006,000	$503,000	$1,100,000	$550,000	$1,568,000	$784,000	$562,000	$281,000	$468,000	$234,000
2362	RECOVERY INCENTIVES CONTINGENCY MANAGEMENT ADMIN	$1,458,000	$0	$1,046,000	$0	$1,046,000	$0	($412,000)	$0	$0	$0
266	MMA - DSH ANNUAL INDEPENDENT AUDIT	$678,000	$339,000	$588,000	$294,000	$444,000	$222,000	($234,000)	($117,000)	($144,000)	($72,000)
2159	HEALTH INFORMATION EXCHANGE INTEROPERABILITY	$1,000,000	$100,000	$500,000	$50,000	$250,000	$31,700	($750,000)	($68,300)	($250,000)	($18,300)
1556	CCT OUTREACH - ADMINISTRATIVE COSTS	$340,000	$0	$364,000	$0	$364,000	$0	$24,000	$0	$0	$0
2438	HEALTH PLAN OF SAN MATEO DENTAL INTEGRATION EVAL	$186,000	$0	$186,000	$0	$186,000	$0	$0	$0	$0	$0
2123	CMS DEFERRED CLAIMS - OTHER ADMIN	$0	$0	$0	$282,975,000	$0	$582,438,000	$0	$582,438,000	$0	$299,463,000
2459	DESIGNATED STATE HEALTH PROGRAMS	$0	($178,255,000)	$0	($178,255,000)	$0	($178,255,000)	$0	$0	$0	$0
2562	EPTP - STATEWIDE LEARNING COLLABORATIVE	$0	$0	$6,900,000	$3,450,000	$6,900,000	$3,450,000	$6,900,000	$3,450,000	$0	$0
2559	STATE ONLY CLAIMING ADJUSTMENTS - ADMIN.	$0	$0	$0	$600,000,000	$0	$622,631,000	$0	$622,631,000	$0	$22,631,000
1370	PUBLIC HEALTH REGISTRIES SUPPORT	$4,441,000	$0	$10,996,000	$0	$0	$0	($4,441,000)	$0	($10,996,000)	$0
2447	CALAIM - JUSTICE INVOLVED MAA	$16,000,000	$8,000,000	$8,000,000	$4,000,000	$0	$0	($16,000,000)	($8,000,000)	($8,000,000)	($4,000,000)
2334	COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE	$21,062,000	$8,400,000	$6,131,000	$2,339,000	$0	$0	($21,062,000)	($8,400,000)	($6,131,000)	($2,339,000)
2533	REINSTATEMENT OF ASSET LIMIT - ADMIN	$5,000,000	$1,250,000	$0	$0	$0	$0	($5,000,000)	($1,250,000)	$0	$0
	DHCS-OTHER SUBTOTAL	**$2,607,502,000**	**$442,099,200**	**$2,910,920,000**	**$1,405,514,000**	**$2,747,334,000**	**$1,697,177,450**	**$139,832,000**	**$1,255,078,250**	**($163,586,000)**	**$291,663,450**
	DHCS-MEDICAL FI										
2115	MEDICAL FI BO & IT COST REIMBURSEMENT	$60,557,000	$16,908,000	$62,572,000	$17,416,650	$63,944,000	$17,717,850	$3,387,000	$809,850	$1,372,000	$301,200
2117	MEDICAL FI BO & IT CHANGE ORDERS	$44,717,000	$11,756,200	$54,236,000	$14,259,250	$41,156,000	$10,822,150	($3,561,000)	($934,050)	($13,080,000)	($3,437,100)
2119	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	$40,544,000	$10,659,450	$46,180,000	$12,141,600	$45,487,000	$11,959,900	$4,943,000	$1,300,450	($693,000)	($181,700)
2118	MEDICAL INFRASTRUCTURE & DATA MGT SVCS	$44,550,000	$11,712,950	$44,411,000	$11,676,250	$44,894,000	$11,801,950	$344,000	$89,000	$483,000	$125,700
2112	MEDICAL FI BO OTHER ESTIMATED COSTS	$26,541,000	$7,972,700	$26,627,000	$7,999,650	$26,475,000	$7,953,850	($66,000)	($18,850)	($152,000)	($45,800)
2116	MEDICAL FI BO TELEPHONE SERVICE CENTER	$19,616,000	$5,872,800	$19,483,000	$5,832,600	$19,370,000	$5,799,000	($246,000)	($73,800)	($113,000)	($33,600)
2111	MEDICAL FI BUSINESS OPERATIONS	$17,659,000	$4,639,650	$17,759,000	$4,665,550	$17,655,000	$4,638,550	($4,000)	($1,100)	($104,000)	($27,000)
2113	MEDICAL FI BO HOURLY REIMBURSEMENT	$13,070,000	$3,436,550	$12,843,000	$3,376,300	$12,768,000	$3,356,850	($302,000)	($79,700)	($75,000)	($19,450)

COMPARISON OF FISCAL IMPACTS OF COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2025-26

		2025-26 APPROPRIATION		NOV. 2025 EST. FOR 2025-26		MAY 2026 EST. FOR 2025-26		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
FRN	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	DHCS-MEDICAL FI										
2114	MEDICAL FI BO MISCELLANEOUS EXPENSES	$1,475,000	$387,850	$1,266,000	$346,450	$1,199,000	$329,100	($276,000)	($58,750)	($67,000)	($17,350)
2564	HR 1 - PROHIBITED ENTITIES SYSTEMS COSTS	$0	$0	$722,000	$722,000	$547,000	$547,000	$547,000	$547,000	($175,000)	($175,000)
	DHCS-MEDICAL FI SUBTOTAL	**$268,729,000**	**$73,346,150**	**$286,099,000**	**$78,436,300**	**$273,495,000**	**$74,926,200**	**$4,766,000**	**$1,580,050**	**($12,604,000)**	**($3,510,100)**
	DHCS-HEALTH CARE OPT										
2051	HCO OPERATIONS	$38,365,000	$18,894,650	$38,103,000	$18,765,750	$36,760,000	$18,104,300	($1,605,000)	($790,350)	($1,343,000)	($661,450)
2052	HCO COST REIMBURSEMENT	$35,308,000	$17,389,100	$34,565,000	$17,030,050	$34,987,000	$17,237,750	($321,000)	($151,350)	$422,000	$207,700
2053	HCO ESR HOURLY REIMBURSEMENT	$15,399,000	$7,584,150	$15,484,000	$7,625,900	$15,590,000	$7,678,000	$191,000	$93,850	$106,000	$52,100
	DHCS-HEALTH CARE OPT SUBTOTAL	**$89,072,000**	**$43,867,900**	**$88,152,000**	**$43,421,700**	**$87,337,000**	**$43,020,050**	**($1,735,000)**	**($847,850)**	**($815,000)**	**($401,650)**
	DHCS-DENTAL FI										
2380	DENTAL FI-DBO ADMIN 2022 CONTRACT	$84,915,000	$22,830,750	$167,402,000	$44,132,500	$162,882,000	$43,563,500	$77,967,000	$20,732,750	($4,520,000)	($569,000)
2006	DENTAL FI ADMINISTRATION 2016 CONTRACT	$22,019,000	$5,514,500	$18,580,000	$4,654,000	$18,474,000	$4,635,500	($3,545,000)	($879,000)	($106,000)	($18,500)
	DHCS-DENTAL FI SUBTOTAL	**$106,934,000**	**$28,345,250**	**$185,982,000**	**$48,786,500**	**$181,356,000**	**$48,199,000**	**$74,422,000**	**$19,853,750**	**($4,626,000)**	**($587,500)**
	OTHER DEPARTMENTS										
236	PERSONAL CARE SERVICES	$569,130,000	$0	$619,619,000	$0	$598,333,000	$0	$29,203,000	$0	($21,286,000)	$0
233	HEALTH-RELATED ACTIVITIES - CDSS	$507,503,000	$0	$512,690,000	$0	$241,720,000	$0	($265,783,000)	$0	($270,970,000)	$0
1679	CALHEERS DEVELOPMENT	$173,767,000	$46,305,250	$173,779,000	$60,668,650	$173,104,000	$46,130,500	($663,000)	($174,750)	($675,000)	($14,538,150)
234	MATERNAL AND CHILD HEALTH	$101,516,000	$0	$109,422,000	$0	$90,793,000	$0	($10,723,000)	$0	($18,629,000)	$0
243	CDDS ADMINISTRATIVE COSTS	$92,097,000	$0	$143,979,000	$0	$143,008,000	$0	$50,911,000	$0	($971,000)	$0
256	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$54,867,000	$0	$58,982,000	$0	$57,744,000	$0	$2,877,000	$0	($1,238,000)	$0
246	HCPCFC CASE MANAGEMENT	$54,682,000	$0	$54,682,000	$0	$74,400,000	$4,929,000	$19,718,000	$4,929,000	$19,718,000	$4,929,000
2455	HCPCFC ADMIN COSTS	$23,757,000	$11,878,500	$23,757,000	$11,878,500	$23,757,000	$11,878,500	$0	$0	$0	$0
1192	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	$9,936,000	$0	$7,812,000	$0	$8,761,000	$0	($1,175,000)	$0	$949,000	$0
253	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$8,132,000	$0	$7,393,000	$0	$7,570,000	$0	($562,000)	$0	$177,000	$0
2244	FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG	$8,063,000	$0	$8,052,000	$0	$8,052,000	$0	($11,000)	$0	$0	$0

COMPARISON OF FISCAL IMPACTS OF COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2025-26

		2025-26 APPROPRIATION		NOV. 2025 EST. FOR 2025-26		MAY 2026 EST. FOR 2025-26		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
FRN	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER DEPARTMENTS										
239	CLPP CASE MANAGEMENT SERVICES	$4,357,000	$0	$8,157,000	$0	$6,502,000	$0	$2,145,000	$0	($1,655,000)	$0
1680	CALIFORNIA SMOKERS' HELPLINE	$3,052,000	$0	$2,390,000	$0	$2,353,000	$0	($699,000)	$0	($37,000)	$0
257	CALHHS AGENCY HIPAA FUNDING	$1,782,000	$891,000	$1,749,000	$874,500	$1,749,000	$874,500	($33,000)	($16,500)	$0	$0
1665	MEDI-CAL INPATIENT SERVICES FOR INMATES	$1,212,000	$0	$1,144,000	$0	$1,144,000	$0	($68,000)	$0	$0	$0
232	VETERANS BENEFITS	$1,100,000	$0	$1,100,000	$0	$1,100,000	$0	$0	$0	$0	$0
1774	VITAL RECORDS	$883,000	$4,000	$883,000	$4,000	$883,000	$4,000	$0	$0	$0	$0
249	KIT FOR NEW PARENTS	$509,000	$0	$509,000	$0	$108,000	$0	($401,000)	$0	($401,000)	$0
263	MERIT SYSTEM SERVICES FOR COUNTIES	$190,000	$95,000	$202,000	$101,000	$202,000	$101,000	$12,000	$6,000	$0	$0
1114	PIA EYEWEAR COURIER SERVICE	$944,000	$472,000	$944,000	$472,000	$726,000	$363,000	($218,000)	($109,000)	($218,000)	($109,000)
	OTHER DEPARTMENTS SUBTOTAL	**$1,617,479,000**	**$59,645,750**	**$1,737,245,000**	**$73,998,650**	**$1,442,009,000**	**$64,280,500**	**($175,470,000)**	**$4,634,750**	**($295,236,000)**	**($9,718,150)**
	GRAND TOTAL	**$7,459,685,000**	**$1,315,902,500**	**$8,008,542,000**	**$2,318,556,650**	**$7,475,070,000**	**$2,579,630,450**	**$15,385,000**	**$1,263,727,950**	**($533,472,000)**	**$261,073,800**

FISCAL YEAR 2025-26 COST PER ELIGIBLE BASED ON MAY 2026 ESTIMATE

SERVICE CATEGORY	TITLE 19 CHILDREN	TITLE 19 ADULTS	TITLE 21	ACA EXPANSION	SPDS	LTC AID CODES
PHYSICIANS	$154,160,360	$72,866,080	$26,043,340	$120,174,240	$73,213,780	$1,788,950
OTHER MEDICAL	$1,669,639,170	$1,906,610,210	$458,759,640	$2,925,230,210	$1,546,648,620	$24,520,150
CO. & COMM. OUTPATIENT	$188,316,890	$84,206,610	$60,050,310	$136,494,870	$150,011,110	$209,800
PHARMACY	$947,267,960	$3,041,493,770	$448,830,590	$7,432,644,760	$3,945,947,310	$29,922,230
COUNTY INPATIENT	$154,457,240	$77,100,240	$9,808,040	$386,324,550	$52,066,920	$738,840
COMMUNITY INPATIENT	$1,511,898,070	$389,217,860	$127,165,140	$831,137,870	$478,272,290	$8,003,620
NURSING FACILITIES	$11,863,310	$4,719,710	$805,390	$58,377,920	$500,201,560	$258,845,180
ICF-DD	$1,467,650	$13,200	$11,710	$235,060	$4,131,460	$2,822,930
MEDICAL TRANSPORTATION	$10,308,920	$21,408,680	$1,081,680	$35,389,860	$13,234,260	$368,700
OTHER SERVICES	$458,879,030	$254,767,690	$139,469,960	$88,857,980	$1,711,668,710	$27,059,180
HOME HEALTH	$36,572,700	$255,960	$11,664,480	$1,849,180	$82,423,330	$800
FFS SUBTOTAL	**$5,144,831,310**	**$5,852,660,010**	**$1,283,690,270**	**$12,016,716,500**	**$8,557,819,360**	**$354,280,390**
DENTAL	$953,938,990	$379,304,070	$323,545,440	$644,372,300	$380,151,940	$27,110,190
MENTAL HEALTH	$3,565,872,530	$854,940,860	$974,777,890	$3,098,945,040	$2,636,527,820	$18,871,160
TWO PLAN MODEL	$3,902,470,680	$5,238,275,660	$1,370,285,910	$15,264,727,760	$15,226,109,940	$242,580,990
COUNTY ORGANIZED HEALTH SYSTEMS	$1,956,521,170	$3,165,063,890	$810,469,990	$8,263,916,550	$7,736,179,860	$127,981,570
GEOGRAPHIC MANAGED CARE	$622,762,340	$886,811,380	$244,052,050	$2,497,938,760	$2,589,196,230	$31,616,340
PHP & OTHER MANAG. CARE	($66,620)	$2,556,010	($136,450)	$38,707,060	$2,513,414,010	$29,247,020
MEDICARE PAYMENTS	$0	$147,559,910	$0	$346,960,240	$9,269,544,240	$212,999,870
MISC. SERVICES	$7,805,440	$123,260	$0	$18,650	$575,887,480	$170
DRUG MEDI-CAL	$357,032,920	$368,706,300	$356,586,730	$381,760,850	$368,596,500	$356,591,650
REGIONAL MODEL	$14,603,470	$27,265,420	$7,193,050	$92,977,690	$116,093,750	$3,887,620
NON-FFS SUBTOTAL	**$11,380,940,900**	**$11,070,606,770**	**$4,086,774,610**	**$30,630,324,900**	**$41,411,701,760**	**$1,050,886,580**
TOTAL DOLLARS (1)	**$16,525,772,210**	**$16,923,266,780**	**$5,370,464,880**	**$42,647,041,400**	**$49,969,521,120**	**$1,405,166,970**
ELIGIBLES ***	**3,515,500**	**2,231,700**	**1,247,100**	**4,846,000**	**2,497,800**	**49,400**
ANNUAL $/ELIGIBLE	**$4,701**	**$7,583**	**$4,306**	**$8,800**	**$20,005**	**$28,445**
AVG. MO. $/ELIGIBLE	**$392**	**$632**	**$359**	**$733**	**$1,667**	**$2,370**

(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 MAY 2026 ESTIMATE

SERVICE CATEGORY	TOTAL
PHYSICIANS	$448,246,750
OTHER MEDICAL	$8,531,407,990
CO. & COMM. OUTPATIENT	$619,289,590
PHARMACY	$15,846,106,630
COUNTY INPATIENT	$680,495,830
COMMUNITY INPATIENT	$3,345,694,850
NURSING FACILITIES	$834,813,070
ICF-DD	$8,682,020
MEDICAL TRANSPORTATION	$81,792,100
OTHER SERVICES	$2,680,702,540
HOME HEALTH	$132,766,460
FFS SUBTOTAL	$33,209,997,840
DENTAL	$2,708,422,920
MENTAL HEALTH	$11,149,935,290
TWO PLAN MODEL	$41,244,450,940
COUNTY ORGANIZED HEALTH SYSTEMS	$22,060,133,020
GEOGRAPHIC MANAGED CARE	$6,872,377,100
PHP & OTHER MANAG. CARE	$2,583,721,040
MEDICARE PAYMENTS	$9,977,064,260
MISC. SERVICES	$583,835,000
DRUG MEDI-CAL	$2,189,274,950
REGIONAL MODEL	$262,021,010
NON-FFS SUBTOTAL	$99,631,235,520
TOTAL DOLLARS (1)	$132,841,233,360
ELIGIBLES ***	14,387,500
ANNUAL $/ELIGIBLE	$9,233
AVG. MO. $/ELIGIBLE	$769

(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 BENEFITS COST PER ELIGIBLE BASED ON MAY 2026 ESTIMATE

EXCLUDED POLICY CHANGES: 103

FISCAL REF NO.	POLICY CHANGE TITLE
2125	QAF WITHHOLD TRANSFER ADJUSTMENT
2126	QAF WITHHOLD ADJUSTMENT
3	BREAST AND CERVICAL CANCER TREATMENT
2422	HEALTH ENROLLMENT NAVIGATORS FOR CLINICS
2155	CS3 PROXY ADJUSTMENT
1595	COMMUNITY FIRST CHOICE OPTION
1791	1% FMAP INCREASE FOR PREVENTIVE SERVICES
1821	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.
1	FAMILY PACT PROGRAM
1228	CALIFORNIA COMMUNITY TRANSITIONS COSTS
2194	PHARMACY RETROACTIVE ADJUSTMENTS
1449	LITIGATION SETTLEMENTS
51	FAMILY PACT DRUG REBATES
1723	DRUG MEDI-CAL PROGRAM COST SETTLEMENT
1660	IMPERIAL AND SISKIYOU COUNTY MHP OVERPAYMENT
1713	INTERIM AND FINAL COST SETTLEMENTS - SMHS
1951	GLOBAL PAYMENT PROGRAM
2245	CALAIM ECM-COMMUNITY SUPPORTS-TRANSITIONAL RENT
1769	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG
2408	2023 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.
2504	MEDI-CAL MANAGED CARE QUALITY WITHHOLD RELEASE
1029	DENTAL MANAGED CARE (Other M/C)
2499	COMMUNITY CLINIC DIRECTED PAYMENT PROGRAM
1837	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL
1823	COUNTY CHILDREN’S HEALTH INITIATIVE PROGRAM
1797	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL
2406	2023 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ
2407	2023 MCO ENROLLMENT TAX MANAGED CARE PLANS
2063	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND
2081	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF
1784	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES
2509	PROP 35 - PROVIDER PAYMENT INCREASE FUNDING

FISCAL YEAR 2025-26 BENEFITS COST PER ELIGIBLE BASED ON MAY 2026 ESTIMATE

EXCLUDED POLICY CHANGES: 103

FISCAL REF NO.	POLICY CHANGE TITLE
2055	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS
1475	HOSPITAL QAF - FFS PAYMENTS
1761	HOSPITAL QAF - MANAGED CARE PAYMENTS
2024	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS
1071	PRIVATE HOSPITAL DSH REPLACEMENT
1073	DSH PAYMENT
1085	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
2130	PROP 56 - MEDI-CAL FAMILY PLANNING
78	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS
1078	DPH PHYSICIAN & NON-PHYS. COST
1899	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS
104	FFP FOR LOCAL TRAUMA CENTERS
82	CAPITAL PROJECT DEBT REIMBURSEMENT
1600	NDPH IGT SUPPLEMENTAL PAYMENTS
2049	PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS
1076	NDPH SUPPLEMENTAL PAYMENT
1616	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS
1038	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH
1039	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH
86	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS
2044	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS
2303	FREE CLINICS AUGMENTATION
2102	PROPOSITION 56 FUNDING
1601	IGT ADMIN. & PROCESSING FEE
1661	GEMT SUPPLEMENTAL PAYMENT PROGRAM
2415	STATE-ONLY CLAIMING ADJUSTMENTS - RETRO ADJ.
1476	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS
22	PERSONAL CARE SERVICES (Misc. Svcs.)
23	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)
2354	BEHAVIORAL HEALTH BRIDGE HOUSING
26	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)
2208	SELF-DETERMINATION PROGRAM - CDDS

FISCAL YEAR 2025-26 BENEFITS COST PER ELIGIBLE BASED ON MAY 2026 ESTIMATE

EXCLUDED POLICY CHANGES: 103

FISCAL REF NO.	POLICY CHANGE TITLE
2080	LAWSUITS/CLAIMS
2092	QAF WITHHOLD TRANSFER
2424	CYBHI - FEE SCHEDULE THIRD PARTY ADMINISTRATOR
1232	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS
2346	EQUITY & PRACTICE TRANSFORMATION PAYMENTS
2097	MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG
2439	CALAIM - PATH WPC
1975	MINIMUM WAGE INCREASE FOR HCBS WAIVERS
77	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC
2009	INFANT DEVELOPMENT PROGRAM
2550	BACKFILL LOST TITLE X FAMILY PLANNING FUNDING
1526	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS
2502	MISC. ONE-TIME PAYMENTS
2375	CYBHI - URGENT NEEDS AND EMERGENT ISSUES
27	MEDI-CAL TCM PROGRAM
2355	CALHOPE
2443	ASSET LIMIT INCREASE & ELIM. - CNTY BH FUNDING
1087	CIGARETTE AND TOBACCO SURTAX FUNDS
1760	HOSPITAL QAF - CHILDREN'S HEALTH CARE
2034	CMS DEFERRED CLAIMS
2503	MEDICAL PROVIDER INTERIM PAYMENT LOAN
2551	HR 1 - UIS EMERGENCY ACA FMAP ADJUSTMENT
2563	ELIMINATE DENTAL FOR ADULT UIS
2497	QUALITY SANCTIONS
2054	ASSISTED LIVING WAIVER EXPANSION
2010	HCBA WAIVER EXPANSION
1906	COUNTY SHARE OF OTLICP-CCS COSTS
2343	COUNTY BH RECOUPMENTS
127	BASE RECOVERIES
2558	MCP NETWORK ADEQUACY & TIMELY ACCESS SANCTIONS
2553	HR 1 - REDUCED RETROACTIVE MEDI-CAL TIMEFRAMES
2569	IMPROVEMENTS AND EFFICIENCIES

FISCAL YEAR 2025-26 BENEFITS COST PER ELIGIBLE BASED ON MAY 2026 ESTIMATE

EXCLUDED POLICY CHANGES: 103

FISCAL REF NO.	POLICY CHANGE TITLE
110	AUDIT SETTLEMENTS
2572	DMPH GME IGT ADMIN. & PROCESSING FEE
2573	GRADUATE MEDICAL EDUCATION PAYMENTS TO DMPHS
2582	OVERPAYMENTS FOR REPRODUCTIVE HEALTH
2585	2027 MCO TAX CAPITATION PAYMENTS
2586	2027 MCO TAX FUNDING ADJUSTMENT - CAPITATION
2587	2027 MCO TAX FUNDING ADJUSTMENT – GENERAL SUPPORT

TABLE OF CONTENTS

BUDGET YEAR

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

MEDI-CAL PROGRAM ESTIMATE SUMMARY EXPENDITURES 1

SUMMARY OF BASE POLICY CHANGES 2-3

SUMMARY OF REGULAR POLICY CHANGES 4-9

SUMMARY OF COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION POLICY CHANGES..10-13

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY AND FUND TYPE 14

MEDI-CAL TOTAL FUND EXPENDITURES BY SERVICE CATEGORY COMPARISONS 15-16

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES, BUDGET YEAR COMPARISONS 17-19

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES, BUDGET YEAR COMPARISONS 20-29

COMPARISON OF FISCAL IMPACTS OF COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION POLICY CHANGES, BUDGET YEAR COMPARISONS 30-35

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES, CURRENT YEAR COMPARED TO BUDGET YEAR 36-38

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES, CURRENT YEAR COMPARED TO BUDGET YEAR 39-48

COMPARISON OF FISCAL IMPACTS OF COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION POLICY CHANGES, CURRENT YEAR COMPARED TO BUDGET YEAR 49-54

COST PER ELIGIBLE BY SERVICE CATEGORY 55-60

MEDI-CAL PROGRAM ESTIMATE SUMMARY
FISCAL YEAR 2026-27

	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER FUNDS
I. BASE ESTIMATES				
A. B/Y BASE POLICY CHANGES	$147,584,693,940	$85,596,108,180	$58,430,992,750	$3,557,593,010
B. BASE ADJUSTMENTS	($282,825,000)	($243,255,800)	($39,569,200)	$0
C. ADJUSTED BASE	**$147,301,868,940**	**$85,352,852,380**	**$58,391,423,550**	**$3,557,593,010**
II. REGULAR POLICY CHANGES				
A. ELIGIBILITY	($2,341,702,480)	($1,254,448,200)	($1,089,814,280)	$2,560,000
B. AFFORDABLE CARE ACT	$12,086,178,000	$12,125,991,200	($39,813,200)	$0
C. BENEFITS	$981,802,390	$893,750,420	$82,951,980	$5,100,000
D. PHARMACY	($9,116,291,030)	($8,271,580,980)	($3,691,253,060)	$2,846,543,000
E. DRUG MEDI-CAL	$33,595,620	$22,942,650	$7,280,110	$3,372,860
F. MENTAL HEALTH	$612,641,000	$277,380,950	$200,471,050	$134,789,000
G. WAIVER--MH/UCD & BTR	$5,719,958,000	$3,094,204,400	$1,119,202,600	$1,506,551,000
H. MANAGED CARE	$22,332,952,000	$14,524,733,360	($5,568,748,360)	$13,376,967,000
I. PROVIDER RATES	$4,632,663,800	$3,179,003,630	($2,038,629,890)	$3,492,290,060
J. SUPPLEMENTAL PMNTS.	$26,013,235,140	$15,929,707,580	$238,803,310	$9,844,724,250
K. COVID-19	($1,757,397,940)	($1,180,614,090)	($576,783,850)	$0
L. STATE-ONLY CLAIMING	$0	($113,311,000)	($275,950,000)	$389,261,000
M. OTHER DEPARTMENTS	$1,325,058,000	$1,325,058,000	$0	$0
N. OTHER	$330,040,290	$131,240,600	($3,653,904,310)	$3,852,704,000
O. TOTAL CHANGES	**$60,852,732,790**	**$40,684,058,510**	**($15,286,187,900)**	**$35,454,862,170**
III. SUBTOTAL BENEFITS	**$208,154,601,730**	**$126,036,910,890**	**$43,105,235,660**	**$39,012,455,180**
IV. COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION	**$8,532,965,000**	**$6,455,561,350**	**$1,837,999,650**	**$239,404,000**
V. TOTAL MEDI-CAL ESTIMATE	**$216,687,566,730**	**$132,492,472,240**	**$44,943,235,310**	**$39,251,859,180**

* Rounded to nearest 10

SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2026-27

FRN	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER FUNDS
	DRUG MEDI-CAL				
2012	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	$1,762,233,000	$1,357,337,000	$132,092,000	$272,804,000
2320	DRUG MEDI-CAL STATE PLAN SERVICES	$51,307,000	$34,638,700	$2,931,300	$13,737,000
	DRUG MEDI-CAL SUBTOTAL	**$1,813,540,000**	**$1,391,975,700**	**$135,023,300**	**$286,541,000**
	MENTAL HEALTH				
1780	SMHS FOR ADULTS	$5,455,610,000	$3,735,626,900	$446,255,100	$1,273,728,000
1779	SMHS FOR CHILDREN	$4,487,212,000	$2,407,560,100	$82,327,900	$1,997,324,000
	MENTAL HEALTH SUBTOTAL	**$9,942,822,000**	**$6,143,187,000**	**$528,583,000**	**$3,271,052,000**
	MANAGED CARE				
56	TWO PLAN MODEL	$38,347,025,000	$21,679,113,500	$16,667,911,500	$0
57	COUNTY ORGANIZED HEALTH SYSTEMS & SINGLE PLAN	$21,305,208,000	$12,210,205,300	$9,095,002,700	$0
58	GEOGRAPHIC MANAGED CARE	$6,690,671,000	$3,963,400,050	$2,727,270,950	$0
62	PACE (Other M/C)	$3,020,768,000	$1,415,460,200	$1,605,307,800	$0
1842	REGIONAL MODEL	$246,982,000	$154,889,950	$92,092,050	$0
1029	DENTAL MANAGED CARE (Other M/C)	$180,042,000	$98,543,650	$81,498,350	$0
61	SENIOR CARE ACTION NETWORK (Other M/C)	$117,169,000	$57,970,500	$59,198,500	$0
1837	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	$62,440,000	$39,409,000	$23,031,000	$0
1823	COUNTY CHILDREN’S HEALTH INITIATIVE PROGRAM	$16,267,000	$10,573,550	$5,693,450	$0
63	AIDS HEALTHCARE CENTERS (Other M/C)	$13,622,000	$8,124,200	$5,497,800	$0
1797	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	$3,069,000	$1,994,850	$1,074,150	$0
2581	CAP PACE RATES AT LOWER BOUND	($67,400,000)	($33,700,000)	($33,700,000)	$0
	MANAGED CARE SUBTOTAL	**$69,935,863,000**	**$39,605,984,750**	**$30,329,878,250**	**$0**
	FEE-FOR-SERVICE BASE				
2540	FFS - PHARMACY	$25,643,326,000	$15,198,806,850	$10,444,519,150	$0
2539	FFS - OTHER MEDICAL	$8,222,865,000	$3,987,635,400	$4,235,229,600	$0
2543	FFS - COMMUNITY INPATIENT	$3,594,693,000	$2,303,836,950	$1,290,856,050	$0
2547	FFS - OTHER SERVICES	$1,967,034,000	$1,011,664,650	$955,369,350	$0
2544	FFS - NURSING FACILITIES	$696,648,000	$357,186,400	$339,461,600	$0
2542	FFS - COUNTY INPATIENT	$660,042,000	$641,008,900	$19,033,100	$0
2541	FFS - CO. & COMM. OUTPATIENT	$646,148,000	$357,354,000	$288,794,000	$0
2538	FFS - PHYSICIANS	$523,847,000	$294,234,400	$229,612,600	$0
2548	FFS - HOME HEALTH	$136,128,000	$70,393,350	$65,734,650	$0
2546	FFS - MEDICAL TRANSPORTATION	$77,918,000	$52,290,100	$25,627,900	$0
2545	FFS - ICF-DD	$8,056,000	$4,091,000	$3,965,000	$0
	FEE-FOR-SERVICE BASE SUBTOTAL	**$42,176,705,000**	**$24,278,502,000**	**$17,898,203,000**	**$0**

SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2026-27

FRN	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER FUNDS
	OTHER				
76	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$6,548,820,000	$2,764,135,500	$3,784,684,500	$0
22	PERSONAL CARE SERVICES (Misc. Svcs.)	$4,875,015,000	$4,875,015,000	$0	$0
23	HOME & COMMUNITY-BASED SVCS.- CDDS (Misc.)	$4,938,732,000	$4,938,732,000	$0	$0
1019	MEDICARE PAYMENTS - PART D PHASED-DOWN	$4,367,207,000	$0	$4,367,207,000	$0
135	DENTAL SERVICES	$2,691,090,000	$1,418,177,400	$1,272,912,600	$0
32	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$616,026,000	$305,361,000	$310,665,000	$0
26	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$518,524,000	$518,524,000	$0	$0
2080	LAWSUITS/CLAIMS	$55,850,000	$27,925,000	$27,925,000	$0
77	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$14,645,000	$14,645,000	$0	$0
27	MEDI-CAL TCM PROGRAM	$9,208,000	$9,208,000	$0	$0
91	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$255,000	$127,500	$127,500	$0
127	BASE RECOVERIES	($919,609,000)	($695,392,310)	($224,216,690)	$0
	OTHER SUBTOTAL	**$23,715,763,000**	**$14,176,458,090**	**$9,539,304,910**	**$0**
	GRAND TOTAL	**$147,584,693,000**	**$85,596,107,540**	**$58,430,992,460**	**$3,557,593,000**

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2026-27

FRN	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER FUNDS
	ELIGIBILITY				
1569	MEDI-CAL STATE INMATE PROGRAMS	$47,616,000	$47,616,000	$0	$0
2529	PREMIUMS FOR ADULTS WITH UNSATIS. IMMIG. STAT.	$28,000,000	$0	$28,000,000	$0
2332	CALAIM - INMATE PRE-RELEASE PROGRAM	$161,801,640	$138,961,170	$22,840,470	$0
3	BREAST AND CERVICAL CANCER TREATMENT	$17,028,000	$8,001,800	$9,026,200	$0
13	NON-OTLICP CHIP	$0	$123,190,200	($123,190,200)	$0
1007	SCHIP FUNDING FOR PRENATAL CARE	$0	$80,575,300	($80,575,300)	$0
2155	CS3 PROXY ADJUSTMENT	$0	$114,308,700	($114,308,700)	$0
2237	REFUGEE MEDICAL ASSISTANCE	$0	$0	($47,000)	$47,000
2029	MEDI-CAL COUNTY INMATE REIMBURSEMENT	$0	$0	($2,513,000)	$2,513,000
2500	SB 525 MINIMUM WAGE - CASELOAD IMPACT	($43,251,590)	($25,950,940)	($17,300,650)	$0
2535	REINSTATEMENT OF ASSET LIMIT	($823,382,450)	($411,691,220)	($411,691,220)	$0
2530	FULL-SCOPE MEDI-CAL EXPANSION ENROLLMENT FREEZE	($859,711,080)	($122,144,410)	($737,566,670)	$0
2553	HR 1 - REDUCED RETROACTIVE MEDI-CAL TIMEFRAMES	($34,562,000)	($19,899,950)	($14,662,050)	$0
2554	HR 1 - RESTRICTED FEDERAL FUNDING FOR CERTAIN QNCS	($13,612,000)	($681,668,000)	$668,056,000	$0
2555	HR 1 - FED WORK & COMMUNITY ENGAGEMENT REQUIREMENT	($357,564,000)	($267,250,800)	($90,313,200)	$0
2575	HR 1 - DEATH MASTER FILE AUTOMATION	($32,665,000)	($22,796,050)	($9,868,950)	$0
2588	FULL REINSTATEMENT OF ASSET LIMIT	($431,400,000)	($215,700,000)	($215,700,000)	$0
	ELIGIBILITY SUBTOTAL	**($2,341,702,480)**	**($1,254,448,210)**	**($1,089,814,280)**	**$2,560,000**
	AFFORDABLE CARE ACT				
1595	COMMUNITY FIRST CHOICE OPTION	$12,068,334,000	$12,068,334,000	$0	$0
1967	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	$17,844,000	$17,844,000	$0	$0
1791	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	$6,050,000	($6,050,000)	$0
1821	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	$0	$33,763,200	($33,763,200)	$0
	AFFORDABLE CARE ACT SUBTOTAL	**$12,086,178,000**	**$12,125,991,200**	**($39,813,200)**	**$0**
	BENEFITS				
25	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$678,367,000	$678,367,000	$0	$0
1	FAMILY PACT PROGRAM	$140,721,000	$105,318,400	$35,402,600	$0
1228	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$127,913,000	$99,562,000	$28,351,000	$0
28	MULTIPURPOSE SENIOR SERVICES PROGRAM	$63,951,000	$31,736,500	$32,214,500	$0
2457	CYBHI WELLNESS COACH BENEFIT	$32,000	$18,000	($5,086,000)	$5,100,000
1855	BEHAVIORAL HEALTH TREATMENT	$6,334,000	$3,167,000	$3,167,000	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2026-27

FRN	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER FUNDS
	BENEFITS				
2189	HEARING AID COVERAGE FOR CHILDREN PROGRAM	$2,470,820	$0	$2,470,820	$0
1562	CCT FUND TRANSFER TO CDSS	$736,000	$736,000	$0	$0
2528	UTILIZATION MANAGEMENT FOR HOSPICE	($39,573,420)	($24,428,830)	($15,144,590)	$0
2570	MEASLES, MUMPS, RUBELLA, VARICELLA (MMRV) VACCINES	$14,451,000	$7,474,350	$6,976,650	$0
2522	ELIMINATE MEDI-CAL OPTIONAL BENEFIT - ACUPUNCTURE	($13,600,000)	($8,200,000)	($5,400,000)	$0
	BENEFITS SUBTOTAL	**$981,802,390**	**$893,750,420**	**$82,951,980**	**$5,100,000**
	PHARMACY				
2512	CELL AND GENE THERAPY ACCESS MODEL	$19,321,000	$9,660,500	$9,660,500	$0
2124	MEDI-CAL DRUG REBATE FUND	$0	$0	($2,846,543,000)	$2,846,543,000
2524	HIV/AIDS AND CANCER DRUG REBATES	($300,000,000)	($150,000,000)	($150,000,000)	$0
1433	BCCTP DRUG REBATES	($1,287,000)	($1,287,000)	$0	$0
51	FAMILY PACT DRUG REBATES	($1,961,000)	($1,961,000)	$0	$0
2519	UPDATES TO OTC COVID-19 TESTS AND OTC PRODUCTS	($12,000,000)	($7,027,100)	($4,972,900)	$0
2526	PHARMACY UTILIZATION MANAGEMENT	($78,172,720)	($45,778,340)	($32,394,390)	$0
2520	ELIMINATE GLP-1 COVERAGE FOR WEIGHT LOSS	($354,518,310)	($935,950)	($353,582,360)	$0
2518	PRIOR AUTH. FOR CONTINUATION OF DRUG THERAPY	($234,650,000)	($137,410,660)	($97,239,340)	$0
1181	MEDICAL SUPPLY REBATES	($204,000,000)	($142,008,200)	($61,991,800)	$0
2527	STEP THERAPY	($328,510,000)	($192,375,130)	($136,134,870)	$0
54	STATE SUPPLEMENTAL DRUG REBATES	($594,791,000)	($594,791,000)	$0	$0
55	FEDERAL DRUG REBATES	($6,982,154,000)	($6,982,154,000)	$0	$0
2557	PHARMACY PAYMENT METHODOLOGY - USUAL AND CUSTOMARY	($8,566,000)	($5,016,200)	($3,549,800)	$0
2579	MEDI-CAL RX FRAUD, WASTE, & ABUSE PREVENTION	($35,002,000)	($20,496,900)	($14,505,100)	$0
	PHARMACY SUBTOTAL	**($9,116,291,030)**	**($8,271,580,980)**	**($3,691,253,060)**	**$2,846,543,000**
	DRUG MEDI-CAL				
2278	RECOVERY INCENTIVES CONTINGENCY MANAGEMENT	$16,478,000	$13,348,000	$0	$3,130,000
1723	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	$15,996,000	$8,789,000	$7,207,000	$0
1724	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	$1,121,620	$805,650	$73,110	$242,860
	DRUG MEDI-CAL SUBTOTAL	**$33,595,620**	**$22,942,650**	**$7,280,110**	**$3,372,860**
	MENTAL HEALTH				
2394	CALAIM - BH - CONNECT DEMONSTRATION	$422,340,000	$273,672,000	$23,815,000	$124,853,000
2252	MHP COSTS FOR FFPSA	$34,943,000	$17,471,000	$8,736,000	$8,736,000
1957	MHP COSTS FOR CONTINUUM OF CARE REFORM	$2,026,000	$114,450	$1,911,550	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2026-27

FRN	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER FUNDS
	MENTAL HEALTH				
2268	OUT OF STATE YOUTH - SMHS	$857,000	$428,500	$428,500	$0
1660	IMPERIAL AND SISKIYOU COUNTY MHP OVERPAYMENT	$0	$0	($1,200,000)	$1,200,000
1713	INTERIM AND FINAL COST SETTLEMENTS - SMHS	($12,525,000)	($14,305,000)	$1,780,000	$0
2574	RETRO PAYMENTS TO COUNTIES FOR STATE-ONLY BH SVCS	$165,000,000	$0	$165,000,000	$0
	MENTAL HEALTH SUBTOTAL	**$612,641,000**	**$277,380,950**	**$200,471,050**	**$134,789,000**
	WAIVER--MH/UCD & BTR				
1951	GLOBAL PAYMENT PROGRAM	$3,013,102,000	$1,506,551,000	$0	$1,506,551,000
2245	CALAIM ECM-COMMUNITY SUPPORTS-TRANSITIONAL RENT	$2,706,233,000	$1,587,030,400	$1,119,202,600	$0
1769	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	$623,000	$623,000	$0	$0
	WAIVER--MH/UCD & BTR SUBTOTAL	**$5,719,958,000**	**$3,094,204,400**	**$1,119,202,600**	**$1,506,551,000**
	MANAGED CARE				
2408	2023 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	$6,849,713,000	$4,046,532,100	$2,803,180,900	$0
2061	MANAGED CARE HEALTH CARE FINANCING PROGRAM	$3,185,536,000	$1,992,401,200	$1,193,134,800	$0
2060	MANAGED CARE PUBLIC HOSPITAL EPP	$6,056,171,000	$3,819,208,200	$2,236,962,800	$0
2062	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	$5,159,793,000	$3,591,978,400	$1,567,814,600	$0
2388	WORKFORCE & QUALITY INCENTIVE PROGRAM	($15,679,000)	($7,738,950)	($7,940,050)	$0
2504	MEDI-CAL MANAGED CARE QUALITY WITHHOLD RELEASE	$593,866,000	$339,891,600	$253,974,400	$0
2437	MANAGED CARE DISTRICT HOSPITAL DIRECTED PAYMENTS	$1,297,033,000	$828,388,000	$0	$468,645,000
2499	COMMUNITY CLINIC DIRECTED PAYMENT PROGRAM	$205,000,000	$134,518,600	$70,481,400	$0
2474	CHILDREN'S HOSPITAL SUPPLEMENTAL PAYMENT PROGRAM	$440,833,000	$220,417,000	$220,416,000	$0
2406	2023 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	$0	$0	($3,639,403,000)	$3,639,403,000
2407	2023 MCO ENROLLMENT TAX MANAGED CARE PLANS	$0	$0	($2,477,639,000)	$2,477,639,000
2063	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	$0	$0	($6,010,266,000)	$6,010,266,000
1788	RETRO MC RATE ADJUSTMENTS	($607,888,000)	($287,397,500)	($474,996,500)	$154,506,000
2558	MCP NETWORK ADEQUACY & TIMELY ACCESS SANCTIONS	($3,500,000)	($1,750,000)	($1,750,000)	$0
2569	IMPROVEMENTS AND EFFICIENCIES	($170,000,000)	($102,000,000)	($68,000,000)	$0
2576	MANAGED CARE RISK CORRIDORS	($485,055,000)	($220,911,290)	($264,143,710)	$0
2577	UIS MEMBER TRANSITION TO FFS	($618,994,000)	($112,176,000)	($506,818,000)	$0
2582	OVERPAYMENTS FOR REPRODUCTIVE HEALTH	$0	($30,000,000)	$30,000,000	$0
2585	2027 MCO TAX CAPITATION PAYMENTS	$539,050,000	$313,372,000	$225,678,000	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2026-27

FRN	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER FUNDS
	MANAGED CARE				
2586	2027 MCO TAX FUNDING ADJUSTMENT - CAPITATION	$0	$0	($135,407,000)	$135,407,000
2587	2027 MCO TAX FUNDING ADJUSTMENT – GENERAL SUPPORT	($92,927,000)	$0	($584,028,000)	$491,101,000
	MANAGED CARE SUBTOTAL	**$22,332,952,000**	**$14,524,733,360**	**($5,568,748,360)**	**$13,376,967,000**
	PROVIDER RATES				
88	RATE INCREASE FOR FQHCS/RHCS/CBRCS	$1,099,256,960	$487,922,500	$611,334,460	$0
2267	PP-GEMT IGT PROGRAM	$696,202,590	$453,599,330	$68,641,740	$173,961,520
2081	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	$122,220,760	$83,181,220	($4,735,010)	$43,774,550
1152	DPH INTERIM & FINAL RECONS	$530,548,000	$530,548,000	$0	$0
2181	NURSING FACILITY RATE ADJUSTMENTS	$33,794,620	$17,965,230	$15,829,390	$0
1329	FQHC/RHC/CBRC RECONCILIATION PROCESS	$108,847,000	$48,313,350	$60,533,650	$0
2184	GDSP NBS & PNS FEE ADJUSTMENTS	$18,457,000	$11,262,700	$7,194,300	$0
1046	LTC RATE ADJUSTMENT	$10,574,520	$5,536,890	$5,037,630	$0
96	HOSPICE RATE INCREASES	$13,586,340	$8,874,550	$4,711,780	$0
1162	DPH INTERIM RATE GROWTH	$19,724,000	$19,724,000	$0	$0
1784	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	$0	$0	($753,912,000)	$753,912,000
2509	PROP 35 - PROVIDER PAYMENT INCREASE FUNDING	$0	$0	($2,439,400,000)	$2,439,400,000
1703	LABORATORY RATE METHODOLOGY CHANGE	($2,046,000)	($1,205,700)	($840,300)	$0
2536	ELIMINATE PPS FOR STATE-ONLY SERVICES	($1,010,655,000)	$0	($1,010,655,000)	$0
1505	REDUCTION TO RADIOLOGY RATES	($65,471,000)	($38,742,450)	($26,728,550)	$0
2458	PROP 35 - PROVIDER PAYMENT INCREASES	$3,057,624,000	$1,552,024,000	$1,505,600,000	$0
2591	2027 MCO TAX FUNDING ADJUSTMENT – TRI	$0	$0	($81,242,000)	$81,242,000
	PROVIDER RATES SUBTOTAL	**$4,632,663,800**	**$3,179,003,630**	**($2,038,629,890)**	**$3,492,290,060**
	SUPPLEMENTAL PMNTS.				
2055	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	$15,828,192,000	$9,879,161,000	$0	$5,949,031,000
1475	HOSPITAL QAF - FFS PAYMENTS	$3,961,466,000	$2,173,312,000	$0	$1,788,154,000
1761	HOSPITAL QAF - MANAGED CARE PAYMENTS	$1,793,000,000	$1,231,935,250	$0	$561,064,750
2024	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	$1,346,207,000	$744,900,000	$0	$601,307,000
1071	PRIVATE HOSPITAL DSH REPLACEMENT	$787,980,000	$393,990,000	$393,990,000	$0
1073	DSH PAYMENT	$606,362,000	$366,725,500	$41,769,000	$197,867,500
1085	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	$439,952,000	$240,631,000	$118,400,000	$80,921,000
2130	PROP 56 - MEDI-CAL FAMILY PLANNING	$433,165,000	$302,044,500	$131,120,500	$0
78	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$209,844,000	$209,844,000	$0	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2026-27

FRN	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER FUNDS
	SUPPLEMENTAL PMNTS.				
1078	DPH PHYSICIAN & NON-PHYS. COST	$85,031,000	$85,031,000	$0	$0
1899	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	$132,843,000	$77,353,000	($1,169,000)	$56,659,000
104	FFP FOR LOCAL TRAUMA CENTERS	$181,489,000	$98,453,000	$0	$83,036,000
82	CAPITAL PROJECT DEBT REIMBURSEMENT	$79,036,000	$55,149,000	$23,887,000	$0
1600	NDPH IGT SUPPLEMENTAL PAYMENTS	$56,001,000	$30,321,000	($972,000)	$26,652,000
2049	PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS	$3,735,140	$2,334,330	$1,400,810	$0
1076	NDPH SUPPLEMENTAL PAYMENT	$2,320,000	$2,320,000	$0	$0
1616	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	$13,267,000	$13,267,000	$0	$0
1038	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	$10,000,000	$5,000,000	$5,000,000	$0
1039	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	$8,000,000	$4,000,000	$4,000,000	$0
86	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	$3,113,000	$3,113,000	$0	$0
2044	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	$6,954,000	$0	$6,954,000	$0
2303	FREE CLINICS AUGMENTATION	$2,000,000	$0	$2,000,000	$0
2102	PROPOSITION 56 FUNDING	$0	$0	($461,274,000)	$461,274,000
1601	IGT ADMIN. & PROCESSING FEE	$0	$0	($26,073,000)	$26,073,000
1661	GEMT SUPPLEMENTAL PAYMENT PROGRAM	($1,632,000)	($1,632,000)	$0	$0
2572	DMPH GME IGT ADMIN. & PROCESSING FEE	$0	$0	($230,000)	$230,000
2573	GRADUATE MEDICAL EDUCATION PAYMENTS TO DMPHS	$24,910,000	$12,455,000	$0	$12,455,000
	SUPPLEMENTAL PMNTS. SUBTOTAL	**$26,013,235,140**	**$15,929,707,580**	**$238,803,310**	**$9,844,724,250**
	COVID-19				
2218	COVID-19 END OF UNWINDING FLEXIBILITIES	($1,757,397,940)	($1,180,614,090)	($576,783,850)	$0
	COVID-19 SUBTOTAL	**($1,757,397,940)**	**($1,180,614,090)**	**($576,783,850)**	**$0**
	STATE-ONLY CLAIMING				
2415	STATE-ONLY CLAIMING ADJUSTMENTS - RETRO ADJ.	$0	($113,311,000)	($275,950,000)	$389,261,000
	STATE-ONLY CLAIMING SUBTOTAL	**$0**	**($113,311,000)**	**($275,950,000)**	**$389,261,000**
	OTHER DEPARTMENTS				
1476	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$1,325,058,000	$1,325,058,000	$0	$0
	OTHER DEPARTMENTS SUBTOTAL	**$1,325,058,000**	**$1,325,058,000**	**$0**	**$0**
	OTHER				
2354	BEHAVIORAL HEALTH BRIDGE HOUSING	$43,000,000	$0	$0	$43,000,000
2208	SELF-DETERMINATION PROGRAM - CDDS	$441,206,000	$441,206,000	$0	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2026-27

FRN	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER FUNDS
	OTHER				
2329	QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES	$217,638,000	$170,903,000	$26,607,000	$20,128,000
2092	QAF WITHHOLD TRANSFER	$62,376,000	$31,188,000	$31,188,000	$0
2424	CYBHI - FEE SCHEDULE THIRD PARTY ADMINISTRATOR	$50,900,000	$0	$0	$50,900,000
1232	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	$77,099,000	$77,099,000	$0	$0
2346	EQUITY & PRACTICE TRANSFORMATION PAYMENTS	$27,300,000	$18,220,000	$9,080,000	$0
2097	MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG	$36,143,000	$0	$0	$36,143,000
1975	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	$52,671,880	$25,598,920	$27,072,960	$0
2396	CARE ACT	$22,481,000	$0	$22,481,000	$0
111	INDIAN HEALTH SERVICES	$16,905,000	$11,270,000	$5,635,000	$0
2009	INFANT DEVELOPMENT PROGRAM	$27,727,000	$27,727,000	$0	$0
1526	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	$13,742,000	$7,506,000	$6,236,000	$0
2355	CALHOPE	$5,000,000	$0	$0	$5,000,000
2443	ASSET LIMIT INCREASE & ELIM. - CNTY BH FUNDING	$4,720,000	$0	$4,720,000	$0
1866	WPCS WORKERS' COMPENSATION	$620,000	$310,000	$310,000	$0
35	IMD ANCILLARY SERVICES	$0	($51,474,000)	$51,474,000	$0
1087	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	$0	($92,561,000)	$92,561,000
1760	HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	$0	($1,710,833,000)	$1,710,833,000
2034	CMS DEFERRED CLAIMS	$0	($200,000,000)	$200,000,000	$0
2156	INDIAN HEALTH SERVICES FUNDING SHIFT	$0	$30,919,500	($30,919,500)	$0
2484	HEALTH CARE SVCS. FINES AND PENALTIES	$0	$0	($12,502,000)	$12,502,000
2551	HR 1 - UIS EMERGENCY ACA FMAP ADJUSTMENT	($51,500,000)	($158,278,000)	$106,778,000	$0
2563	ELIMINATE DENTAL FOR ADULT UIS	($360,827,000)	$0	($360,827,000)	$0
2531	RESIDENCY VERIFICATION IMPROVEMENTS	($418,230,000)	($291,870,000)	($126,360,000)	$0
2497	QUALITY SANCTIONS	($2,000,000)	($1,000,000)	($1,000,000)	$0
2054	ASSISTED LIVING WAIVER EXPANSION	$9,413,000	$4,523,000	$4,890,000	$0
2010	HCBA WAIVER EXPANSION	($25,434,580)	($12,607,810)	($12,826,770)	$0
1906	COUNTY SHARE OF OTLICP-CCS COSTS	($17,000,000)	$0	($17,000,000)	$0
2343	COUNTY BH RECOUPMENTS	($85,547,000)	$0	($85,547,000)	$0
2590	MCO TAX REVENUE TO SUPPORT MEDI-CAL	$181,637,000	$0	($1,700,000,000)	$1,881,637,000
	OTHER SUBTOTAL	**$330,040,290**	**$131,240,600**	**($3,653,904,310)**	**$3,852,704,000**
	GRAND TOTAL	**$60,852,732,790**	**$40,684,058,520**	**($15,286,187,900)**	**$35,454,862,170**

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

SUMMARY OF COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION POLICY CHANGES FISCAL YEAR 2026-27

FRN.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER FUNDS
	COUNTY ADMIN				
1704	COUNTY ADMINISTRATION ALLOCATION	$2,377,805,000	$1,188,902,500	$1,188,902,500	$0
214	SAWS	$196,915,000	$196,846,000	$69,000	$0
217	CALWORKS APPLICATIONS	$99,964,000	$49,982,000	$49,982,000	$0
1598	CASE MANAGEMENT FOR OTLICP	$46,391,000	$23,195,500	$23,195,500	$0
213	LOS ANGELES COUNTY HOSPITAL INTAKES	$20,166,000	$17,430,000	$2,736,000	$0
215	SAVE	$0	$4,000,000	($4,000,000)	$0
1835	ENHANCED FEDERAL FUNDING	$0	$633,390,000	($633,390,000)	$0
2580	HR 1 - COUNTY ADMINISTRATION ALLOCATION	$262,101,000	$188,242,500	$73,858,500	$0
	COUNTY ADMIN SUBTOTAL	**$3,003,342,000**	**$2,301,988,500**	**$701,353,500**	**$0**
	DHCS-OTHER				
2389	CALAIM - PATH	$515,456,000	$257,728,000	$181,355,000	$76,373,000
1721	COUNTY SPECIALTY MENTAL HEALTH ADMIN	$304,523,000	$290,611,000	$13,912,000	$0
1757	INTERIM AND FINAL COST SETTLEMENTS-SMHS	$182,450,000	$182,450,000	$0	$0
230	CCS PROGRAM COUNTY ADMINISTRATIVE BUDGET	$206,028,000	$131,578,400	$74,449,600	$0
2289	CYBHI - BH SERVICES AND SUPPORTS PLATFORM	$109,900,000	$0	$53,400,000	$56,500,000
2167	MEDI-CAL RX - ADMINISTRATIVE COSTS	$127,329,000	$93,946,700	$33,382,300	$0
1963	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	$148,013,000	$148,013,000	$0	$0
235	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	$148,168,000	$148,168,000	$0	$0
1813	DRUG MEDI-CAL COUNTY ADMINISTRATION	$123,527,000	$122,956,000	$571,000	$0
2517	CALAIM-BH-CONNECT WORKFORCE INITIATIVE	$213,750,000	$213,750,000	$0	$0
2491	BH TRANSFORMATION FUNDING FOR COUNTY BH DEPTS.	$17,001,000	$7,001,000	$0	$10,000,000
231	POSTAGE & PRINTING	$71,362,000	$35,552,500	$35,809,500	$0
2288	CALAIM - POPULATION HEALTH MANAGEMENT	$54,604,000	$50,994,200	$3,609,800	$0
1722	SMH MAA	$55,641,000	$55,641,000	$0	$0
2398	CALAIM - BH - CONNECT DEMONSTRATION ADMIN	$176,866,000	$88,433,000	$8,433,000	$80,000,000
1937	ACTUARIAL COSTS FOR RATE DEVELOPMENT	$45,000,000	$22,500,000	$22,500,000	$0
1551	MEDI-CAL RECOVERY CONTRACTS	$35,100,000	$26,325,000	$8,775,000	$0
252	ENTERPRISE DATA ENVIRONMENT	$52,166,000	$38,264,300	$13,901,700	$0
1748	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	$28,424,000	$13,990,550	$14,433,450	$0
1137	MITA	$45,858,000	$40,033,250	$5,824,750	$0
2505	ELECTRONIC VISIT VERIFICATION M&O COSTS	$39,190,000	$39,190,000	$0	$0
2402	EMSA - CALIFORNIA POISON CONTROL SYSTEM SVCS.	$18,291,000	$18,291,000	$0	$0

SUMMARY OF COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION POLICY CHANGES FISCAL YEAR 2026-27

FRN.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER FUNDS
	DHCS-OTHER				
2152	HCBA WAIVER ADMINISTRATIVE COST	$23,380,000	$11,589,000	$11,791,000	$0
1932	PAVE SYSTEM	$30,784,000	$22,152,650	$8,631,350	$0
1318	CAPMAN	$19,309,000	$14,240,750	$5,068,250	$0
1720	PASRR	$9,637,000	$7,227,750	$2,409,250	$0
1370	PUBLIC HEALTH REGISTRIES SUPPORT	$13,480,000	$13,480,000	$0	$0
1732	SDMC SYSTEM M&O SUPPORT	$2,319,000	$1,159,500	$1,159,500	$0
2002	ELECTRONIC ASSET VERIFICATION PROGRAM	$10,909,000	$5,454,500	$5,454,500	$0
2447	CALAIM - JUSTICE INVOLVED MAA	$8,000,000	$4,000,000	$4,000,000	$0
1452	PROTECTION OF PHI DATA	$14,980,000	$7,490,000	$7,490,000	$0
2467	MOBILE VISION SERVICES	$2,208,000	$1,435,000	$0	$773,000
1982	MEDCOMPASS SOLUTION	$8,062,000	$5,942,100	$2,119,900	$0
1824	NEWBORN HEARING SCREENING PROGRAM	$6,313,000	$3,156,500	$3,156,500	$0
2334	COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE	$13,267,000	$7,360,000	$5,907,000	$0
2206	DRUG MEDI-CAL PARITY RULE ADMINISTRATION	$5,875,000	$3,917,000	$1,958,000	$0
1972	PACES	$4,318,000	$3,182,950	$1,135,050	$0
2413	CALAIM - INMATE PRE-RELEASE PROGRAM ADMIN	$2,746,000	$1,373,000	$1,373,000	$0
1902	DATA ANALYTICS	$5,641,000	$3,812,000	$1,829,000	$0
2321	MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM	$2,200,000	$1,100,000	$1,100,000	$0
2392	MFP/CCT SUPPLEMENTAL FUNDING	$1,952,000	$1,952,000	$0	$0
1768	T-MSIS	$1,887,000	$1,413,250	$473,750	$0
237	SSA COSTS FOR HEALTH COVERAGE INFO.	$1,820,000	$910,000	$910,000	$0
1441	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$994,000	$715,000	$279,000	$0
1675	FAMILY PACT PROGRAM ADMIN.	$1,100,000	$550,000	$550,000	$0
2362	RECOVERY INCENTIVES CONTINGENCY MANAGEMENT ADMIN	$1,275,000	$1,275,000	$0	$0
266	MMA - DSH ANNUAL INDEPENDENT AUDIT	$613,000	$306,500	$306,500	$0
2159	HEALTH INFORMATION EXCHANGE INTEROPERABILITY	$2,750,000	$2,400,600	$349,400	$0
1556	CCT OUTREACH - ADMINISTRATIVE COSTS	$364,000	$364,000	$0	$0
2438	HEALTH PLAN OF SAN MATEO DENTAL INTEGRATION EVAL	$152,000	$76,000	$0	$76,000
2123	CMS DEFERRED CLAIMS - OTHER ADMIN	$0	($145,000,000)	$145,000,000	$0
2459	DESIGNATED STATE HEALTH PROGRAMS	$0	$346,856,000	($346,856,000)	$0
2562	EPTP - STATEWIDE LEARNING COLLABORATIVE	$2,900,000	$1,450,000	$1,450,000	$0
2559	STATE ONLY CLAIMING ADJUSTMENTS - ADMIN.	$0	($600,000,000)	$600,000,000	$0
2552	TRANSFORMING MATERNAL HEALTH PROVIDER INFR PYMT	$1,750,000	$1,750,000	$0	$0
2567	HR 1 - HEALTH ENROLLMENT NAVIGATORS	$4,000,000	$2,000,000	$0	$2,000,000
2592	RECONCILIATION - ADMIN	($81,400,000)	($7,700,000)	($7,700,000)	($66,000,000)

SUMMARY OF COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION POLICY CHANGES FISCAL YEAR 2026-27

FRN.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER FUNDS
	DHCS-OTHER				
2593	PROPOSITION 35 FUNDING – CYBHI & BH-CONNECT	$0	$0	($66,000,000)	$66,000,000
	DHCS-OTHER SUBTOTAL	**$2,842,232,000**	**$1,752,807,950**	**$863,702,050**	**$225,722,000**
	DHCS-MEDICAL FI				
2115	MEDICAL FI BO & IT COST REIMBURSEMENT	$65,381,000	$47,187,050	$18,193,950	$0
2117	MEDICAL FI BO & IT CHANGE ORDERS	$36,601,000	$26,978,700	$9,622,300	$0
2119	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	$50,974,000	$37,572,000	$13,402,000	$0
2118	MEDICAL INFRASTRUCTURE & DATA MGT SVCS	$35,744,000	$26,348,050	$9,395,950	$0
2112	MEDICAL FI BO OTHER ESTIMATED COSTS	$26,951,000	$18,852,250	$8,098,750	$0
2116	MEDICAL FI BO TELEPHONE SERVICE CENTER	$19,718,000	$13,815,400	$5,902,600	$0
2111	MEDICAL FI BUSINESS OPERATIONS	$17,972,000	$13,238,150	$4,722,850	$11,000
2113	MEDICAL FI BO HOURLY REIMBURSEMENT	$12,998,000	$9,580,800	$3,417,200	$0
2114	MEDICAL FI BO MISCELLANEOUS EXPENSES	$1,189,000	$863,150	$325,850	$0
2564	HR 1 - PROHIBITED ENTITIES SYSTEMS COSTS	$137,000	$0	$137,000	$0
2594	UIS MEMBER TRANSITION TO FFS SYSTEMS COSTS	$33,300,000	$0	$33,300,000	$0
	DHCS-MEDICAL FI SUBTOTAL	**$300,965,000**	**$194,435,550**	**$106,518,450**	**$11,000**
	DHCS-HEALTH CARE OPT				
2051	HCO OPERATIONS	$36,638,000	$18,593,800	$18,044,200	$0
2052	HCO COST REIMBURSEMENT	$40,621,000	$20,531,450	$20,089,550	$0
2053	HCO ESR HOURLY REIMBURSEMENT	$15,590,000	$7,912,000	$7,678,000	$0
	DHCS-HEALTH CARE OPT SUBTOTAL	**$92,849,000**	**$47,037,250**	**$45,811,750**	**$0**
	DHCS-DENTAL FI				
2380	DENTAL FI-DBO ADMIN 2022 CONTRACT	$132,472,000	$96,907,000	$35,565,000	$0
2006	DENTAL FI ADMINISTRATION 2016 CONTRACT	$18,760,000	$14,062,000	$4,698,000	$0
	DHCS-DENTAL FI SUBTOTAL	**$151,232,000**	**$110,969,000**	**$40,263,000**	**$0**
	OTHER DEPARTMENTS				
236	PERSONAL CARE SERVICES	$653,534,000	$653,534,000	$0	$0
233	HEALTH-RELATED ACTIVITIES - CDSS	$804,896,000	$804,896,000	$0	$0
1679	CALHEERS DEVELOPMENT	$227,558,000	$165,525,100	$62,032,900	$0
234	MATERNAL AND CHILD HEALTH	$114,846,000	$114,846,000	$0	$0
243	CDDS ADMINISTRATIVE COSTS	$129,193,000	$129,193,000	$0	$0
256	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$60,356,000	$60,356,000	$0	$0
246	HCPCFC CASE MANAGEMENT	$74,400,000	$55,800,000	$4,929,000	$13,671,000
2455	HCPCFC ADMIN COSTS	$23,757,000	$11,878,500	$11,878,500	$0

SUMMARY OF COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION POLICY CHANGES FISCAL YEAR 2026-27

FRN.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER FUNDS
	OTHER DEPARTMENTS				
1192	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	$13,656,000	$13,656,000	$0	$0
253	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$8,200,000	$8,200,000	$0	$0
2244	FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG	$8,391,000	$8,391,000	$0	$0
239	CLPP CASE MANAGEMENT SERVICES	$13,726,000	$13,726,000	$0	$0
1680	CALIFORNIA SMOKERS' HELPLINE	$3,564,000	$3,564,000	$0	$0
257	CALHHS AGENCY HIPAA FUNDING	$1,908,000	$954,000	$954,000	$0
1665	MEDI-CAL INPATIENT SERVICES FOR INMATES	$1,189,000	$1,189,000	$0	$0
232	VETERANS BENEFITS	$1,100,000	$1,100,000	$0	$0
1774	VITAL RECORDS	$883,000	$879,000	$4,000	$0
249	KIT FOR NEW PARENTS	$83,000	$83,000	$0	$0
263	MERIT SYSTEM SERVICES FOR COUNTIES	$211,000	$105,500	$105,500	$0
1114	PIA EYEWEAR COURIER SERVICE	$894,000	$447,000	$447,000	$0
	OTHER DEPARTMENTS SUBTOTAL	**$2,142,345,000**	**$2,048,323,100**	**$80,350,900**	**$13,671,000**
	GRAND TOTAL	**$8,532,965,000**	**$6,455,561,350**	**$1,837,999,650**	**$239,404,000**

MEDI-CAL BENEFITS EXPENDITURES BY SERVICE CATEGORY
FISCAL YEAR 2026-27

SERVICE CATEGORY	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER FUNDS
PROFESSIONAL	$11,845,245,700	$6,503,884,480	$3,990,100,250	$1,351,260,970
PHYSICIANS	$527,761,210	$319,046,370	$158,289,730	$50,425,110
OTHER MEDICAL	$8,406,568,250	$4,497,645,230	$3,651,314,890	$257,608,130
CO. & COMM. OUTPATIENT	$2,910,916,250	$1,687,192,880	$180,495,640	$1,043,227,730
PHARMACY	$15,803,646,110	$6,467,259,470	$6,483,357,730	$2,853,028,910
HOSPITAL INPATIENT	$13,577,629,600	$8,193,421,370	$1,796,504,510	$3,587,703,720
COUNTY INPATIENT	$3,964,498,740	$2,373,472,210	$19,213,780	$1,571,812,750
COMMUNITY INPATIENT	$9,613,130,860	$5,819,949,160	$1,777,290,730	$2,015,890,970
LONG TERM CARE	$792,000,120	$410,143,360	$373,040,340	$8,816,420
NURSING FACILITIES	$770,247,270	$398,778,200	$362,816,920	$8,652,160
ICF-DD	$21,752,840	$11,365,160	$10,223,420	$164,260
OTHER SERVICES	$2,857,409,490	$1,835,280,220	$977,480,150	$44,649,120
MEDICAL TRANSPORTATION	$129,556,360	$83,241,430	$30,708,450	$15,606,470
OTHER SERVICES	$2,594,666,830	$1,683,232,910	$885,159,850	$26,274,070
HOME HEALTH	$133,186,310	$68,805,870	$61,611,850	$2,768,580
TOTAL FEE-FOR-SERVICE	**$44,875,931,020**	**$23,409,988,900**	**$13,620,482,980**	**$7,845,459,140**
MANAGED CARE	$113,723,824,110	$67,051,938,310	$20,100,755,360	$26,571,130,440
TWO PLAN MODEL	$65,776,930,060	$38,889,547,030	$11,173,837,320	$15,713,545,710
COUNTY ORGANIZED HEALTH SYSTEMS	$33,258,144,990	$19,698,913,960	$5,545,864,940	$8,013,366,090
GEOGRAPHIC MANAGED CARE	$11,069,104,220	$6,671,340,570	$1,688,393,120	$2,709,370,530
PHP & OTHER MANAG. CARE	$3,181,838,240	$1,517,295,220	$1,635,595,810	$28,947,210
REGIONAL MODEL	$437,806,610	$274,841,530	$57,064,180	$105,900,900
DENTAL	$2,306,980,300	$1,391,281,570	$804,017,180	$111,681,560
MENTAL HEALTH	$10,585,074,010	$6,541,931,730	$348,196,200	$3,694,946,080
AUDITS/ LAWSUITS	$54,905,930	($172,733,840)	$227,639,770	$0
EPSDT SCREENS	$0	$0	$0	$0
MEDICARE PAYMENTS	$10,640,166,860	$2,625,737,080	$8,014,429,790	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$13,707,780	$13,990,940	($283,160)	$0
MISC. SERVICES	$25,022,517,670	$24,473,261,070	$49,932,510	$499,324,090
RECOVERIES	($920,306,230)	($695,878,880)	($224,427,340)	$0
DRUG MEDI-CAL	$1,851,800,280	$1,397,394,030	$164,492,390	$289,913,860
GRAND TOTAL MEDI-CAL BENEFITS	**$208,154,601,730**	**$126,036,910,890**	**$43,105,235,660**	**$39,012,455,180**

MEDI-CAL BENEFITS EXPENDITURES BY SERVICE CATEGORY
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2025-26 AND 2026-27

SERVICE CATEGORY	MAY 2026 EST. FOR 2025-26	MAY 2026 EST. FOR 2026-27	DOLLAR DIFFERENCE	% CHANGE
PROFESSIONAL	$10,311,572,840	$11,845,245,700	$1,533,672,870	14.87%
PHYSICIANS	$680,453,600	$527,761,210	($152,692,390)	-22.44%
OTHER MEDICAL	$8,627,143,100	$8,406,568,250	($220,574,850)	-2.56%
CO. & COMM. OUTPATIENT	$1,003,976,140	$2,910,916,250	$1,906,940,110	189.94%
PHARMACY	$15,843,851,930	$15,803,646,110	($40,205,830)	-0.25%
HOSPITAL INPATIENT	$10,073,510,640	$13,577,629,600	$3,504,118,960	34.79%
COUNTY INPATIENT	$3,720,152,230	$3,964,498,740	$244,346,510	6.57%
COMMUNITY INPATIENT	$6,353,358,410	$9,613,130,860	$3,259,772,450	51.31%
LONG TERM CARE	$892,049,450	$792,000,120	($100,049,340)	-11.22%
NURSING FACILITIES	$867,788,820	$770,247,270	($97,541,550)	-11.24%
ICF-DD	$24,260,630	$21,752,840	($2,507,790)	-10.34%
OTHER SERVICES	$3,001,064,950	$2,857,409,490	($143,655,460)	-4.79%
MEDICAL TRANSPORTATION	$72,291,420	$129,556,360	$57,264,930	79.21%
OTHER SERVICES	$2,796,152,460	$2,594,666,830	($201,485,640)	-7.21%
HOME HEALTH	$132,621,060	$133,186,310	$565,250	0.43%
TOTAL FEE-FOR-SERVICE	**$40,122,049,810**	**$44,875,931,020**	**$4,753,881,200**	**11.85%**
MANAGED CARE	$98,158,234,880	$113,723,824,110	$15,565,589,230	15.86%
TWO PLAN MODEL	$54,622,447,780	$65,776,930,060	$11,154,482,280	20.42%
COUNTY ORGANIZED HEALTH SYSTEMS	$29,881,349,310	$33,258,144,990	$3,376,795,680	11.30%
GEOGRAPHIC MANAGED CARE	$10,204,866,970	$11,069,104,220	$864,237,250	8.47%
PHP & OTHER MANAG. CARE	$2,865,118,510	$3,181,838,240	$316,719,720	11.05%
REGIONAL MODEL	$584,452,310	$437,806,610	($146,645,700)	-25.09%
DENTAL	$2,715,106,910	$2,306,980,300	($408,126,610)	-15.03%
MENTAL HEALTH	$11,056,545,960	$10,585,074,010	($471,471,950)	-4.26%
AUDITS/ LAWSUITS	$208,513,000	$54,905,930	($153,607,080)	-73.67%
MEDICARE PAYMENTS	$9,977,064,260	$10,640,166,860	$663,102,600	6.65%
STATE HOSP./DEVELOPMENTAL CNTRS.	$18,877,000	$13,707,780	($5,169,220)	-27.38%
MISC. SERVICES	$23,411,680,000	$25,022,517,670	$1,610,837,670	6.88%
RECOVERIES	($966,554,000)	($920,306,230)	$46,247,770	-4.78%
DRUG MEDI-CAL	$2,209,233,280	$1,851,800,280	($357,433,000)	-16.18%
GRAND TOTAL MEDI-CAL	**$186,910,751,110**	**$208,154,601,730**	**$21,243,850,620**	**11.37%**
GENERAL FUNDS	**$46,040,974,730**	**$43,105,235,660**	**($2,935,739,080)**	**-6.38%**
OTHER FUNDS	**$28,683,969,830**	**$39,012,455,180**	**$10,328,485,350**	**36.01%**

MEDI-CAL BENEFITS EXPENDITURES BY SERVICE CATEGORY
MAY 2026 ESTIMATE COMPARED TO NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2026-27

SERVICE CATEGORY	NOV. 2025 EST. FOR 2026-27	MAY 2026 EST. FOR 2026-27	DOLLAR DIFFERENCE	% CHANGE
PROFESSIONAL	$10,762,237,460	$11,845,245,700	$1,083,008,250	10.06%
PHYSICIANS	$618,284,310	$527,761,210	($90,523,100)	-14.64%
OTHER MEDICAL	$8,005,141,310	$8,406,568,250	$401,426,940	5.01%
CO. & COMM. OUTPATIENT	$2,138,811,840	$2,910,916,250	$772,104,410	36.10%
PHARMACY	$16,069,085,640	$15,803,646,110	($265,439,530)	-1.65%
HOSPITAL INPATIENT	$12,771,407,440	$13,577,629,600	$806,222,160	6.31%
COUNTY INPATIENT	$3,998,263,060	$3,964,498,740	($33,764,320)	-0.84%
COMMUNITY INPATIENT	$8,773,144,380	$9,613,130,860	$839,986,480	9.57%
LONG TERM CARE	$951,054,630	$792,000,120	($159,054,510)	-16.72%
NURSING FACILITIES	$921,810,760	$770,247,270	($151,563,480)	-16.44%
ICF-DD	$29,243,870	$21,752,840	($7,491,030)	-25.62%
OTHER SERVICES	$2,920,151,680	$2,857,409,490	($62,742,190)	-2.15%
MEDICAL TRANSPORTATION	$132,514,690	$129,556,360	($2,958,340)	-2.23%
OTHER SERVICES	$2,658,589,500	$2,594,666,830	($63,922,670)	-2.40%
HOME HEALTH	$129,047,490	$133,186,310	$4,138,820	3.21%
TOTAL FEE-FOR-SERVICE	**$43,473,936,850**	**$44,875,931,020**	**$1,401,994,170**	**3.22%**
MANAGED CARE	$123,223,186,150	$113,723,824,110	($9,499,362,040)	-7.71%
TWO PLAN MODEL	$71,428,590,220	$65,776,930,060	($5,651,660,160)	-7.91%
COUNTY ORGANIZED HEALTH SYSTEMS	$34,810,093,450	$33,258,144,990	($1,551,948,460)	-4.46%
GEOGRAPHIC MANAGED CARE	$12,725,746,010	$11,069,104,220	($1,656,641,790)	-13.02%
PHP & OTHER MANAG. CARE	$3,466,965,430	$3,181,838,240	($285,127,190)	-8.22%
REGIONAL MODEL	$791,791,030	$437,806,610	($353,984,430)	-44.71%
DENTAL	$2,657,933,290	$2,306,980,300	($350,952,990)	-13.20%
MENTAL HEALTH	$9,345,080,510	$10,585,074,010	$1,239,993,500	13.27%
AUDITS/ LAWSUITS	$562,330	$54,905,930	$54,343,600	9,664.04%
MEDICARE PAYMENTS	$10,852,234,810	$10,640,166,860	($212,067,940)	-1.95%
STATE HOSP./DEVELOPMENTAL CNTRS.	$19,215,330	$13,707,780	($5,507,550)	-28.66%
MISC. SERVICES	$24,564,820,070	$25,022,517,670	$457,697,600	1.86%
RECOVERIES	($929,153,260)	($920,306,230)	$8,847,030	-0.95%
DRUG MEDI-CAL	$1,531,665,610	$1,851,800,280	$320,134,670	20.90%
GRAND TOTAL MEDI-CAL	**$214,739,481,680**	**$208,154,601,730**	**($6,584,879,940)**	**-3.07%**
GENERAL FUNDS	**$46,981,324,740**	**$43,105,235,660**	**($3,876,089,090)**	**-8.25%**
OTHER FUNDS	**$36,083,860,430**	**$39,012,455,180**	**$2,928,594,750**	**8.12%**

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2026-27

FRN.	POLICY CHANGE TITLE	NOV. 2025 EST. FOR 2026-27 TOTAL FUNDS	NOV. 2025 EST. FOR 2026-27 GENERAL FUNDS	MAY 2026 EST. FOR 2026-27 TOTAL FUNDS	MAY 2026 EST. FOR 2026-27 GENERAL FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE GENERAL FUNDS
	DRUG MEDI-CAL						
2012	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	$1,473,221,000	$232,795,750	$1,762,233,000	$132,092,000	$289,012,000	($100,703,750)
2320	DRUG MEDI-CAL STATE PLAN SERVICES	$56,357,000	$3,367,800	$51,307,000	$2,931,300	($5,050,000)	($436,500)
	DRUG MEDI-CAL SUBTOTAL	**$1,529,578,000**	**$236,163,550**	**$1,813,540,000**	**$135,023,300**	**$283,962,000**	**($101,140,250)**
	MENTAL HEALTH						
1780	SMHS FOR ADULTS	$4,849,240,000	$417,629,500	$5,455,610,000	$446,255,100	$606,370,000	$28,625,600
1779	SMHS FOR CHILDREN	$3,933,167,000	$77,855,700	$4,487,212,000	$82,327,900	$554,045,000	$4,472,200
	MENTAL HEALTH SUBTOTAL	**$8,782,407,000**	**$495,485,200**	**$9,942,822,000**	**$528,583,000**	**$1,160,415,000**	**$33,097,800**
	MANAGED CARE						
56	TWO PLAN MODEL	$39,171,218,000	$16,841,148,150	$38,347,025,000	$16,667,911,500	($824,193,000)	($173,236,650)
57	COUNTY ORGANIZED HEALTH SYSTEMS & SINGLE PLAN	$21,993,408,000	$9,350,499,350	$21,305,208,000	$9,095,002,700	($688,200,000)	($255,496,650)
58	GEOGRAPHIC MANAGED CARE	$6,942,350,000	$2,777,803,150	$6,690,671,000	$2,727,270,950	($251,679,000)	($50,532,200)
62	PACE (Other M/C)	$3,271,641,000	$1,697,509,500	$3,020,768,000	$1,605,307,800	($250,873,000)	($92,201,700)
1842	REGIONAL MODEL	$254,573,000	$93,468,350	$246,982,000	$92,092,050	($7,591,000)	($1,376,300)
1029	DENTAL MANAGED CARE (Other M/C)	$185,492,000	$78,377,450	$180,042,000	$81,498,350	($5,450,000)	$3,120,900
61	SENIOR CARE ACTION NETWORK (Other M/C)	$118,883,000	$59,778,500	$117,169,000	$59,198,500	($1,714,000)	($580,000)
1837	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	$48,570,000	$20,180,000	$62,440,000	$23,031,000	$13,870,000	$2,851,000
1823	COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM	$15,632,000	$5,471,200	$16,267,000	$5,693,450	$635,000	$222,250
63	AIDS HEALTHCARE CENTERS (Other M/C)	$14,378,000	$6,073,300	$13,622,000	$5,497,800	($756,000)	($575,500)
1797	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	$2,191,000	$766,850	$3,069,000	$1,074,150	$878,000	$307,300
2581	CAP PACE RATES AT LOWER BOUND	$0	$0	($67,400,000)	($33,700,000)	($67,400,000)	($33,700,000)
	MANAGED CARE SUBTOTAL	**$72,018,336,000**	**$30,931,075,800**	**$69,935,863,000**	**$30,329,878,250**	**($2,082,473,000)**	**($601,197,550)**

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2026-27

FRN.	POLICY CHANGE TITLE	NOV. 2025 EST. FOR 2026-27 TOTAL FUNDS	NOV. 2025 EST. FOR 2026-27 GENERAL FUNDS	MAY 2026 EST. FOR 2026-27 TOTAL FUNDS	MAY 2026 EST. FOR 2026-27 GENERAL FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE GENERAL FUNDS
	FEE-FOR-SERVICE BASE						
2540	FFS - PHARMACY	$25,658,484,000	$10,632,869,700	$25,643,326,000	$10,444,519,150	($15,158,000)	($188,350,550)
2539	FFS - OTHER MEDICAL	$7,692,256,000	$4,096,239,200	$8,222,865,000	$4,235,229,600	$530,609,000	$138,990,400
2543	FFS - COMMUNITY INPATIENT	$3,564,755,000	$1,272,854,100	$3,594,693,000	$1,290,856,050	$29,938,000	$18,001,950
2547	FFS - OTHER SERVICES	$2,038,293,000	$1,001,021,350	$1,967,034,000	$955,369,350	($71,259,000)	($45,652,000)
2544	FFS - NURSING FACILITIES	$810,530,000	$422,138,600	$696,648,000	$339,461,600	($113,882,000)	($82,677,000)
2542	FFS - COUNTY INPATIENT	$662,954,000	$45,367,900	$660,042,000	$19,033,100	($2,912,000)	($26,334,800)
2541	FFS - CO. & COMM. OUTPATIENT	$654,506,000	$306,659,550	$646,148,000	$288,794,000	($8,358,000)	($17,865,550)
2538	FFS - PHYSICIANS	$614,676,000	$270,715,650	$523,847,000	$229,612,600	($90,829,000)	($41,103,050)
2548	FFS - HOME HEALTH	$133,933,000	$64,227,200	$136,128,000	$65,734,650	$2,195,000	$1,507,450
2546	FFS - MEDICAL TRANSPORTATION	$81,984,000	$27,178,950	$77,918,000	$25,627,900	($4,066,000)	($1,551,050)
2545	FFS - ICF-DD	$11,868,000	$6,064,400	$8,056,000	$3,965,000	($3,812,000)	($2,099,400)
	FEE-FOR-SERVICE BASE SUBTOTAL	**$41,924,239,000**	**$18,145,336,600**	**$42,176,705,000**	**$17,898,203,000**	**$252,466,000**	**($247,133,600)**
	OTHER						
76	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$6,591,980,000	$3,811,371,000	$6,548,820,000	$3,784,684,500	($43,160,000)	($26,686,500)
22	PERSONAL CARE SERVICES (Misc. Svcs.)	$4,911,772,000	$0	$4,875,015,000	$0	($36,757,000)	$0
23	HOME & COMMUNITY-BASED SVCS.- CDDS (Misc.)	$4,773,038,000	$0	$4,938,732,000	$0	$165,694,000	$0
1019	MEDICARE PAYMENTS - PART D PHASED-DOWN	$4,354,830,000	$4,354,830,000	$4,367,207,000	$4,367,207,000	$12,377,000	$12,377,000
135	DENTAL SERVICES	$2,912,222,000	$1,115,101,700	$2,691,090,000	$1,272,912,600	($221,132,000)	$157,810,900
32	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$665,629,000	$335,800,000	$616,026,000	$310,665,000	($49,603,000)	($25,135,000)
26	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$467,173,000	$0	$518,524,000	$0	$51,351,000	$0
2080	LAWSUITS/CLAIMS	$1,350,000	$675,000	$55,850,000	$27,925,000	$54,500,000	$27,250,000
77	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$20,003,000	$0	$14,645,000	$0	($5,358,000)	$0

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2026-27

FRN.	POLICY CHANGE TITLE	NOV. 2025 EST. FOR 2026-27 TOTAL FUNDS	NOV. 2025 EST. FOR 2026-27 GENERAL FUNDS	MAY 2026 EST. FOR 2026-27 TOTAL FUNDS	MAY 2026 EST. FOR 2026-27 GENERAL FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE GENERAL FUNDS
	OTHER						
27	MEDI-CAL TCM PROGRAM	$4,826,000	$0	$9,208,000	$0	$4,382,000	$0
91	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$321,000	$160,500	$255,000	$127,500	($66,000)	($33,000)
127	BASE RECOVERIES	($931,529,000)	($227,123,360)	($919,609,000)	($224,216,690)	$11,920,000	$2,906,670
	OTHER SUBTOTAL	**$23,771,615,000**	**$9,390,814,840**	**$23,715,763,000**	**$9,539,304,910**	**($55,852,000)**	**$148,490,070**
	GRAND TOTAL	**$148,026,175,000**	**$59,198,875,990**	**$147,584,693,000**	**$58,430,992,460**	**($441,482,000)**	**($767,883,530)**

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2026-27

FRN.	POLICY CHANGE TITLE	NOV. 2025 EST. FOR 2026-27		MAY 2026 EST. FOR 2026-27		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	ELIGIBILITY						
1569	MEDI-CAL STATE INMATE PROGRAMS	$42,390,000	$0	$47,616,000	$0	$5,226,000	$0
2529	PREMIUMS FOR ADULTS WITH UNSATIS. IMMIG. STAT.	$28,000,000	$28,000,000	$28,000,000	$28,000,000	$0	$0
2332	CALAIM - INMATE PRE-RELEASE PROGRAM	$198,358,000	$29,175,000	$191,799,000	$27,075,000	($6,559,000)	($2,100,000)
3	BREAST AND CERVICAL CANCER TREATMENT	$21,410,000	$11,066,400	$17,028,000	$9,026,200	($4,382,000)	($2,040,200)
13	NON-OTLICP CHIP	$0	($114,336,000)	$0	($123,190,200)	$0	($8,854,200)
1007	SCHIP FUNDING FOR PRENATAL CARE	$0	($76,662,300)	$0	($80,575,300)	$0	($3,913,000)
2155	CS3 PROXY ADJUSTMENT	$0	($102,427,900)	$0	($114,308,700)	$0	($11,880,800)
2237	REFUGEE MEDICAL ASSISTANCE	$0	($100,000)	$0	($47,000)	$0	$53,000
2029	MEDI-CAL COUNTY INMATE REIMBURSEMENT	$0	($2,572,000)	$0	($2,513,000)	$0	$59,000
2500	SB 525 MINIMUM WAGE - CASELOAD IMPACT	($239,621,000)	($95,848,500)	($239,621,000)	($95,848,500)	$0	$0
2535	REINSTATEMENT OF ASSET LIMIT	($698,495,000)	($349,247,500)	($862,813,000)	($431,406,500)	($164,318,000)	($82,159,000)
2530	FULL-SCOPE MEDI-CAL EXPANSION ENROLLMENT FREEZE	($865,510,000)	($742,541,700)	($865,510,000)	($742,541,700)	$0	$0
2553	HR 1 - REDUCED RETROACTIVE MEDI-CAL TIMEFRAMES	($23,072,000)	($9,607,350)	($34,562,000)	($14,662,050)	($11,490,000)	($5,054,700)
2554	HR 1 - RESTRICTED FEDERAL FUNDING FOR CERTAIN QNCS	$0	$0	($13,612,000)	$668,056,000	($13,612,000)	$668,056,000
2555	HR 1 - FED WORK & COMMUNITY ENGAGEMENT REQUIREMENT	($373,277,000)	($102,445,100)	($357,564,000)	($90,313,200)	$15,713,000	$12,131,900
2575	HR 1 - DEATH MASTER FILE AUTOMATION	$0	$0	($32,665,000)	($9,868,950)	($32,665,000)	($9,868,950)
2588	FULL REINSTATEMENT OF ASSET LIMIT	$0	$0	($431,400,000)	($215,700,000)	($431,400,000)	($215,700,000)
2561	HR 1 - ACA ADULT EXP GROUP 6-MONTH REDETERMINATION	($463,312,000)	($74,130,400)	$0	$0	$463,312,000	$74,130,400
	ELIGIBILITY SUBTOTAL	**($2,373,129,000)**	**($1,601,677,350)**	**($2,553,304,000)**	**($1,188,817,900)**	**($180,175,000)**	**$412,859,450**

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2026-27

FRN.	POLICY CHANGE TITLE	NOV. 2025 EST. FOR 2026-27		MAY 2026 EST. FOR 2026-27		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	AFFORDABLE CARE ACT						
1595	COMMUNITY FIRST CHOICE OPTION	$12,056,278,000	$0	$12,068,334,000	$0	$12,056,000	$0
1967	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	$17,844,000	$0	$17,844,000	$0	$0	$0
1791	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	($5,939,000)	$0	($6,050,000)	$0	($111,000)
1821	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	$0	($31,928,400)	$0	($33,763,200)	$0	($1,834,800)
	AFFORDABLE CARE ACT SUBTOTAL	**$12,074,122,000**	**($37,867,400)**	**$12,086,178,000**	**($39,813,200)**	**$12,056,000**	**($1,945,800)**
	BENEFITS						
25	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$678,385,000	$0	$678,367,000	$0	($18,000)	$0
1	FAMILY PACT PROGRAM	$147,653,000	$37,122,300	$140,721,000	$35,402,600	($6,932,000)	($1,719,700)
1228	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$130,186,000	$28,367,000	$127,913,000	$28,351,000	($2,273,000)	($16,000)
28	MULTIPURPOSE SENIOR SERVICES PROGRAM	$63,951,000	$32,212,500	$63,951,000	$32,214,500	$0	$2,000
2457	CYBHI WELLNESS COACH BENEFIT	$73,607,000	$31,917,600	$32,000	($5,086,000)	($73,575,000)	($37,003,600)
1855	BEHAVIORAL HEALTH TREATMENT	$6,200,000	$3,100,000	$6,334,000	$3,167,000	$134,000	$67,000
2189	HEARING AID COVERAGE FOR CHILDREN PROGRAM	$2,621,000	$2,621,000	$2,621,000	$2,621,000	$0	$0
1562	CCT FUND TRANSFER TO CDSS	$38,000	$0	$736,000	$0	$698,000	$0
2528	UTILIZATION MANAGEMENT FOR HOSPICE	($100,000,000)	($50,000,000)	($110,171,000)	($42,162,000)	($10,171,000)	$7,838,000
2570	MEASLES, MUMPS, RUBELLA, VARICELLA (MMRV) VACCINES	$0	$0	$14,451,000	$6,976,650	$14,451,000	$6,976,650
2522	ELIMINATE MEDI-CAL OPTIONAL BENEFIT - ACUPUNCTURE	$0	$0	($13,600,000)	($5,400,000)	($13,600,000)	($5,400,000)
	BENEFITS SUBTOTAL	**$1,002,641,000**	**$85,340,400**	**$911,355,000**	**$56,084,750**	**($91,286,000)**	**($29,255,650)**

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2026-27

		NOV. 2025 EST. FOR 2026-27		MAY 2026 EST. FOR 2026-27		DIFFERENCE	
FRN.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	PHARMACY						
2512	CELL AND GENE THERAPY ACCESS MODEL	$19,321,000	$9,660,500	$19,321,000	$9,660,500	$0	$0
2124	MEDI-CAL DRUG REBATE FUND	$0	($2,350,812,000)	$0	($2,846,543,000)	$0	($495,731,000)
2524	HIV/AIDS AND CANCER DRUG REBATES	($300,000,000)	($150,000,000)	($300,000,000)	($150,000,000)	$0	$0
1433	BCCTP DRUG REBATES	($1,205,000)	$0	($1,287,000)	$0	($82,000)	$0
51	FAMILY PACT DRUG REBATES	($1,900,000)	$0	($1,961,000)	$0	($61,000)	$0
2519	UPDATES TO OTC COVID-19 TESTS AND OTC PRODUCTS	($12,000,000)	($4,972,900)	($12,000,000)	($4,972,900)	$0	$0
2526	PHARMACY UTILIZATION MANAGEMENT	($100,000,000)	($41,440,200)	($80,632,000)	($33,413,500)	$19,368,000	$8,026,700
2520	ELIMINATE GLP-1 COVERAGE FOR WEIGHT LOSS	($365,144,000)	($364,180,000)	($365,144,000)	($364,180,000)	$0	$0
2518	PRIOR AUTH. FOR CONTINUATION OF DRUG THERAPY	($250,000,000)	($103,600,400)	($250,000,000)	($103,600,400)	$0	$0
1181	MEDICAL SUPPLY REBATES	($194,400,000)	($60,182,650)	($204,000,000)	($61,991,800)	($9,600,000)	($1,809,150)
2527	STEP THERAPY	($350,000,000)	($145,040,350)	($350,000,000)	($145,040,350)	$0	$0
54	STATE SUPPLEMENTAL DRUG REBATES	($539,232,000)	$0	($594,791,000)	$0	($55,559,000)	$0
55	FEDERAL DRUG REBATES	($5,649,935,000)	$0	($6,982,154,000)	$0	($1,332,219,000)	$0
2557	PHARMACY PAYMENT METHODOLOGY - USUAL AND CUSTOMARY	($53,040,000)	($21,979,850)	($8,566,000)	($3,549,800)	$44,474,000	$18,430,050
2579	MEDI-CAL RX FRAUD, WASTE, & ABUSE PREVENTION	$0	$0	($35,002,000)	($14,505,100)	($35,002,000)	($14,505,100)
2525	MEDI-CAL RX REBATE AGGREGATOR	($435,000,000)	($435,000,000)	$0	$0	$435,000,000	$435,000,000
	PHARMACY SUBTOTAL	**($8,232,535,000)**	**($3,667,547,850)**	**($9,166,216,000)**	**($3,718,136,350)**	**($933,681,000)**	**($50,588,500)**
	DRUG MEDI-CAL						
2278	RECOVERY INCENTIVES CONTINGENCY MANAGEMENT	$16,478,000	$0	$16,478,000	$0	$0	$0
1723	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	$3,351,000	$288,000	$15,996,000	$7,207,000	$12,645,000	$6,919,000

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2026-27

FRN.	POLICY CHANGE TITLE	NOV. 2025 EST. FOR 2026-27 TOTAL FUNDS	NOV. 2025 EST. FOR 2026-27 GENERAL FUNDS	MAY 2026 EST. FOR 2026-27 TOTAL FUNDS	MAY 2026 EST. FOR 2026-27 GENERAL FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE GENERAL FUNDS
	DRUG MEDI-CAL						
1724	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	$1,734,000	$107,150	$1,755,000	$114,400	$21,000	$7,250
	DRUG MEDI-CAL SUBTOTAL	**$21,563,000**	**$395,150**	**$34,229,000**	**$7,321,400**	**$12,666,000**	**$6,926,250**
	MENTAL HEALTH						
2394	CALAIM - BH - CONNECT DEMONSTRATION	$450,300,000	$23,815,000	$422,340,000	$23,815,000	($27,960,000)	$0
2252	MHP COSTS FOR FFPSA	$35,897,000	$8,975,000	$34,943,000	$8,736,000	($954,000)	($239,000)
1957	MHP COSTS FOR CONTINUUM OF CARE REFORM	$5,479,000	$3,616,650	$2,026,000	$1,911,550	($3,453,000)	($1,705,100)
2268	OUT OF STATE YOUTH - SMHS	$630,000	$315,000	$857,000	$428,500	$227,000	$113,500
1660	IMPERIAL AND SISKIYOU COUNTY MHP OVERPAYMENT	$0	($200,000)	$0	($1,200,000)	$0	($1,000,000)
1713	INTERIM AND FINAL COST SETTLEMENTS - SMHS	($6,567,000)	$632,000	($12,525,000)	$1,780,000	($5,958,000)	$1,148,000
2574	RETRO PAYMENTS TO COUNTIES FOR STATE-ONLY BH SVCS	$0	$0	$165,000,000	$165,000,000	$165,000,000	$165,000,000
	MENTAL HEALTH SUBTOTAL	**$485,739,000**	**$37,153,650**	**$612,641,000**	**$200,471,050**	**$126,902,000**	**$163,317,400**
	WAIVER--MH/UCD & BTR						
1951	GLOBAL PAYMENT PROGRAM	$3,022,096,000	$0	$3,013,102,000	$0	($8,994,000)	$0
2245	CALAIM ECM-COMMUNITY SUPPORTS-TRANSITIONAL RENT	$2,748,746,000	$1,142,771,050	$2,706,233,000	$1,119,202,600	($42,513,000)	($23,568,450)
1769	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	$650,000	$0	$623,000	$0	($27,000)	$0
2452	ENHANCED CARE MANAGEMENT RISK CORRIDOR	($21,000,000)	($21,000,000)	$0	$0	$21,000,000	$21,000,000
	WAIVER--MH/UCD & BTR SUBTOTAL	**$5,750,492,000**	**$1,121,771,050**	**$5,719,958,000**	**$1,119,202,600**	**($30,534,000)**	**($2,568,450)**

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2026-27

FRN.	POLICY CHANGE TITLE	NOV. 2025 EST. FOR 2026-27		MAY 2026 EST. FOR 2026-27		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	MANAGED CARE						
2408	2023 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	$6,910,698,000	$2,810,448,150	$6,849,713,000	$2,803,180,900	($60,985,000)	($7,267,250)
2061	MANAGED CARE HEALTH CARE FINANCING PROGRAM	$3,284,465,000	$1,235,964,900	$3,185,536,000	$1,193,134,800	($98,929,000)	($42,830,100)
2060	MANAGED CARE PUBLIC HOSPITAL EPP	$6,056,171,000	$2,236,962,800	$6,056,171,000	$2,236,962,800	$0	$0
2062	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	$5,159,793,000	$1,544,341,750	$5,159,793,000	$1,567,814,600	$0	$23,472,850
2388	WORKFORCE & QUALITY INCENTIVE PROGRAM	$0	$8,487,550	($15,679,000)	($7,940,050)	($15,679,000)	($16,427,600)
2504	MEDI-CAL MANAGED CARE QUALITY WITHHOLD RELEASE	$593,866,000	$253,974,400	$593,866,000	$253,974,400	$0	$0
2437	MANAGED CARE DISTRICT HOSPITAL DIRECTED PAYMENTS	$1,297,033,000	$0	$1,297,033,000	$0	$0	$0
2499	COMMUNITY CLINIC DIRECTED PAYMENT PROGRAM	$105,000,000	$36,100,400	$205,000,000	$70,481,400	$100,000,000	$34,381,000
2474	CHILDREN'S HOSPITAL SUPPLEMENTAL PAYMENT PROGRAM	$440,833,000	$220,416,000	$440,833,000	$220,416,000	$0	$0
2406	2023 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	$0	($3,645,180,000)	$0	($3,639,403,000)	$0	$5,777,000
2407	2023 MCO ENROLLMENT TAX MANAGED CARE PLANS	$0	($2,530,602,000)	$0	($2,477,639,000)	$0	$52,963,000
2063	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	$0	($5,687,698,000)	$0	($6,010,266,000)	$0	($322,568,000)
1788	RETRO MC RATE ADJUSTMENTS	($339,510,000)	($539,117,850)	($607,888,000)	($474,996,500)	($268,378,000)	$64,121,350
2558	MCP NETWORK ADEQUACY & TIMELY ACCESS SANCTIONS	($3,500,000)	($1,750,000)	($3,500,000)	($1,750,000)	$0	$0
2569	IMPROVEMENTS AND EFFICIENCIES	($120,000,000)	($120,000,000)	($170,000,000)	($68,000,000)	($50,000,000)	$52,000,000
2576	MANAGED CARE RISK CORRIDORS	$0	$0	($485,055,000)	($264,143,710)	($485,055,000)	($264,143,710)
2577	UIS MEMBER TRANSITION TO FFS	$0	$0	($618,994,000)	($506,818,000)	($618,994,000)	($506,818,000)
2582	OVERPAYMENTS FOR REPRODUCTIVE HEALTH	$0	$0	$0	$30,000,000	$0	$30,000,000
2585	2027 MCO TAX CAPITATION PAYMENTS	$0	$0	$539,050,000	$225,678,000	$539,050,000	$225,678,000

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2026-27

		NOV. 2025 EST. FOR 2026-27		MAY 2026 EST. FOR 2026-27		DIFFERENCE	
FRN.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	MANAGED CARE						
2586	2027 MCO TAX FUNDING ADJUSTMENT - CAPITATION	$0	$0	$0	($135,407,000)	$0	($135,407,000)
2587	2027 MCO TAX FUNDING ADJUSTMENT – GENERAL SUPPORT	$0	$0	($92,927,000)	($584,028,000)	($92,927,000)	($584,028,000)
2135	COORDINATED CARE INITIATIVE RISK MITIGATION	$63,734,000	$31,867,000	$0	$0	($63,734,000)	($31,867,000)
	MANAGED CARE SUBTOTAL	**$23,448,583,000**	**($4,145,784,900)**	**$22,332,952,000**	**($5,568,748,360)**	**($1,115,631,000)**	**($1,422,963,460)**
	PROVIDER RATES						
88	RATE INCREASE FOR FQHCS/RHCS/CBRCS	$1,694,139,000	$942,169,100	$1,697,432,000	$944,000,100	$3,293,000	$1,831,000
2267	PP-GEMT IGT PROGRAM	$680,015,000	$0	$736,177,000	$72,583,000	$56,162,000	$72,583,000
2081	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	$167,052,000	($6,412,000)	$140,986,000	($5,462,000)	($26,066,000)	$950,000
1152	DPH INTERIM & FINAL RECONS	$512,709,000	$0	$530,548,000	$0	$17,839,000	$0
2181	NURSING FACILITY RATE ADJUSTMENTS	$789,577,000	$369,522,100	$698,236,000	$327,053,600	($91,341,000)	($42,468,500)
1329	FQHC/RHC/CBRC RECONCILIATION PROCESS	$106,598,000	$59,282,650	$108,847,000	$60,533,650	$2,249,000	$1,251,000
2184	GDSP NBS & PNS FEE ADJUSTMENTS	$18,482,000	$7,207,150	$18,457,000	$7,194,300	($25,000)	($12,850)
1046	LTC RATE ADJUSTMENT	$343,142,000	$164,950,050	$294,555,000	$140,324,000	($48,587,000)	($24,626,050)
96	HOSPICE RATE INCREASES	$17,307,000	$5,954,700	$17,345,000	$6,015,300	$38,000	$60,600
1162	DPH INTERIM RATE GROWTH	$26,154,000	$0	$19,724,000	$0	($6,430,000)	$0
1784	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	$0	($618,750,000)	$0	($753,912,000)	$0	($135,162,000)
2509	PROP 35 - PROVIDER PAYMENT INCREASE FUNDING	($200,000,000)	($3,176,000,000)	$0	($2,439,400,000)	$200,000,000	$736,600,000
1703	LABORATORY RATE METHODOLOGY CHANGE	($8,131,000)	($3,359,300)	($2,046,000)	($840,300)	$6,085,000	$2,519,000
2536	ELIMINATE PPS FOR STATE-ONLY SERVICES	($1,010,655,000)	($1,010,655,000)	($1,010,655,000)	($1,010,655,000)	$0	$0
1505	REDUCTION TO RADIOLOGY RATES	($67,166,000)	($27,463,950)	($65,471,000)	($26,728,550)	$1,695,000	$735,400

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2026-27

FRN.	POLICY CHANGE TITLE	NOV. 2025 EST. FOR 2026-27		MAY 2026 EST. FOR 2026-27		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	PROVIDER RATES						
2458	PROP 35 - PROVIDER PAYMENT INCREASES	$5,749,164,000	$2,461,000,000	$3,057,624,000	$1,505,600,000	($2,691,540,000)	($955,400,000)
2591	2027 MCO TAX FUNDING ADJUSTMENT – TRI	$0	$0	$0	($81,242,000)	$0	($81,242,000)
	PROVIDER RATES SUBTOTAL	**$8,818,387,000**	**($832,554,500)**	**$6,241,759,000**	**($1,254,935,900)**	**($2,576,628,000)**	**($422,381,400)**
	SUPPLEMENTAL PMNTS.						
2055	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	$22,275,575,000	$0	$15,828,192,000	$0	($6,447,383,000)	$0
1475	HOSPITAL QAF - FFS PAYMENTS	$2,615,175,000	$0	$3,961,466,000	$0	$1,346,291,000	$0
1761	HOSPITAL QAF - MANAGED CARE PAYMENTS	$893,000,000	$0	$1,793,000,000	$0	$900,000,000	$0
2024	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	$1,348,989,000	$0	$1,346,207,000	$0	($2,782,000)	$0
1071	PRIVATE HOSPITAL DSH REPLACEMENT	$783,936,000	$391,968,000	$787,980,000	$393,990,000	$4,044,000	$2,022,000
1073	DSH PAYMENT	$571,494,000	$29,000,000	$606,362,000	$41,769,000	$34,868,000	$12,769,000
1085	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	$435,361,000	$118,400,000	$439,952,000	$118,400,000	$4,591,000	$0
2130	PROP 56 - MEDI-CAL FAMILY PLANNING	$466,281,000	$217,300,500	$433,165,000	$131,120,500	($33,116,000)	($86,180,000)
78	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$219,140,000	$0	$209,844,000	$0	($9,296,000)	$0
1078	DPH PHYSICIAN & NON-PHYS. COST	$103,414,000	$0	$85,031,000	$0	($18,383,000)	$0
1899	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	$133,171,000	($989,000)	$132,843,000	($1,169,000)	($328,000)	($180,000)
104	FFP FOR LOCAL TRAUMA CENTERS	$179,777,000	$0	$181,489,000	$0	$1,712,000	$0
82	CAPITAL PROJECT DEBT REIMBURSEMENT	$79,229,000	$19,670,000	$79,036,000	$23,887,000	($193,000)	$4,217,000
1600	NDPH IGT SUPPLEMENTAL PAYMENTS	$56,309,000	($979,000)	$56,001,000	($972,000)	($308,000)	$7,000
2049	PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS	$98,205,000	$36,820,250	$82,091,000	$30,787,050	($16,114,000)	($6,033,200)
1076	NDPH SUPPLEMENTAL PAYMENT	$2,162,000	$0	$2,320,000	$0	$158,000	$0

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2026-27

		NOV. 2025 EST. FOR 2026-27		MAY 2026 EST. FOR 2026-27		DIFFERENCE	
FRN.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	SUPPLEMENTAL PMNTS.						
1616	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	$12,910,000	$0	$13,267,000	$0	$357,000	$0
1038	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	$10,000,000	$5,000,000	$10,000,000	$5,000,000	$0	$0
1039	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	$8,000,000	$4,000,000	$8,000,000	$4,000,000	$0	$0
86	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	$3,097,000	$0	$3,113,000	$0	$16,000	$0
2044	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	$6,087,000	$6,087,000	$6,954,000	$6,954,000	$867,000	$867,000
2303	FREE CLINICS AUGMENTATION	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$0	$0
2102	PROPOSITION 56 FUNDING	$0	($461,817,000)	$0	($461,274,000)	$0	$543,000
1601	IGT ADMIN. & PROCESSING FEE	$0	($26,035,000)	$0	($26,073,000)	$0	($38,000)
1661	GEMT SUPPLEMENTAL PAYMENT PROGRAM	($558,000)	$0	($1,632,000)	$0	($1,074,000)	$0
2572	DMPH GME IGT ADMIN. & PROCESSING FEE	$0	$0	$0	($230,000)	$0	($230,000)
2573	GRADUATE MEDICAL EDUCATION PAYMENTS TO DMPHS	$0	$0	$24,910,000	$0	$24,910,000	$0
	SUPPLEMENTAL PMNTS. SUBTOTAL	**$30,302,754,000**	**$340,425,750**	**$26,091,591,000**	**$268,189,550**	**($4,211,163,000)**	**($72,236,200)**
	COVID-19						
2218	COVID-19 END OF UNWINDING FLEXIBILITIES	($3,736,709,000)	($1,232,041,900)	($3,788,312,000)	($1,243,336,600)	($51,603,000)	($11,294,700)
	COVID-19 SUBTOTAL	**($3,736,709,000)**	**($1,232,041,900)**	**($3,788,312,000)**	**($1,243,336,600)**	**($51,603,000)**	**($11,294,700)**
	STATE-ONLY CLAIMING						
2415	STATE-ONLY CLAIMING ADJUSTMENTS - RETRO ADJ.	$0	$1,888,000	$0	($275,950,000)	$0	($277,838,000)
	STATE-ONLY CLAIMING SUBTOTAL	**$0**	**$1,888,000**	**$0**	**($275,950,000)**	**$0**	**($277,838,000)**

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2026-27

FRN.	POLICY CHANGE TITLE	NOV. 2025 EST. FOR 2026-27		MAY 2026 EST. FOR 2026-27		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER DEPARTMENTS						
1476	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$1,074,564,000	$0	$1,325,058,000	$0	$250,494,000	$0
	OTHER DEPARTMENTS SUBTOTAL	**$1,074,564,000**	**$0**	**$1,325,058,000**	**$0**	**$250,494,000**	**$0**
	OTHER						
2354	BEHAVIORAL HEALTH BRIDGE HOUSING	$43,000,000	$0	$43,000,000	$0	$0	$0
2208	SELF-DETERMINATION PROGRAM - CDDS	$369,165,000	$0	$441,206,000	$0	$72,041,000	$0
2329	QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES	$243,637,000	$28,083,000	$217,638,000	$26,607,000	($25,999,000)	($1,476,000)
2092	QAF WITHHOLD TRANSFER	$1,070,000	$535,000	$62,376,000	$31,188,000	$61,306,000	$30,653,000
2424	CYBHI - FEE SCHEDULE THIRD PARTY ADMINISTRATOR	$69,300,000	$0	$50,900,000	$0	($18,400,000)	$0
1232	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	$78,115,000	$0	$77,099,000	$0	($1,016,000)	$0
2346	EQUITY & PRACTICE TRANSFORMATION PAYMENTS	$27,300,000	$9,701,850	$27,300,000	$9,080,000	$0	($621,850)
2097	MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG	$48,351,000	$0	$36,143,000	$0	($12,208,000)	$0
1975	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	$99,571,000	$51,299,500	$93,906,000	$48,267,000	($5,665,000)	($3,032,500)
2396	CARE ACT	$39,557,000	$39,557,000	$22,481,000	$22,481,000	($17,076,000)	($17,076,000)
111	INDIAN HEALTH SERVICES	$26,807,000	$8,935,500	$16,905,000	$5,635,000	($9,902,000)	($3,300,500)
2009	INFANT DEVELOPMENT PROGRAM	$21,886,000	$0	$27,727,000	$0	$5,841,000	$0
1526	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	$16,085,000	$7,365,000	$13,742,000	$6,236,000	($2,343,000)	($1,129,000)
2355	CALHOPE	$0	$0	$5,000,000	$0	$5,000,000	$0
2443	ASSET LIMIT INCREASE & ELIM. - CNTY BH FUNDING	$3,314,000	$3,314,000	$4,720,000	$4,720,000	$1,406,000	$1,406,000

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2026-27

		NOV. 2025 EST. FOR 2026-27		MAY 2026 EST. FOR 2026-27		DIFFERENCE	
FRN.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER						
1866	WPCS WORKERS' COMPENSATION	$620,000	$310,000	$620,000	$310,000	$0	$0
35	IMD ANCILLARY SERVICES	$0	$51,474,000	$0	$51,474,000	$0	$0
1087	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	($90,303,000)	$0	($92,561,000)	$0	($2,258,000)
1760	HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	($1,424,027,000)	$0	($1,710,833,000)	$0	($286,806,000)
2034	CMS DEFERRED CLAIMS	$0	$100,000,000	$0	$200,000,000	$0	$100,000,000
2156	INDIAN HEALTH SERVICES FUNDING SHIFT	$0	($32,460,000)	$0	($30,919,500)	$0	$1,540,500
2484	HEALTH CARE SVCS. FINES AND PENALTIES	$0	$0	$0	($12,502,000)	$0	($12,502,000)
2551	HR 1 - UIS EMERGENCY ACA FMAP ADJUSTMENT	($51,500,000)	$106,778,000	($51,500,000)	$106,778,000	$0	$0
2563	ELIMINATE DENTAL FOR ADULT UIS	($134,637,000)	($134,637,000)	($360,827,000)	($360,827,000)	($226,190,000)	($226,190,000)
2531	RESIDENCY VERIFICATION IMPROVEMENTS	($285,029,000)	($114,011,000)	($418,230,000)	($126,360,000)	($133,201,000)	($12,349,000)
2497	QUALITY SANCTIONS	($3,500,000)	($1,750,000)	($2,000,000)	($1,000,000)	$1,500,000	$750,000
2054	ASSISTED LIVING WAIVER EXPANSION	($2,911,000)	($1,513,000)	$9,413,000	$4,890,000	$12,324,000	$6,403,000
2010	HCBA WAIVER EXPANSION	($38,561,000)	($19,453,000)	($28,808,000)	($14,528,000)	$9,753,000	$4,925,000
1906	COUNTY SHARE OF OTLICP-CCS COSTS	($14,951,000)	($14,951,000)	($17,000,000)	($17,000,000)	($2,049,000)	($2,049,000)
2343	COUNTY BH RECOUPMENTS	($85,546,000)	($85,546,000)	($85,547,000)	($85,547,000)	($1,000)	($1,000)
2590	MCO TAX REVENUE TO SUPPORT MEDI-CAL	$0	$0	$181,637,000	($1,700,000,000)	$181,637,000	($1,700,000,000)
2442	MEDICARE PART A BUY-IN PROGRAM	($26,161,000)	($17,003,500)	$0	$0	$26,161,000	$17,003,500
2306	RECONCILIATION - BENEFITS	($553,265,000)	($1,570,000)	$0	$0	$553,265,000	$1,570,000
	OTHER SUBTOTAL	**($108,283,000)**	**($1,529,871,650)**	**$367,901,000**	**($3,634,411,500)**	**$476,184,000**	**($2,104,539,850)**
	GRAND TOTAL	**$68,528,189,000**	**($11,460,371,550)**	**$60,215,790,000**	**($15,272,880,460)**	**($8,312,399,000)**	**($3,812,508,910)**

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

COMPARISON OF FISCAL IMPACTS OF COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2026-27

		NOV. 2025 EST. FOR 2026-27		MAY 2026 EST. FOR 2026-27		DIFFERENCE	
FRN	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	COUNTY ADMIN						
1704	COUNTY ADMINISTRATION ALLOCATION	$2,377,805,000	$1,188,902,500	$2,377,805,000	$1,188,902,500	$0	$0
214	SAWS	$213,376,000	$20,750	$196,915,000	$69,000	($16,461,000)	$48,250
217	CALWORKS APPLICATIONS	$99,217,000	$49,608,500	$99,964,000	$49,982,000	$747,000	$373,500
1598	CASE MANAGEMENT FOR OTLICP	$44,030,000	$22,015,000	$46,391,000	$23,195,500	$2,361,000	$1,180,500
213	LOS ANGELES COUNTY HOSPITAL INTAKES	$34,034,000	$2,735,500	$20,166,000	$2,736,000	($13,868,000)	$500
215	SAVE	$0	($4,000,000)	$0	($4,000,000)	$0	$0
1835	ENHANCED FEDERAL FUNDING	$0	($545,146,500)	$0	($633,390,000)	$0	($88,243,500)
2580	HR 1 - COUNTY ADMINISTRATION ALLOCATION	$0	$0	$262,101,000	$73,858,500	$262,101,000	$73,858,500
	COUNTY ADMIN SUBTOTAL	**$2,768,462,000**	**$714,135,750**	**$3,003,342,000**	**$701,353,500**	**$234,880,000**	**($12,782,250)**
	DHCS-OTHER						
2389	CALAIM - PATH	$411,794,000	$163,949,000	$515,456,000	$181,355,000	$103,662,000	$17,406,000
1721	COUNTY SPECIALTY MENTAL HEALTH ADMIN	$300,771,000	$14,932,000	$304,523,000	$13,912,000	$3,752,000	($1,020,000)
1757	INTERIM AND FINAL COST SETTLEMENTS-SMHS	$102,926,000	$0	$182,450,000	$0	$79,524,000	$0
230	CCS PROGRAM COUNTY ADMINISTRATIVE BUDGET	$204,125,000	$72,561,350	$206,028,000	$74,449,600	$1,903,000	$1,888,250
2289	CYBHI - BH SERVICES AND SUPPORTS PLATFORM	$109,900,000	$109,900,000	$109,900,000	$53,400,000	$0	($56,500,000)
2167	MEDI-CAL RX - ADMINISTRATIVE COSTS	$127,329,000	$33,382,300	$127,329,000	$33,382,300	$0	$0
1963	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	$131,696,000	$0	$148,013,000	$0	$16,317,000	$0
235	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	$132,200,000	$0	$148,168,000	$0	$15,968,000	$0
1813	DRUG MEDI-CAL COUNTY ADMINISTRATION	$123,527,000	$571,000	$123,527,000	$571,000	$0	$0
2517	CALAIM-BH-CONNECT WORKFORCE INITIATIVE	$213,750,000	$0	$213,750,000	$0	$0	$0
2491	BH TRANSFORMATION FUNDING FOR COUNTY BH DEPTS.	$17,001,000	$0	$17,001,000	$0	$0	$0
231	POSTAGE & PRINTING	$70,815,000	$35,536,000	$71,362,000	$35,809,500	$547,000	$273,500

COMPARISON OF FISCAL IMPACTS OF COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2026-27

		NOV. 2025 EST. FOR 2026-27		MAY 2026 EST. FOR 2026-27		DIFFERENCE	
FRN	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	DHCS-OTHER						
2288	CALAIM - POPULATION HEALTH MANAGEMENT	$57,141,000	$7,921,850	$54,604,000	$3,609,800	($2,537,000)	($4,312,050)
1722	SMH MAA	$56,679,000	$0	$55,641,000	$0	($1,038,000)	$0
2398	CALAIM - BH - CONNECT DEMONSTRATION ADMIN	$41,866,000	$8,433,000	$176,866,000	$8,433,000	$135,000,000	$0
1937	ACTUARIAL COSTS FOR RATE DEVELOPMENT	$45,085,000	$22,392,500	$45,000,000	$22,500,000	($85,000)	$107,500
1551	MEDI-CAL RECOVERY CONTRACTS	$34,037,000	$8,509,250	$35,100,000	$8,775,000	$1,063,000	$265,750
252	ENTERPRISE DATA ENVIRONMENT	$30,263,000	$7,986,600	$52,166,000	$13,901,700	$21,903,000	$5,915,100
1748	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	$32,885,000	$16,419,900	$28,424,000	$14,433,450	($4,461,000)	($1,986,450)
1137	MITA	$43,889,000	$5,574,450	$45,858,000	$5,824,750	$1,969,000	$250,300
2505	ELECTRONIC VISIT VERIFICATION M&O COSTS	$39,580,000	$0	$39,190,000	$0	($390,000)	$0
2402	EMSA - CALIFORNIA POISON CONTROL SYSTEM SVCS.	$18,291,000	$0	$18,291,000	$0	$0	$0
2152	HCBA WAIVER ADMINISTRATIVE COST	$24,113,000	$12,165,000	$23,380,000	$11,791,000	($733,000)	($374,000)
1932	PAVE SYSTEM	$15,599,000	$4,298,150	$30,784,000	$8,631,350	$15,185,000	$4,333,200
1318	CAPMAN	$18,635,000	$4,882,500	$19,309,000	$5,068,250	$674,000	$185,750
1720	PASRR	$9,047,000	$2,261,750	$9,637,000	$2,409,250	$590,000	$147,500
1370	PUBLIC HEALTH REGISTRIES SUPPORT	$21,996,000	$0	$13,480,000	$0	($8,516,000)	$0
1732	SDMC SYSTEM M&O SUPPORT	$5,428,000	$2,714,000	$2,319,000	$1,159,500	($3,109,000)	($1,554,500)
2002	ELECTRONIC ASSET VERIFICATION PROGRAM	$10,909,000	$5,454,500	$10,909,000	$5,454,500	$0	$0
2447	CALAIM - JUSTICE INVOLVED MAA	$90,000,000	$45,000,000	$8,000,000	$4,000,000	($82,000,000)	($41,000,000)
1452	PROTECTION OF PHI DATA	$5,757,000	$2,878,500	$14,980,000	$7,490,000	$9,223,000	$4,611,500
2467	MOBILE VISION SERVICES	$6,933,000	$0	$2,208,000	$0	($4,725,000)	$0
1982	MEDCOMPASS SOLUTION	$5,771,000	$1,517,100	$8,062,000	$2,119,900	$2,291,000	$602,800
1824	NEWBORN HEARING SCREENING PROGRAM	$6,313,000	$3,156,500	$6,313,000	$3,156,500	$0	$0
2334	COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE	$5,164,000	$1,972,000	$13,267,000	$5,907,000	$8,103,000	$3,935,000

COMPARISON OF FISCAL IMPACTS OF COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2026-27

		NOV. 2025 EST. FOR 2026-27		MAY 2026 EST. FOR 2026-27		DIFFERENCE	
FRN	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	DHCS-OTHER						
2206	DRUG MEDI-CAL PARITY RULE ADMINISTRATION	$5,875,000	$1,958,000	$5,875,000	$1,958,000	$0	$0
1972	PACES	$3,736,000	$982,100	$4,318,000	$1,135,050	$582,000	$152,950
2413	CALAIM - INMATE PRE-RELEASE PROGRAM ADMIN	$2,746,000	$1,373,000	$2,746,000	$1,373,000	$0	$0
1902	DATA ANALYTICS	$2,626,000	$321,500	$5,641,000	$1,829,000	$3,015,000	$1,507,500
2321	MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM	$2,200,000	$1,100,000	$2,200,000	$1,100,000	$0	$0
2392	MFP/CCT SUPPLEMENTAL FUNDING	$2,116,000	$0	$1,952,000	$0	($164,000)	$0
1768	T-MSIS	$1,720,000	$421,200	$1,887,000	$473,750	$167,000	$52,550
237	SSA COSTS FOR HEALTH COVERAGE INFO.	$1,788,000	$894,000	$1,820,000	$910,000	$32,000	$16,000
1441	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$1,333,000	$448,250	$994,000	$279,000	($339,000)	($169,250)
1675	FAMILY PACT PROGRAM ADMIN.	$1,100,000	$550,000	$1,100,000	$550,000	$0	$0
2362	RECOVERY INCENTIVES CONTINGENCY MANAGEMENT ADMIN	$1,275,000	$0	$1,275,000	$0	$0	$0
266	MMA - DSH ANNUAL INDEPENDENT AUDIT	$613,000	$306,500	$613,000	$306,500	$0	$0
2159	HEALTH INFORMATION EXCHANGE INTEROPERABILITY	$1,000,000	$100,000	$2,750,000	$349,400	$1,750,000	$249,400
1556	CCT OUTREACH - ADMINISTRATIVE COSTS	$364,000	$0	$364,000	$0	$0	$0
2438	HEALTH PLAN OF SAN MATEO DENTAL INTEGRATION EVAL	$152,000	$0	$152,000	$0	$0	$0
2123	CMS DEFERRED CLAIMS - OTHER ADMIN	$0	$0	$0	$145,000,000	$0	$145,000,000
2459	DESIGNATED STATE HEALTH PROGRAMS	$0	($346,856,000)	$0	($346,856,000)	$0	$0
2562	EPTP - STATEWIDE LEARNING COLLABORATIVE	$2,900,000	$1,450,000	$2,900,000	$1,450,000	$0	$0
2559	STATE ONLY CLAIMING ADJUSTMENTS - ADMIN.	$0	$600,000,000	$0	$600,000,000	$0	$0
2552	TRANSFORMING MATERNAL HEALTH PROVIDER INFR PYMT	$3,500,000	$0	$1,750,000	$0	($1,750,000)	$0
2567	HR 1 - HEALTH ENROLLMENT NAVIGATORS	$4,000,000	$0	$4,000,000	$0	$0	$0
2592	RECONCILIATION - ADMIN	$0	$0	($81,400,000)	($7,700,000)	($81,400,000)	($7,700,000)

COMPARISON OF FISCAL IMPACTS OF COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2026-27

		NOV. 2025 EST. FOR 2026-27		MAY 2026 EST. FOR 2026-27		DIFFERENCE	
FRN	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	DHCS-OTHER						
2593	PROPOSITION 35 FUNDING – CYBHI & BH-CONNECT	$0	$0	$0	($66,000,000)	$0	($66,000,000)
	DHCS-OTHER SUBTOTAL	**$2,610,259,000**	**$857,417,750**	**$2,842,232,000**	**$863,702,050**	**$231,973,000**	**$6,284,300**
	DHCS-MEDICAL FI						
2115	MEDICAL FI BO & IT COST REIMBURSEMENT	$63,471,000	$17,760,400	$65,381,000	$18,193,950	$1,910,000	$433,550
2117	MEDICAL FI BO & IT CHANGE ORDERS	$35,204,000	$9,256,150	$36,601,000	$9,622,300	$1,397,000	$366,150
2119	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	$50,974,000	$13,402,100	$50,974,000	$13,402,000	$0	($100)
2118	MEDICAL INFRASTRUCTURE & DATA MGT SVCS	$37,842,000	$9,948,050	$35,744,000	$9,395,950	($2,098,000)	($552,100)
2112	MEDICAL FI BO OTHER ESTIMATED COSTS	$27,016,000	$8,114,300	$26,951,000	$8,098,750	($65,000)	($15,550)
2116	MEDICAL FI BO TELEPHONE SERVICE CENTER	$19,715,000	$5,901,200	$19,718,000	$5,902,600	$3,000	$1,400
2111	MEDICAL FI BUSINESS OPERATIONS	$17,966,000	$4,720,600	$17,972,000	$4,722,850	$6,000	$2,250
2113	MEDICAL FI BO HOURLY REIMBURSEMENT	$12,998,000	$3,417,200	$12,998,000	$3,417,200	$0	$0
2114	MEDICAL FI BO MISCELLANEOUS EXPENSES	$1,243,000	$340,500	$1,189,000	$325,850	($54,000)	($14,650)
2564	HR 1 - PROHIBITED ENTITIES SYSTEMS COSTS	$0	$0	$137,000	$137,000	$137,000	$137,000
2594	UIS MEMBER TRANSITION TO FFS SYSTEMS COSTS	$0	$0	$33,300,000	$33,300,000	$33,300,000	$33,300,000
	DHCS-MEDICAL FI SUBTOTAL	**$266,429,000**	**$72,860,500**	**$300,965,000**	**$106,518,450**	**$34,536,000**	**$33,657,950**
	DHCS-HEALTH CARE OPT						
2051	HCO OPERATIONS	$38,103,000	$18,765,750	$36,638,000	$18,044,200	($1,465,000)	($721,550)
2052	HCO COST REIMBURSEMENT	$40,347,000	$19,954,650	$40,621,000	$20,089,550	$274,000	$134,900
2053	HCO ESR HOURLY REIMBURSEMENT	$15,484,000	$7,625,900	$15,590,000	$7,678,000	$106,000	$52,100
	DHCS-HEALTH CARE OPT SUBTOTAL	**$93,934,000**	**$46,346,300**	**$92,849,000**	**$45,811,750**	**($1,085,000)**	**($534,550)**

COMPARISON OF FISCAL IMPACTS OF COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2026-27

		NOV. 2025 EST. FOR 2026-27		MAY 2026 EST. FOR 2026-27		DIFFERENCE	
FRN	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	DHCS-DENTAL FI						
2380	DENTAL FI-DBO ADMIN 2022 CONTRACT	$124,722,000	$32,893,500	$132,472,000	$35,565,000	$7,750,000	$2,671,500
2006	DENTAL FI ADMINISTRATION 2016 CONTRACT	$18,808,000	$4,710,000	$18,760,000	$4,698,000	($48,000)	($12,000)
	DHCS-DENTAL FI SUBTOTAL	**$143,530,000**	**$37,603,500**	**$151,232,000**	**$40,263,000**	**$7,702,000**	**$2,659,500**
	OTHER DEPARTMENTS						
236	PERSONAL CARE SERVICES	$665,992,000	$0	$653,534,000	$0	($12,458,000)	$0
233	HEALTH-RELATED ACTIVITIES - CDSS	$571,238,000	$0	$804,896,000	$0	$233,658,000	$0
1679	CALHEERS DEVELOPMENT	$199,708,000	$70,387,600	$227,558,000	$62,032,900	$27,850,000	($8,354,700)
234	MATERNAL AND CHILD HEALTH	$95,644,000	$0	$114,846,000	$0	$19,202,000	$0
243	CDDS ADMINISTRATIVE COSTS	$99,990,000	$0	$129,193,000	$0	$29,203,000	$0
256	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$61,135,000	$0	$60,356,000	$0	($779,000)	$0
246	HCPCFC CASE MANAGEMENT	$54,682,000	$0	$74,400,000	$4,929,000	$19,718,000	$4,929,000
2455	HCPCFC ADMIN COSTS	$23,757,000	$11,878,500	$23,757,000	$11,878,500	$0	$0
1192	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	$11,746,000	$0	$13,656,000	$0	$1,910,000	$0
253	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$6,996,000	$0	$8,200,000	$0	$1,204,000	$0
2244	FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG	$7,872,000	$0	$8,391,000	$0	$519,000	$0
239	CLPP CASE MANAGEMENT SERVICES	$6,779,000	$0	$13,726,000	$0	$6,947,000	$0
1680	CALIFORNIA SMOKERS' HELPLINE	$3,063,000	$0	$3,564,000	$0	$501,000	$0
257	CALHHS AGENCY HIPAA FUNDING	$1,908,000	$954,000	$1,908,000	$954,000	$0	$0
1665	MEDI-CAL INPATIENT SERVICES FOR INMATES	$1,189,000	$0	$1,189,000	$0	$0	$0
232	VETERANS BENEFITS	$1,100,000	$0	$1,100,000	$0	$0	$0
1774	VITAL RECORDS	$883,000	$4,000	$883,000	$4,000	$0	$0

COMPARISON OF FISCAL IMPACTS OF COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION POLICY CHANGES
MAY 2026 ESTIMATE COMPARED TO NOVEMBER 2025 ESTIMATE
FISCAL YEAR 2026-27

		NOV. 2025 EST. FOR 2026-27		MAY 2026 EST. FOR 2026-27		DIFFERENCE	
FRN	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER DEPARTMENTS						
249	KIT FOR NEW PARENTS	$290,000	$0	$83,000	$0	($207,000)	$0
263	MERIT SYSTEM SERVICES FOR COUNTIES	$211,000	$105,500	$211,000	$105,500	$0	$0
1114	PIA EYEWEAR COURIER SERVICE	$944,000	$472,000	$894,000	$447,000	($50,000)	($25,000)
	OTHER DEPARTMENTS SUBTOTAL	**$1,815,127,000**	**$83,801,600**	**$2,142,345,000**	**$80,350,900**	**$327,218,000**	**($3,450,700)**
	GRAND TOTAL	**$7,697,741,000**	**$1,812,165,400**	**$8,532,965,000**	**$1,837,999,650**	**$835,224,000**	**$25,834,250**

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2025-26 AND 2026-27

		MAY 2026 EST. FOR 2025-26		MAY 2026 EST. FOR 2026-27		DIFFERENCE	
FRN.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	DRUG MEDI-CAL						
2012	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	$2,125,136,000	$322,603,450	$1,762,233,000	$132,092,000	($362,903,000)	($190,511,450)
2320	DRUG MEDI-CAL STATE PLAN SERVICES	$49,221,000	$3,394,700	$51,307,000	$2,931,300	$2,086,000	($463,400)
	DRUG MEDI-CAL SUBTOTAL	**$2,174,357,000**	**$325,998,150**	**$1,813,540,000**	**$135,023,300**	**($360,817,000)**	**($190,974,850)**
	MENTAL HEALTH						
1780	SMHS FOR ADULTS	$5,958,142,000	$504,458,700	$5,455,610,000	$446,255,100	($502,532,000)	($58,203,600)
1779	SMHS FOR CHILDREN	$4,861,069,000	$92,988,300	$4,487,212,000	$82,327,900	($373,857,000)	($10,660,400)
	MENTAL HEALTH SUBTOTAL	**$10,819,211,000**	**$597,447,000**	**$9,942,822,000**	**$528,583,000**	**($876,389,000)**	**($68,864,000)**
	MANAGED CARE						
56	TWO PLAN MODEL	$35,773,534,000	$15,430,802,500	$38,347,025,000	$16,667,911,500	$2,573,491,000	$1,237,109,000
57	COUNTY ORGANIZED HEALTH SYSTEMS & SINGLE PLAN	$19,965,233,000	$8,454,791,600	$21,305,208,000	$9,095,002,700	$1,339,975,000	$640,211,100
58	GEOGRAPHIC MANAGED CARE	$6,238,879,000	$2,510,450,050	$6,690,671,000	$2,727,270,950	$451,792,000	$216,820,900
62	PACE (Other M/C)	$2,474,328,000	$1,314,916,400	$3,020,768,000	$1,605,307,800	$546,440,000	$290,391,400
1842	REGIONAL MODEL	$226,218,000	$82,778,700	$246,982,000	$92,092,050	$20,764,000	$9,313,350
1029	DENTAL MANAGED CARE (Other M/C)	$175,042,000	$78,861,800	$180,042,000	$81,498,350	$5,000,000	$2,636,550
61	SENIOR CARE ACTION NETWORK (Other M/C)	$109,154,000	$55,057,000	$117,169,000	$59,198,500	$8,015,000	$4,141,500
1837	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	$59,467,000	$21,934,000	$62,440,000	$23,031,000	$2,973,000	$1,097,000
1823	COUNTY CHILDREN’S HEALTH INITIATIVE PROGRAM	$16,267,000	$5,693,450	$16,267,000	$5,693,450	$0	$0
63	AIDS HEALTHCARE CENTERS (Other M/C)	$12,536,000	$4,920,000	$13,622,000	$5,497,800	$1,086,000	$577,800
1797	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	$3,051,000	$1,067,850	$3,069,000	$1,074,150	$18,000	$6,300
2581	CAP PACE RATES AT LOWER BOUND	$0	$0	($67,400,000)	($33,700,000)	($67,400,000)	($33,700,000)
	MANAGED CARE SUBTOTAL	**$65,053,709,000**	**$27,961,273,350**	**$69,935,863,000**	**$30,329,878,250**	**$4,882,154,000**	**$2,368,604,900**

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2025-26 AND 2026-27

		MAY 2026 EST. FOR 2025-26		MAY 2026 EST. FOR 2026-27		DIFFERENCE	
FRN.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	FEE-FOR-SERVICE BASE						
2540	FFS - PHARMACY	$24,051,152,000	$10,248,694,000	$25,643,326,000	$10,444,519,150	$1,592,174,000	$195,825,150
2539	FFS - OTHER MEDICAL	$7,999,778,000	$3,927,680,050	$8,222,865,000	$4,235,229,600	$223,087,000	$307,549,550
2543	FFS - COMMUNITY INPATIENT	$3,206,229,000	$1,141,308,400	$3,594,693,000	$1,290,856,050	$388,464,000	$149,547,650
2547	FFS - OTHER SERVICES	$1,841,281,000	$898,593,250	$1,967,034,000	$955,369,350	$125,753,000	$56,776,100
2544	FFS - NURSING FACILITIES	$737,897,000	$332,231,700	$696,648,000	$339,461,600	($41,249,000)	$7,229,900
2542	FFS - COUNTY INPATIENT	$615,158,000	$8,345,050	$660,042,000	$19,033,100	$44,884,000	$10,688,050
2541	FFS - CO. & COMM. OUTPATIENT	$619,973,000	$277,716,050	$646,148,000	$288,794,000	$26,175,000	$11,077,950
2538	FFS - PHYSICIANS	$521,854,000	$230,646,350	$523,847,000	$229,612,600	$1,993,000	($1,033,750)
2548	FFS - HOME HEALTH	$132,896,000	$64,207,800	$136,128,000	$65,734,650	$3,232,000	$1,526,850
2546	FFS - MEDICAL TRANSPORTATION	$75,851,000	$25,011,900	$77,918,000	$25,627,900	$2,067,000	$616,000
2545	FFS - ICF-DD	$8,148,000	$4,000,600	$8,056,000	$3,965,000	($92,000)	($35,600)
	FEE-FOR-SERVICE BASE SUBTOTAL	**$39,810,217,000**	**$17,158,435,150**	**$42,176,705,000**	**$17,898,203,000**	**$2,366,488,000**	**$739,767,850**
	OTHER						
76	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$5,975,627,000	$3,448,599,000	$6,548,820,000	$3,784,684,500	$573,193,000	$336,085,500
22	PERSONAL CARE SERVICES (Misc. Svcs.)	$4,224,145,000	$0	$4,875,015,000	$0	$650,870,000	$0
23	HOME & COMMUNITY-BASED SVCS.- CDDS (Misc.)	$4,605,030,000	$0	$4,938,732,000	$0	$333,702,000	$0
1019	MEDICARE PAYMENTS - PART D PHASED-DOWN	$4,024,294,000	$4,024,294,000	$4,367,207,000	$4,367,207,000	$342,913,000	$342,913,000
135	DENTAL SERVICES	$2,701,106,000	$1,274,478,900	$2,691,090,000	$1,272,912,600	($10,016,000)	($1,566,300)
32	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$525,081,000	$264,801,000	$616,026,000	$310,665,000	$90,945,000	$45,864,000
26	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$502,052,000	$0	$518,524,000	$0	$16,472,000	$0
2080	LAWSUITS/CLAIMS	$208,519,000	$104,259,500	$55,850,000	$27,925,000	($152,669,000)	($76,334,500)
77	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$18,877,000	$0	$14,645,000	$0	($4,232,000)	$0
27	MEDI-CAL TCM PROGRAM	$12,304,000	$0	$9,208,000	$0	($3,096,000)	$0

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2025-26 AND 2026-27

		MAY 2026 EST. FOR 2025-26		MAY 2026 EST. FOR 2026-27		DIFFERENCE	
FRN.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER						
91	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$243,000	$121,500	$255,000	$127,500	$12,000	$6,000
127	BASE RECOVERIES	($966,554,000)	($235,663,300)	($919,609,000)	($224,216,690)	$46,945,000	$11,446,610
	OTHER SUBTOTAL	**$21,830,724,000**	**$8,880,890,600**	**$23,715,763,000**	**$9,539,304,910**	**$1,885,039,000**	**$658,414,310**
	GRAND TOTAL	**$139,688,218,000**	**$54,924,044,250**	**$147,584,693,000**	**$58,430,992,460**	**$7,896,475,000**	**$3,506,948,210**

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2025-26 AND 2026-27

		MAY 2026 EST. FOR 2025-26		MAY 2026 EST. FOR 2026-27		DIFFERENCE	
FRN.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	ELIGIBILITY						
1569	MEDI-CAL STATE INMATE PROGRAMS	$47,616,000	$0	$47,616,000	$0	$0	$0
2529	PREMIUMS FOR ADULTS WITH UNSATIS. IMMIG. STAT.	$0	$0	$28,000,000	$28,000,000	$28,000,000	$28,000,000
2332	CALAIM - INMATE PRE-RELEASE PROGRAM	$39,297,000	$5,548,000	$191,799,000	$27,075,000	$152,502,000	$21,527,000
3	BREAST AND CERVICAL CANCER TREATMENT	$12,399,000	$6,061,350	$17,028,000	$9,026,200	$4,629,000	$2,964,850
2422	HEALTH ENROLLMENT NAVIGATORS FOR CLINICS	$8,244,000	$4,122,000	$0	$0	($8,244,000)	($4,122,000)
13	NON-OTLICP CHIP	$0	($126,430,800)	$0	($123,190,200)	$0	$3,240,600
1007	SCHIP FUNDING FOR PRENATAL CARE	$0	($80,347,150)	$0	($80,575,300)	$0	($228,150)
2155	CS3 PROXY ADJUSTMENT	$0	($113,512,600)	$0	($114,308,700)	$0	($796,100)
2237	REFUGEE MEDICAL ASSISTANCE	$0	($47,000)	$0	($47,000)	$0	$0
2029	MEDI-CAL COUNTY INMATE REIMBURSEMENT	$0	($2,436,000)	$0	($2,513,000)	$0	($77,000)
2500	SB 525 MINIMUM WAGE - CASELOAD IMPACT	($188,536,000)	($75,414,400)	($239,621,000)	($95,848,500)	($51,085,000)	($20,434,100)
2535	REINSTATEMENT OF ASSET LIMIT	($113,411,000)	($56,705,500)	($862,813,000)	($431,406,500)	($749,402,000)	($374,701,000)
2530	FULL-SCOPE MEDI-CAL EXPANSION ENROLLMENT FREEZE	($94,693,000)	($83,381,950)	($865,510,000)	($742,541,700)	($770,817,000)	($659,159,750)
2553	HR 1 - REDUCED RETROACTIVE MEDI-CAL TIMEFRAMES	$0	$0	($34,562,000)	($14,662,050)	($34,562,000)	($14,662,050)
2554	HR 1 - RESTRICTED FEDERAL FUNDING FOR CERTAIN QNCS	$0	$0	($13,612,000)	$668,056,000	($13,612,000)	$668,056,000
2555	HR 1 - FED WORK & COMMUNITY ENGAGEMENT REQUIREMENT	$0	$0	($357,564,000)	($90,313,200)	($357,564,000)	($90,313,200)
2575	HR 1 - DEATH MASTER FILE AUTOMATION	$0	$0	($32,665,000)	($9,868,950)	($32,665,000)	($9,868,950)
2588	FULL REINSTATEMENT OF ASSET LIMIT	$0	$0	($431,400,000)	($215,700,000)	($431,400,000)	($215,700,000)
	ELIGIBILITY SUBTOTAL	**($289,084,000)**	**($522,544,050)**	**($2,553,304,000)**	**($1,188,817,900)**	**($2,264,220,000)**	**($666,273,850)**
	AFFORDABLE CARE ACT						
1595	COMMUNITY FIRST CHOICE OPTION	$11,410,654,000	$0	$12,068,334,000	$0	$657,680,000	$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 2025-26 AND 2026-27

		MAY 2026 EST. FOR 2025-26		MAY 2026 EST. FOR 2026-27		DIFFERENCE	
FRN.	**POLICY CHANGE TITLE**	**TOTAL FUNDS**	**GENERAL FUNDS**	**TOTAL FUNDS**	**GENERAL FUNDS**	**TOTAL FUNDS**	**GENERAL FUNDS**
	AFFORDABLE CARE ACT						
1967	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	$13,572,000	$0	$17,844,000	$0	$4,272,000	$0
1791	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	($6,154,000)	$0	($6,050,000)	$0	$104,000
1821	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	$0	($36,025,600)	$0	($33,763,200)	$0	$2,262,400
	AFFORDABLE CARE ACT SUBTOTAL	**$11,424,226,000**	**($42,179,600)**	**$12,086,178,000**	**($39,813,200)**	**$661,952,000**	**$2,366,400**
	BENEFITS						
25	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$976,828,000	$0	$678,367,000	$0	($298,461,000)	$0
1	FAMILY PACT PROGRAM	$105,766,000	$26,782,400	$140,721,000	$35,402,600	$34,955,000	$8,620,200
1228	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$111,759,000	$24,786,000	$127,913,000	$28,351,000	$16,154,000	$3,565,000
28	MULTIPURPOSE SENIOR SERVICES PROGRAM	$63,951,000	$32,214,500	$63,951,000	$32,214,500	$0	$0
2457	CYBHI WELLNESS COACH BENEFIT	$99,000	$43,000	$32,000	($5,086,000)	($67,000)	($5,129,000)
1855	BEHAVIORAL HEALTH TREATMENT	$7,792,000	$3,896,000	$6,334,000	$3,167,000	($1,458,000)	($729,000)
2189	HEARING AID COVERAGE FOR CHILDREN PROGRAM	$1,552,000	$1,552,000	$2,621,000	$2,621,000	$1,069,000	$1,069,000
1562	CCT FUND TRANSFER TO CDSS	$736,000	$0	$736,000	$0	$0	$0
2528	UTILIZATION MANAGEMENT FOR HOSPICE	($100,000,000)	($38,269,550)	($110,171,000)	($42,162,000)	($10,171,000)	($3,892,450)
2570	MEASLES, MUMPS, RUBELLA, VARICELLA (MMRV) VACCINES	$3,076,000	$1,484,900	$14,451,000	$6,976,650	$11,375,000	$5,491,750
2522	ELIMINATE MEDI-CAL OPTIONAL BENEFIT - ACUPUNCTURE	$0	$0	($13,600,000)	($5,400,000)	($13,600,000)	($5,400,000)
	BENEFITS SUBTOTAL	**$1,171,559,000**	**$52,489,250**	**$911,355,000**	**$56,084,750**	**($260,204,000)**	**$3,595,500**
	PHARMACY						
2512	CELL AND GENE THERAPY ACCESS MODEL	$18,110,000	$9,055,000	$19,321,000	$9,660,500	$1,211,000	$605,500

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 2025-26 AND 2026-27

		MAY 2026 EST. FOR 2025-26		MAY 2026 EST. FOR 2026-27		DIFFERENCE	
FRN.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	PHARMACY						
2194	PHARMACY RETROACTIVE ADJUSTMENTS	$800,000	$31,749,250	$0	$0	($800,000)	($31,749,250)
2124	MEDI-CAL DRUG REBATE FUND	$0	($2,386,754,000)	$0	($2,846,543,000)	$0	($459,789,000)
2524	HIV/AIDS AND CANCER DRUG REBATES	$0	$0	($300,000,000)	($150,000,000)	($300,000,000)	($150,000,000)
1449	LITIGATION SETTLEMENTS	($6,000)	($6,000)	$0	$0	$6,000	$6,000
1433	BCCTP DRUG REBATES	($1,320,000)	$0	($1,287,000)	$0	$33,000	$0
51	FAMILY PACT DRUG REBATES	($2,477,000)	$0	($1,961,000)	$0	$516,000	$0
2519	UPDATES TO OTC COVID-19 TESTS AND OTC PRODUCTS	($4,360,000)	($1,828,900)	($12,000,000)	($4,972,900)	($7,640,000)	($3,144,000)
2526	PHARMACY UTILIZATION MANAGEMENT	($17,860,000)	($7,490,850)	($80,632,000)	($33,413,500)	($62,772,000)	($25,922,650)
2520	ELIMINATE GLP-1 COVERAGE FOR WEIGHT LOSS	($86,567,000)	($86,355,000)	($365,144,000)	($364,180,000)	($278,577,000)	($277,825,000)
2518	PRIOR AUTH. FOR CONTINUATION OF DRUG THERAPY	($111,625,000)	($46,821,900)	($250,000,000)	($103,600,400)	($138,375,000)	($56,778,500)
1181	MEDICAL SUPPLY REBATES	($153,000,000)	($76,500,000)	($204,000,000)	($61,991,800)	($51,000,000)	$14,508,200
2527	STEP THERAPY	($156,275,000)	($65,550,800)	($350,000,000)	($145,040,350)	($193,725,000)	($79,489,550)
54	STATE SUPPLEMENTAL DRUG REBATES	($637,806,000)	$0	($594,791,000)	$0	$43,015,000	$0
55	FEDERAL DRUG REBATES	($7,210,876,000)	$0	($6,982,154,000)	$0	$228,722,000	$0
2557	PHARMACY PAYMENT METHODOLOGY - USUAL AND CUSTOMARY	($8,641,000)	$93,710,100	($8,566,000)	($3,549,800)	$75,000	($97,259,900)
2579	MEDI-CAL RX FRAUD, WASTE, & ABUSE PREVENTION	($14,586,000)	($6,118,200)	($35,002,000)	($14,505,100)	($20,416,000)	($8,386,900)
	PHARMACY SUBTOTAL	**($8,386,489,000)**	**($2,542,911,300)**	**($9,166,216,000)**	**($3,718,136,350)**	**($779,727,000)**	**($1,175,225,050)**
	DRUG MEDI-CAL						
2278	RECOVERY INCENTIVES CONTINGENCY MANAGEMENT	$13,299,000	$0	$16,478,000	$0	$3,179,000	$0
1723	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	$19,878,000	$8,914,000	$15,996,000	$7,207,000	($3,882,000)	($1,707,000)
1724	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	$657,000	$42,700	$1,755,000	$114,400	$1,098,000	$71,700
	DRUG MEDI-CAL SUBTOTAL	**$33,834,000**	**$8,956,700**	**$34,229,000**	**$7,321,400**	**$395,000**	**($1,635,300)**

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 2025-26 AND 2026-27

		MAY 2026 EST. FOR 2025-26		MAY 2026 EST. FOR 2026-27		DIFFERENCE	
FRN.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	MENTAL HEALTH						
2394	CALAIM - BH - CONNECT DEMONSTRATION	$113,933,000	$11,908,000	$422,340,000	$23,815,000	$308,407,000	$11,907,000
2252	MHP COSTS FOR FFPSA	$34,932,000	$8,732,000	$34,943,000	$8,736,000	$11,000	$4,000
1957	MHP COSTS FOR CONTINUUM OF CARE REFORM	$2,024,000	$1,911,300	$2,026,000	$1,911,550	$2,000	$250
2268	OUT OF STATE YOUTH - SMHS	$930,000	$465,000	$857,000	$428,500	($73,000)	($36,500)
1660	IMPERIAL AND SISKIYOU COUNTY MHP OVERPAYMENT	$0	($200,000)	$0	($1,200,000)	$0	($1,000,000)
1713	INTERIM AND FINAL COST SETTLEMENTS - SMHS	($13,451,000)	$2,287,000	($12,525,000)	$1,780,000	$926,000	($507,000)
2574	RETRO PAYMENTS TO COUNTIES FOR STATE-ONLY BH SVCS	$20,000,000	$20,000,000	$165,000,000	$165,000,000	$145,000,000	$145,000,000
	MENTAL HEALTH SUBTOTAL	**$158,368,000**	**$45,103,300**	**$612,641,000**	**$200,471,050**	**$454,273,000**	**$155,367,750**
	WAIVER--MH/UCD & BTR						
1951	GLOBAL PAYMENT PROGRAM	$2,981,620,000	$0	$3,013,102,000	$0	$31,482,000	$0
2245	CALAIM ECM-COMMUNITY SUPPORTS-TRANSITIONAL RENT	$2,415,193,000	$1,013,404,300	$2,706,233,000	$1,119,202,600	$291,040,000	$105,798,300
1769	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	$336,000	$0	$623,000	$0	$287,000	$0
	WAIVER--MH/UCD & BTR SUBTOTAL	**$5,397,149,000**	**$1,013,404,300**	**$5,719,958,000**	**$1,119,202,600**	**$322,809,000**	**$105,798,300**
	MANAGED CARE						
2408	2023 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	$15,208,141,000	$5,549,105,300	$6,849,713,000	$2,803,180,900	($8,358,428,000)	($2,745,924,400)
2061	MANAGED CARE HEALTH CARE FINANCING PROGRAM	$2,990,968,000	$1,119,520,150	$3,185,536,000	$1,193,134,800	$194,568,000	$73,614,650
2060	MANAGED CARE PUBLIC HOSPITAL EPP	$2,362,740,000	$849,553,200	$6,056,171,000	$2,236,962,800	$3,693,431,000	$1,387,409,600
2062	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	$2,204,499,000	$662,722,100	$5,159,793,000	$1,567,814,600	$2,955,294,000	$905,092,500
2388	WORKFORCE & QUALITY INCENTIVE PROGRAM	$310,868,000	$165,846,050	($15,679,000)	($7,940,050)	($326,547,000)	($173,786,100)

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 2025-26 AND 2026-27

		MAY 2026 EST. FOR 2025-26		MAY 2026 EST. FOR 2026-27		DIFFERENCE	
FRN.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	MANAGED CARE						
2504	MEDI-CAL MANAGED CARE QUALITY WITHHOLD RELEASE	$252,096,000	$103,638,600	$593,866,000	$253,974,400	$341,770,000	$150,335,800
2437	MANAGED CARE DISTRICT HOSPITAL DIRECTED PAYMENTS	$204,032,000	$0	$1,297,033,000	$0	$1,093,001,000	$0
2499	COMMUNITY CLINIC DIRECTED PAYMENT PROGRAM	$0	$0	$205,000,000	$70,481,400	$205,000,000	$70,481,400
2448	MANAGED CARE PUBLIC DP-NF PASS-THROUGH PYMT PROG	$76,397,000	$39,773,900	$0	$0	($76,397,000)	($39,773,900)
2031	CCI-QUALITY WITHHOLD REPAYMENTS	$15,837,000	$7,918,500	$0	$0	($15,837,000)	($7,918,500)
2474	CHILDREN'S HOSPITAL SUPPLEMENTAL PAYMENT PROGRAM	$0	$0	$440,833,000	$220,416,000	$440,833,000	$220,416,000
2406	2023 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	$0	($4,712,883,000)	$0	($3,639,403,000)	$0	$1,073,480,000
2407	2023 MCO ENROLLMENT TAX MANAGED CARE PLANS	$0	($4,478,050,000)	$0	($2,477,639,000)	$0	$2,000,411,000
2063	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	$0	($3,054,480,000)	$0	($6,010,266,000)	$0	($2,955,786,000)
1788	RETRO MC RATE ADJUSTMENTS	$154,235,000	($2,629,200)	($607,888,000)	($474,996,500)	($762,123,000)	($472,367,300)
2558	MCP NETWORK ADEQUACY & TIMELY ACCESS SANCTIONS	$0	$0	($3,500,000)	($1,750,000)	($3,500,000)	($1,750,000)
2569	IMPROVEMENTS AND EFFICIENCIES	$0	$0	($170,000,000)	($68,000,000)	($170,000,000)	($68,000,000)
2576	MANAGED CARE RISK CORRIDORS	($41,718,000)	($13,920,500)	($485,055,000)	($264,143,710)	($443,337,000)	($250,223,210)
2577	UIS MEMBER TRANSITION TO FFS	$0	$0	($618,994,000)	($506,818,000)	($618,994,000)	($506,818,000)
2582	OVERPAYMENTS FOR REPRODUCTIVE HEALTH	$0	$0	$0	$30,000,000	$0	$30,000,000
2585	2027 MCO TAX CAPITATION PAYMENTS	$0	$0	$539,050,000	$225,678,000	$539,050,000	$225,678,000
2586	2027 MCO TAX FUNDING ADJUSTMENT - CAPITATION	$0	$0	$0	($135,407,000)	$0	($135,407,000)
2587	2027 MCO TAX FUNDING ADJUSTMENT – GENERAL SUPPORT	$0	$0	($92,927,000)	($584,028,000)	($92,927,000)	($584,028,000)
	MANAGED CARE SUBTOTAL	**$23,738,095,000**	**($3,763,884,900)**	**$22,332,952,000**	**($5,568,748,360)**	**($1,405,143,000)**	**($1,804,863,460)**

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 2025-26 AND 2026-27

		MAY 2026 EST. FOR 2025-26		MAY 2026 EST. FOR 2026-27		DIFFERENCE	
FRN.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	PROVIDER RATES						
88	RATE INCREASE FOR FQHCS/RHCS/CBRCS	$1,028,121,000	$571,773,450	$1,697,432,000	$944,000,100	$669,311,000	$372,226,650
2267	PP-GEMT IGT PROGRAM	$450,469,000	$9,824,000	$736,177,000	$72,583,000	$285,708,000	$62,759,000
2081	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	$157,594,000	($6,061,000)	$140,986,000	($5,462,000)	($16,608,000)	$599,000
1152	DPH INTERIM & FINAL RECONS	$130,113,000	$0	$530,548,000	$0	$400,435,000	$0
2181	NURSING FACILITY RATE ADJUSTMENTS	$725,253,000	$339,708,500	$698,236,000	$327,053,600	($27,017,000)	($12,654,900)
1329	FQHC/RHC/CBRC RECONCILIATION PROCESS	$108,847,000	$60,533,650	$108,847,000	$60,533,650	$0	$0
2184	GDSP NBS & PNS FEE ADJUSTMENTS	$44,550,000	$17,364,950	$18,457,000	$7,194,300	($26,093,000)	($10,170,650)
1046	LTC RATE ADJUSTMENT	$205,820,000	$98,051,050	$294,555,000	$140,324,000	$88,735,000	$42,272,950
96	HOSPICE RATE INCREASES	$14,341,000	$4,973,450	$17,345,000	$6,015,300	$3,004,000	$1,041,850
1162	DPH INTERIM RATE GROWTH	$0	$0	$19,724,000	$0	$19,724,000	$0
1784	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	$0	($688,731,000)	$0	($753,912,000)	$0	($65,181,000)
2509	PROP 35 - PROVIDER PAYMENT INCREASE FUNDING	$0	($1,585,433,000)	$0	($2,439,400,000)	$0	($853,967,000)
1703	LABORATORY RATE METHODOLOGY CHANGE	$0	$0	($2,046,000)	($840,300)	($2,046,000)	($840,300)
2536	ELIMINATE PPS FOR STATE-ONLY SERVICES	$0	$0	($1,010,655,000)	($1,010,655,000)	($1,010,655,000)	($1,010,655,000)
1505	REDUCTION TO RADIOLOGY RATES	$0	$0	($65,471,000)	($26,728,550)	($65,471,000)	($26,728,550)
2458	PROP 35 - PROVIDER PAYMENT INCREASES	$0	$0	$3,057,624,000	$1,505,600,000	$3,057,624,000	$1,505,600,000
2591	2027 MCO TAX FUNDING ADJUSTMENT – TRI	$0	$0	$0	($81,242,000)	$0	($81,242,000)
	PROVIDER RATES SUBTOTAL	**$2,865,108,000**	**($1,177,995,950)**	**$6,241,759,000**	**($1,254,935,900)**	**$3,376,651,000**	**($76,939,950)**
	SUPPLEMENTAL PMNTS.						
2055	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	$6,291,696,000	$0	$15,828,192,000	$0	$9,536,496,000	$0
1475	HOSPITAL QAF - FFS PAYMENTS	($199,543,000)	$0	$3,961,466,000	$0	$4,161,009,000	$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 2025-26 AND 2026-27

		MAY 2026 EST. FOR 2025-26		MAY 2026 EST. FOR 2026-27		DIFFERENCE	
FRN.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	SUPPLEMENTAL PMNTS.						
1761	HOSPITAL QAF - MANAGED CARE PAYMENTS	$0	$0	$1,793,000,000	$0	$1,793,000,000	$0
2024	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	$1,110,346,000	$0	$1,346,207,000	$0	$235,861,000	$0
1071	PRIVATE HOSPITAL DSH REPLACEMENT	$769,852,000	$384,926,000	$787,980,000	$393,990,000	$18,128,000	$9,064,000
1073	DSH PAYMENT	$604,637,000	$43,553,000	$606,362,000	$41,769,000	$1,725,000	($1,784,000)
1085	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	$505,332,000	$118,400,000	$439,952,000	$118,400,000	($65,380,000)	$0
2130	PROP 56 - MEDI-CAL FAMILY PLANNING	$442,849,000	$146,154,100	$433,165,000	$131,120,500	($9,684,000)	($15,033,600)
78	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$231,553,000	$0	$209,844,000	$0	($21,709,000)	$0
1078	DPH PHYSICIAN & NON-PHYS. COST	$181,065,000	$0	$85,031,000	$0	($96,034,000)	$0
1899	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	$134,080,000	($1,388,000)	$132,843,000	($1,169,000)	($1,237,000)	$219,000
104	FFP FOR LOCAL TRAUMA CENTERS	$131,325,000	$0	$181,489,000	$0	$50,164,000	$0
82	CAPITAL PROJECT DEBT REIMBURSEMENT	$81,745,000	$23,315,000	$79,036,000	$23,887,000	($2,709,000)	$572,000
1600	NDPH IGT SUPPLEMENTAL PAYMENTS	$43,685,000	($1,397,000)	$56,001,000	($972,000)	$12,316,000	$425,000
2049	PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS	$765,052,000	$287,732,000	$82,091,000	$30,787,050	($682,961,000)	($256,944,950)
1076	NDPH SUPPLEMENTAL PAYMENT	$18,234,000	$1,900,000	$2,320,000	$0	($15,914,000)	($1,900,000)
1616	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	$15,425,000	$0	$13,267,000	$0	($2,158,000)	$0
1038	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	$10,000,000	$5,000,000	$10,000,000	$5,000,000	$0	$0
1039	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	$8,000,000	$4,000,000	$8,000,000	$4,000,000	$0	$0
86	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	$7,087,000	$0	$3,113,000	$0	($3,974,000)	$0
2044	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	$6,226,000	$6,226,000	$6,954,000	$6,954,000	$728,000	$728,000
2303	FREE CLINICS AUGMENTATION	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$0	$0
2102	PROPOSITION 56 FUNDING	$0	($473,209,000)	$0	($461,274,000)	$0	$11,935,000

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 2025-26 AND 2026-27

		MAY 2026 EST. FOR 2025-26		MAY 2026 EST. FOR 2026-27		DIFFERENCE	
FRN.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	SUPPLEMENTAL PMNTS.						
1601	IGT ADMIN. & PROCESSING FEE	$0	($21,515,000)	$0	($26,073,000)	$0	($4,558,000)
1661	GEMT SUPPLEMENTAL PAYMENT PROGRAM	($9,594,000)	$0	($1,632,000)	$0	$7,962,000	$0
2572	DMPH GME IGT ADMIN. & PROCESSING FEE	$0	$0	$0	($230,000)	$0	($230,000)
2573	GRADUATE MEDICAL EDUCATION PAYMENTS TO DMPHS	$0	$0	$24,910,000	$0	$24,910,000	$0
	SUPPLEMENTAL PMNTS. SUBTOTAL	**$11,151,052,000**	**$525,697,100**	**$26,091,591,000**	**$268,189,550**	**$14,940,539,000**	**($257,507,550)**
	COVID-19						
2363	COVID-19 VACCINE FUNDING ADJUSTMENT	$0	($11,893,000)	$0	$0	$0	$11,893,000
2218	COVID-19 END OF UNWINDING FLEXIBILITIES	($1,437,539,000)	($453,124,300)	($3,788,312,000)	($1,243,336,600)	($2,350,773,000)	($790,212,300)
	COVID-19 SUBTOTAL	**($1,437,539,000)**	**($465,017,300)**	**($3,788,312,000)**	**($1,243,336,600)**	**($2,350,773,000)**	**($778,319,300)**
	STATE-ONLY CLAIMING						
2415	STATE-ONLY CLAIMING ADJUSTMENTS - RETRO ADJ.	$0	$686,577,000	$0	($275,950,000)	$0	($962,527,000)
	STATE-ONLY CLAIMING SUBTOTAL	**$0**	**$686,577,000**	**$0**	**($275,950,000)**	**$0**	**($962,527,000)**
	OTHER DEPARTMENTS						
1476	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$1,235,310,000	$0	$1,325,058,000	$0	$89,748,000	$0
	OTHER DEPARTMENTS SUBTOTAL	**$1,235,310,000**	**$0**	**$1,325,058,000**	**$0**	**$89,748,000**	**$0**
	OTHER						
2354	BEHAVIORAL HEALTH BRIDGE HOUSING	$281,087,000	$239,087,000	$43,000,000	$0	($238,087,000)	($239,087,000)
2208	SELF-DETERMINATION PROGRAM - CDDS	$345,739,000	$0	$441,206,000	$0	$95,467,000	$0
2329	QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES	$155,373,000	$23,306,000	$217,638,000	$26,607,000	$62,265,000	$3,301,000

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 2025-26 AND 2026-27

		MAY 2026 EST. FOR 2025-26		MAY 2026 EST. FOR 2026-27		DIFFERENCE	
FRN.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER						
2092	QAF WITHHOLD TRANSFER	$9,624,000	$4,812,000	$62,376,000	$31,188,000	$52,752,000	$26,376,000
2424	CYBHI - FEE SCHEDULE THIRD PARTY ADMINISTRATOR	$39,500,000	$39,500,000	$50,900,000	$0	$11,400,000	($39,500,000)
1232	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	$94,506,000	$0	$77,099,000	$0	($17,407,000)	$0
2346	EQUITY & PRACTICE TRANSFORMATION PAYMENTS	$59,200,000	$19,674,050	$27,300,000	$9,080,000	($31,900,000)	($10,594,050)
2097	MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG	$44,217,000	$0	$36,143,000	$0	($8,074,000)	$0
2549	PROPOSITION 36 FUNDING	$50,000,000	$50,000,000	$0	$0	($50,000,000)	($50,000,000)
2439	CALAIM - PATH WPC	$21,627,000	$0	$0	$0	($21,627,000)	$0
1975	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	$52,271,000	$26,867,000	$93,906,000	$48,267,000	$41,635,000	$21,400,000
2396	CARE ACT	$13,804,000	$13,804,000	$22,481,000	$22,481,000	$8,677,000	$8,677,000
111	INDIAN HEALTH SERVICES	$18,278,000	$6,092,500	$16,905,000	$5,635,000	($1,373,000)	($457,500)
2009	INFANT DEVELOPMENT PROGRAM	$34,868,000	$0	$27,727,000	$0	($7,141,000)	$0
2550	BACKFILL LOST TITLE X FAMILY PLANNING FUNDING	$15,000,000	$15,000,000	$0	$0	($15,000,000)	($15,000,000)
1526	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	$15,559,000	$7,120,000	$13,742,000	$6,236,000	($1,817,000)	($884,000)
2502	MISC. ONE-TIME PAYMENTS	$12,550,000	$12,550,000	$0	$0	($12,550,000)	($12,550,000)
2375	CYBHI - URGENT NEEDS AND EMERGENT ISSUES	$10,100,000	$10,100,000	$0	$0	($10,100,000)	($10,100,000)
2355	CALHOPE	$5,000,000	$0	$5,000,000	$0	$0	$0
2443	ASSET LIMIT INCREASE & ELIM. - CNTY BH FUNDING	$5,688,000	$5,688,000	$4,720,000	$4,720,000	($968,000)	($968,000)
1866	WPCS WORKERS' COMPENSATION	$620,000	$310,000	$620,000	$310,000	$0	$0
35	IMD ANCILLARY SERVICES	$0	$57,766,000	$0	$51,474,000	$0	($6,292,000)
1087	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	($87,385,000)	$0	($92,561,000)	$0	($5,176,000)
1760	HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	($84,698,000)	$0	($1,710,833,000)	$0	($1,626,135,000)
2034	CMS DEFERRED CLAIMS	$0	$477,700,000	$0	$200,000,000	$0	($277,700,000)

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 2025-26 AND 2026-27

		MAY 2026 EST. FOR 2025-26		MAY 2026 EST. FOR 2026-27		DIFFERENCE	
FRN.	**POLICY CHANGE TITLE**	**TOTAL FUNDS**	**GENERAL FUNDS**	**TOTAL FUNDS**	**GENERAL FUNDS**	**TOTAL FUNDS**	**GENERAL FUNDS**
	OTHER						
2156	INDIAN HEALTH SERVICES FUNDING SHIFT	$0	($28,729,000)	$0	($30,919,500)	$0	($2,190,500)
2503	MEDICAL PROVIDER INTERIM PAYMENT LOAN	$0	($2,541,324,000)	$0	$0	$0	$2,541,324,000
2484	HEALTH CARE SVCS. FINES AND PENALTIES	$0	($20,400,000)	$0	($12,502,000)	$0	$7,898,000
2551	HR 1 - UIS EMERGENCY ACA FMAP ADJUSTMENT	$0	$0	($51,500,000)	$106,778,000	($51,500,000)	$106,778,000
2563	ELIMINATE DENTAL FOR ADULT UIS	$0	$0	($360,827,000)	($360,827,000)	($360,827,000)	($360,827,000)
2531	RESIDENCY VERIFICATION IMPROVEMENTS	$0	$0	($418,230,000)	($126,360,000)	($418,230,000)	($126,360,000)
2497	QUALITY SANCTIONS	($1,460,000)	($730,000)	($2,000,000)	($1,000,000)	($540,000)	($270,000)
2054	ASSISTED LIVING WAIVER EXPANSION	($953,000)	($495,000)	$9,413,000	$4,890,000	$10,366,000	$5,385,000
2010	HCBA WAIVER EXPANSION	($10,118,000)	($5,102,000)	($28,808,000)	($14,528,000)	($18,690,000)	($9,426,000)
1906	COUNTY SHARE OF OTLICP-CCS COSTS	($17,000,000)	($17,000,000)	($17,000,000)	($17,000,000)	$0	$0
2343	COUNTY BH RECOUPMENTS	($85,546,000)	($85,546,000)	($85,547,000)	($85,547,000)	($1,000)	($1,000)
110	AUDIT SETTLEMENTS	$0	$57,239,000	$0	$0	$0	($57,239,000)
2590	MCO TAX REVENUE TO SUPPORT MEDI-CAL	$0	$0	$181,637,000	($1,700,000,000)	$181,637,000	($1,700,000,000)
	OTHER SUBTOTAL	**$1,169,534,000**	**($1,804,793,450)**	**$367,901,000**	**($3,634,411,500)**	**($801,633,000)**	**($1,829,618,050)**
	GRAND TOTAL	**$48,231,123,000**	**($7,987,098,900)**	**$60,215,790,000**	**($15,272,880,460)**	**$11,984,667,000**	**($7,285,781,560)**

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

COMPARISON OF FISCAL IMPACTS OF COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2025-26 AND 2026-27

		MAY 2026 EST. FOR 2025-26		MAY 2026 EST. FOR 2026-27		DIFFERENCE	
FRN	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	COUNTY ADMIN						
1704	COUNTY ADMINISTRATION ALLOCATION	$2,377,805,000	$1,188,902,500	$2,377,805,000	$1,188,902,500	$0	$0
214	SAWS	$200,841,000	$405,500	$196,915,000	$69,000	($3,926,000)	($336,500)
217	CALWORKS APPLICATIONS	$99,964,000	$49,982,000	$99,964,000	$49,982,000	$0	$0
1598	CASE MANAGEMENT FOR OTLICP	$44,763,000	$22,381,500	$46,391,000	$23,195,500	$1,628,000	$814,000
213	LOS ANGELES COUNTY HOSPITAL INTAKES	$20,166,000	$2,736,000	$20,166,000	$2,736,000	$0	$0
215	SAVE	$0	($4,000,000)	$0	($4,000,000)	$0	$0
1835	ENHANCED FEDERAL FUNDING	$0	($608,380,250)	$0	($633,390,000)	$0	($25,009,750)
2580	HR 1 - COUNTY ADMINISTRATION ALLOCATION	$0	$0	$262,101,000	$73,858,500	$262,101,000	$73,858,500
	COUNTY ADMIN SUBTOTAL	**$2,743,539,000**	**$652,027,250**	**$3,003,342,000**	**$701,353,500**	**$259,803,000**	**$49,326,250**
	DHCS-OTHER						
2389	CALAIM - PATH	$473,522,000	$214,535,000	$515,456,000	$181,355,000	$41,934,000	($33,180,000)
1721	COUNTY SPECIALTY MENTAL HEALTH ADMIN	$284,592,000	$10,643,000	$304,523,000	$13,912,000	$19,931,000	$3,269,000
1757	INTERIM AND FINAL COST SETTLEMENTS-SMHS	$186,894,000	$0	$182,450,000	$0	($4,444,000)	$0
230	CCS PROGRAM COUNTY ADMINISTRATIVE BUDGET	$204,223,000	$72,594,050	$206,028,000	$74,449,600	$1,805,000	$1,855,550
2289	CYBHI - BH SERVICES AND SUPPORTS PLATFORM	$175,900,000	$175,900,000	$109,900,000	$53,400,000	($66,000,000)	($122,500,000)
2167	MEDI-CAL RX - ADMINISTRATIVE COSTS	$158,298,000	$41,501,250	$127,329,000	$33,382,300	($30,969,000)	($8,118,950)
1963	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	$167,907,000	$0	$148,013,000	$0	($19,894,000)	$0
235	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	$153,579,000	$0	$148,168,000	$0	($5,411,000)	$0
1813	DRUG MEDI-CAL COUNTY ADMINISTRATION	$119,212,000	$632,000	$123,527,000	$571,000	$4,315,000	($61,000)
2517	CALAIM-BH-CONNECT WORKFORCE INITIATIVE	$95,095,000	$0	$213,750,000	$0	$118,655,000	$0
2491	BH TRANSFORMATION FUNDING FOR COUNTY BH DEPTS.	$93,508,000	$0	$17,001,000	$0	($76,507,000)	$0
231	POSTAGE & PRINTING	$71,362,000	$35,809,500	$71,362,000	$35,809,500	$0	$0

COMPARISON OF FISCAL IMPACTS OF COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2025-26 AND 2026-27

		MAY 2026 EST. FOR 2025-26		MAY 2026 EST. FOR 2026-27		DIFFERENCE	
FRN	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	DHCS-OTHER						
2288	CALAIM - POPULATION HEALTH MANAGEMENT	$71,365,000	$2,799,000	$54,604,000	$3,609,800	($16,761,000)	$810,800
1722	SMH MAA	$52,327,000	$0	$55,641,000	$0	$3,314,000	$0
2398	CALAIM - BH - CONNECT DEMONSTRATION ADMIN	$65,490,000	$8,433,000	$176,866,000	$8,433,000	$111,376,000	$0
1937	ACTUARIAL COSTS FOR RATE DEVELOPMENT	$41,000,000	$20,350,000	$45,000,000	$22,500,000	$4,000,000	$2,150,000
1551	MEDI-CAL RECOVERY CONTRACTS	$41,445,000	$10,361,250	$35,100,000	$8,775,000	($6,345,000)	($1,586,250)
252	ENTERPRISE DATA ENVIRONMENT	$29,978,000	$8,053,600	$52,166,000	$13,901,700	$22,188,000	$5,848,100
1748	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	$29,494,000	$15,018,300	$28,424,000	$14,433,450	($1,070,000)	($584,850)
1137	MITA	$33,594,000	$4,266,300	$45,858,000	$5,824,750	$12,264,000	$1,558,450
2505	ELECTRONIC VISIT VERIFICATION M&O COSTS	$37,762,000	$0	$39,190,000	$0	$1,428,000	$0
2402	EMSA - CALIFORNIA POISON CONTROL SYSTEM SVCS.	$16,289,000	$0	$18,291,000	$0	$2,002,000	$0
2152	HCBA WAIVER ADMINISTRATIVE COST	$22,026,000	$11,108,000	$23,380,000	$11,791,000	$1,354,000	$683,000
1932	PAVE SYSTEM	$16,316,000	$4,526,700	$30,784,000	$8,631,350	$14,468,000	$4,104,650
1318	CAPMAN	$19,788,000	$5,113,450	$19,309,000	$5,068,250	($479,000)	($45,200)
1720	PASRR	$11,373,000	$2,843,250	$9,637,000	$2,409,250	($1,736,000)	($434,000)
1370	PUBLIC HEALTH REGISTRIES SUPPORT	$0	$0	$13,480,000	$0	$13,480,000	$0
1732	SDMC SYSTEM M&O SUPPORT	$2,689,000	$1,344,500	$2,319,000	$1,159,500	($370,000)	($185,000)
2002	ELECTRONIC ASSET VERIFICATION PROGRAM	$8,632,000	$4,316,000	$10,909,000	$5,454,500	$2,277,000	$1,138,500
2447	CALAIM - JUSTICE INVOLVED MAA	$0	$0	$8,000,000	$4,000,000	$8,000,000	$4,000,000
1452	PROTECTION OF PHI DATA	$5,538,000	$2,769,000	$14,980,000	$7,490,000	$9,442,000	$4,721,000
2414	BHSF - PROVIDER ACES TRAININGS	$7,415,000	$0	$0	$0	($7,415,000)	$0
2467	MOBILE VISION SERVICES	$2,114,000	$0	$2,208,000	$0	$94,000	$0
1982	MEDCOMPASS SOLUTION	$7,036,000	$1,849,800	$8,062,000	$2,119,900	$1,026,000	$270,100
1824	NEWBORN HEARING SCREENING PROGRAM	$6,220,000	$3,110,000	$6,313,000	$3,156,500	$93,000	$46,500

COMPARISON OF FISCAL IMPACTS OF COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2025-26 AND 2026-27

		MAY 2026 EST. FOR 2025-26		MAY 2026 EST. FOR 2026-27		DIFFERENCE	
FRN	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	DHCS-OTHER						
2334	COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE	$0	$0	$13,267,000	$5,907,000	$13,267,000	$5,907,000
2206	DRUG MEDI-CAL PARITY RULE ADMINISTRATION	$5,875,000	$1,958,000	$5,875,000	$1,958,000	$0	$0
1972	PACES	$3,761,000	$988,550	$4,318,000	$1,135,050	$557,000	$146,500
2413	CALAIM - INMATE PRE-RELEASE PROGRAM ADMIN	$2,746,000	$1,373,000	$2,746,000	$1,373,000	$0	$0
2358	STATEWIDE VERIFICATION HUB	$112,000	$11,200	$0	$0	($112,000)	($11,200)
1902	DATA ANALYTICS	$3,357,000	$930,000	$5,641,000	$1,829,000	$2,284,000	$899,000
2321	MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM	$2,200,000	$1,100,000	$2,200,000	$1,100,000	$0	$0
2392	MFP/CCT SUPPLEMENTAL FUNDING	$1,871,000	$0	$1,952,000	$0	$81,000	$0
1768	T-MSIS	$1,849,000	$445,050	$1,887,000	$473,750	$38,000	$28,700
237	SSA COSTS FOR HEALTH COVERAGE INFO.	$1,800,000	$900,000	$1,820,000	$910,000	$20,000	$10,000
1441	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$1,022,000	$293,000	$994,000	$279,000	($28,000)	($14,000)
1675	FAMILY PACT PROGRAM ADMIN.	$1,568,000	$784,000	$1,100,000	$550,000	($468,000)	($234,000)
2362	RECOVERY INCENTIVES CONTINGENCY MANAGEMENT ADMIN	$1,046,000	$0	$1,275,000	$0	$229,000	$0
266	MMA - DSH ANNUAL INDEPENDENT AUDIT	$444,000	$222,000	$613,000	$306,500	$169,000	$84,500
2159	HEALTH INFORMATION EXCHANGE INTEROPERABILITY	$250,000	$31,700	$2,750,000	$349,400	$2,500,000	$317,700
1556	CCT OUTREACH - ADMINISTRATIVE COSTS	$364,000	$0	$364,000	$0	$0	$0
2438	HEALTH PLAN OF SAN MATEO DENTAL INTEGRATION EVAL	$186,000	$0	$152,000	$0	($34,000)	$0
2123	CMS DEFERRED CLAIMS - OTHER ADMIN	$0	$582,438,000	$0	$145,000,000	$0	($437,438,000)
2459	DESIGNATED STATE HEALTH PROGRAMS	$0	($178,255,000)	$0	($346,856,000)	$0	($168,601,000)
2562	EPTP - STATEWIDE LEARNING COLLABORATIVE	$6,900,000	$3,450,000	$2,900,000	$1,450,000	($4,000,000)	($2,000,000)
2559	STATE ONLY CLAIMING ADJUSTMENTS - ADMIN.	$0	$622,631,000	$0	$600,000,000	$0	($22,631,000)
2552	TRANSFORMING MATERNAL HEALTH PROVIDER INFR PYMT	$0	$0	$1,750,000	$0	$1,750,000	$0

COMPARISON OF FISCAL IMPACTS OF COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2025-26 AND 2026-27

		MAY 2026 EST. FOR 2025-26		MAY 2026 EST. FOR 2026-27		DIFFERENCE	
FRN	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	DHCS-OTHER						
2567	HR 1 - HEALTH ENROLLMENT NAVIGATORS	$0	$0	$4,000,000	$0	$4,000,000	$0
2592	RECONCILIATION - ADMIN	$0	$0	($81,400,000)	($7,700,000)	($81,400,000)	($7,700,000)
2593	PROPOSITION 35 FUNDING – CYBHI & BH-CONNECT	$0	$0	$0	($66,000,000)	$0	($66,000,000)
	DHCS-OTHER SUBTOTAL	**$2,747,334,000**	**$1,697,177,450**	**$2,842,232,000**	**$863,702,050**	**$94,898,000**	**($833,475,400)**
	DHCS-MEDICAL FI						
2115	MEDICAL FI BO & IT COST REIMBURSEMENT	$63,944,000	$17,717,850	$65,381,000	$18,193,950	$1,437,000	$476,100
2117	MEDICAL FI BO & IT CHANGE ORDERS	$41,156,000	$10,822,150	$36,601,000	$9,622,300	($4,555,000)	($1,199,850)
2119	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	$45,487,000	$11,959,900	$50,974,000	$13,402,000	$5,487,000	$1,442,100
2118	MEDICAL INFRASTRUCTURE & DATA MGT SVCS	$44,894,000	$11,801,950	$35,744,000	$9,395,950	($9,150,000)	($2,406,000)
2112	MEDICAL FI BO OTHER ESTIMATED COSTS	$26,475,000	$7,953,850	$26,951,000	$8,098,750	$476,000	$144,900
2116	MEDICAL FI BO TELEPHONE SERVICE CENTER	$19,370,000	$5,799,000	$19,718,000	$5,902,600	$348,000	$103,600
2111	MEDICAL FI BUSINESS OPERATIONS	$17,655,000	$4,638,550	$17,972,000	$4,722,850	$317,000	$84,300
2113	MEDICAL FI BO HOURLY REIMBURSEMENT	$12,768,000	$3,356,850	$12,998,000	$3,417,200	$230,000	$60,350
2114	MEDICAL FI BO MISCELLANEOUS EXPENSES	$1,199,000	$329,100	$1,189,000	$325,850	($10,000)	($3,250)
2564	HR 1 - PROHIBITED ENTITIES SYSTEMS COSTS	$547,000	$547,000	$137,000	$137,000	($410,000)	($410,000)
2594	UIS MEMBER TRANSITION TO FFS SYSTEMS COSTS	$0	$0	$33,300,000	$33,300,000	$33,300,000	$33,300,000
	DHCS-MEDICAL FI SUBTOTAL	**$273,495,000**	**$74,926,200**	**$300,965,000**	**$106,518,450**	**$27,470,000**	**$31,592,250**
	DHCS-HEALTH CARE OPT						
2051	HCO OPERATIONS	$36,760,000	$18,104,300	$36,638,000	$18,044,200	($122,000)	($60,100)
2052	HCO COST REIMBURSEMENT	$34,987,000	$17,237,750	$40,621,000	$20,089,550	$5,634,000	$2,851,800
2053	HCO ESR HOURLY REIMBURSEMENT	$15,590,000	$7,678,000	$15,590,000	$7,678,000	$0	$0
	DHCS-HEALTH CARE OPT SUBTOTAL	**$87,337,000**	**$43,020,050**	**$92,849,000**	**$45,811,750**	**$5,512,000**	**$2,791,700**

COMPARISON OF FISCAL IMPACTS OF COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2025-26 AND 2026-27

		MAY 2026 EST. FOR 2025-26		MAY 2026 EST. FOR 2026-27		DIFFERENCE	
FRN	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	DHCS-DENTAL FI						
2380	DENTAL FI-DBO ADMIN 2022 CONTRACT	$162,882,000	$43,563,500	$132,472,000	$35,565,000	($30,410,000)	($7,998,500)
2006	DENTAL FI ADMINISTRATION 2016 CONTRACT	$18,474,000	$4,635,500	$18,760,000	$4,698,000	$286,000	$62,500
	DHCS-DENTAL FI SUBTOTAL	**$181,356,000**	**$48,199,000**	**$151,232,000**	**$40,263,000**	**($30,124,000)**	**($7,936,000)**
	OTHER DEPARTMENTS						
236	PERSONAL CARE SERVICES	$598,333,000	$0	$653,534,000	$0	$55,201,000	$0
233	HEALTH-RELATED ACTIVITIES - CDSS	$241,720,000	$0	$804,896,000	$0	$563,176,000	$0
1679	CALHEERS DEVELOPMENT	$173,104,000	$46,130,500	$227,558,000	$62,032,900	$54,454,000	$15,902,400
234	MATERNAL AND CHILD HEALTH	$90,793,000	$0	$114,846,000	$0	$24,053,000	$0
243	CDDS ADMINISTRATIVE COSTS	$143,008,000	$0	$129,193,000	$0	($13,815,000)	$0
256	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$57,744,000	$0	$60,356,000	$0	$2,612,000	$0
246	HCPCFC CASE MANAGEMENT	$74,400,000	$4,929,000	$74,400,000	$4,929,000	$0	$0
2455	HCPCFC ADMIN COSTS	$23,757,000	$11,878,500	$23,757,000	$11,878,500	$0	$0
1192	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	$8,761,000	$0	$13,656,000	$0	$4,895,000	$0
253	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$7,570,000	$0	$8,200,000	$0	$630,000	$0
2244	FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG	$8,052,000	$0	$8,391,000	$0	$339,000	$0
239	CLPP CASE MANAGEMENT SERVICES	$6,502,000	$0	$13,726,000	$0	$7,224,000	$0
1680	CALIFORNIA SMOKERS' HELPLINE	$2,353,000	$0	$3,564,000	$0	$1,211,000	$0
257	CALHHS AGENCY HIPAA FUNDING	$1,749,000	$874,500	$1,908,000	$954,000	$159,000	$79,500
1665	MEDI-CAL INPATIENT SERVICES FOR INMATES	$1,144,000	$0	$1,189,000	$0	$45,000	$0
232	VETERANS BENEFITS	$1,100,000	$0	$1,100,000	$0	$0	$0
1774	VITAL RECORDS	$883,000	$4,000	$883,000	$4,000	$0	$0

COMPARISON OF FISCAL IMPACTS OF COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2025-26 AND 2026-27

		MAY 2026 EST. FOR 2025-26		MAY 2026 EST. FOR 2026-27		DIFFERENCE	
FRN	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER DEPARTMENTS						
249	KIT FOR NEW PARENTS	$108,000	$0	$83,000	$0	($25,000)	$0
263	MERIT SYSTEM SERVICES FOR COUNTIES	$202,000	$101,000	$211,000	$105,500	$9,000	$4,500
1114	PIA EYEWEAR COURIER SERVICE	$726,000	$363,000	$894,000	$447,000	$168,000	$84,000
	OTHER DEPARTMENTS SUBTOTAL	**$1,442,009,000**	**$64,280,500**	**$2,142,345,000**	**$80,350,900**	**$700,336,000**	**$16,070,400**
	GRAND TOTAL	**$7,475,070,000**	**$2,579,630,450**	**$8,532,965,000**	**$1,837,999,650**	**$1,057,895,000**	**($741,630,800)**

FISCAL YEAR 2026-27 COST PER ELIGIBLE BASED ON MAY 2026 ESTIMATE

SERVICE CATEGORY	TITLE 19 CHILDREN	TITLE 19 ADULTS	TITLE 21	ACA EXPANSION	SPDS	LTC AID CODES
PHYSICIANS	$136,708,300	$60,123,100	$25,001,300	$110,018,980	$67,628,560	$1,637,400
OTHER MEDICAL	$1,684,077,540	$1,911,097,070	$440,930,110	$2,657,206,780	$1,578,385,330	$24,842,530
CO. & COMM. OUTPATIENT	$192,611,330	$89,038,040	$52,768,900	$141,516,310	$146,147,420	$219,910
PHARMACY	$1,031,617,350	$3,268,738,060	$464,450,840	$7,006,291,290	$4,021,090,360	$30,914,770
COUNTY INPATIENT	$171,424,390	$82,316,000	$9,917,140	$493,193,560	$60,228,480	$898,220
COMMUNITY INPATIENT	$1,771,624,350	$454,434,500	$147,272,090	$1,220,901,060	$586,894,150	$8,047,050
NURSING FACILITIES	$11,219,690	$4,182,890	$781,950	$50,509,230	$447,570,910	$217,863,960
ICF-DD	$1,448,560	$0	$0	$182,970	$3,522,320	$2,741,810
MEDICAL TRANSPORTATION	$17,308,870	$36,157,620	$1,896,830	$53,785,630	$21,404,790	$648,930
OTHER SERVICES	$344,130,500	$179,446,890	$104,493,850	$112,853,710	$1,664,238,230	$26,781,150
HOME HEALTH	$36,550,050	$263,210	$12,062,750	$1,814,520	$82,709,200	$670
FFS SUBTOTAL	**$5,398,720,940**	**$6,085,797,360**	**$1,259,575,760**	**$11,848,274,040**	**$8,679,819,740**	**$314,596,390**
DENTAL	$936,166,690	$372,368,150	$314,325,030	$626,913,500	$370,969,260	$26,184,020
MENTAL HEALTH	$3,423,871,320	$821,049,530	$925,943,270	$2,966,493,950	$2,528,436,370	$17,946,650
TWO PLAN MODEL	$4,537,669,360	$5,961,165,510	$1,698,560,030	$18,617,912,060	$17,546,501,390	$291,279,560
COUNTY ORGANIZED HEALTH SYSTEMS	$2,178,323,410	$3,430,685,930	$943,848,570	$9,586,558,770	$8,666,355,150	$146,510,390
GEOGRAPHIC MANAGED CARE	$649,652,860	$944,808,350	$272,677,930	$2,875,071,700	$2,963,645,720	$38,556,280
PHP & OTHER MANAG. CARE	$547,350	$1,542,170	($1,897,170)	$42,486,900	$2,872,792,280	$33,900,550
MEDICARE PAYMENTS	$0	$160,186,560	$0	$376,787,120	$9,874,278,150	$228,915,030
STATE HOSP./DEVELOPMENTAL CNTRS.	$0	($15,820)	($16,970)	$0	($904,430)	$0
MISC. SERVICES	$6,334,010	$9,435,810	$0	$18,656,570	$614,561,980	$0
DRUG MEDI-CAL	$297,229,920	$312,379,660	$293,853,100	$323,924,470	$312,013,120	$297,348,390
REGIONAL MODEL	$15,302,680	$31,399,490	$9,174,670	$120,434,960	$147,344,090	$5,223,220
NON-FFS SUBTOTAL	**$12,045,097,590**	**$12,045,005,360**	**$4,456,468,480**	**$35,555,240,010**	**$45,895,993,070**	**$1,085,864,100**
TOTAL DOLLARS (1)	**$17,443,818,530**	**$18,130,802,720**	**$5,716,044,240**	**$47,403,514,050**	**$54,575,812,810**	**$1,400,460,490**
ELIGIBLES * **	**3,411,900**	**2,097,200**	**1,265,200**	**4,545,600**	**2,477,500**	**50,200**
ANNUAL $/ELIGIBLE	**$5,113**	**$8,645**	**$4,518**	**$10,428**	**$22,029**	**$27,898**
AVG. MO. $/ELIGIBLE	**$426**	**$720**	**$376**	**$869**	**$1,836**	**$2,325**

(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 2026-27 COST PER ELIGIBLE BASED ON MAY 2026 ESTIMATE

SERVICE CATEGORY	TOTAL
PHYSICIANS	$401,117,640
OTHER MEDICAL	$8,296,539,360
CO. & COMM. OUTPATIENT	$622,301,900
PHARMACY	$15,823,102,660
COUNTY INPATIENT	$817,977,770
COMMUNITY INPATIENT	$4,189,173,200
NURSING FACILITIES	$732,128,630
ICF-DD	$7,895,660
MEDICAL TRANSPORTATION	$131,202,680
OTHER SERVICES	$2,431,944,330
HOME HEALTH	$133,400,400
FFS SUBTOTAL	$33,586,784,240
DENTAL	$2,646,926,640
MENTAL HEALTH	$10,683,741,100
TWO PLAN MODEL	$48,653,087,920
COUNTY ORGANIZED HEALTH SYSTEMS	$24,952,282,230
GEOGRAPHIC MANAGED CARE	$7,744,412,840
PHP & OTHER MANAG. CARE	$2,949,372,100
MEDICARE PAYMENTS	$10,640,166,870
STATE HOSP./DEVELOPMENTAL CNTRS.	($937,220)
MISC. SERVICES	$648,988,380
DRUG MEDI-CAL	$1,836,748,650
REGIONAL MODEL	$328,879,110
NON-FFS SUBTOTAL	$111,083,668,600
TOTAL DOLLARS (1)	$144,670,452,830
ELIGIBLES ***	13,847,600
ANNUAL $/ELIGIBLE	$10,447
AVG. MO. $/ELIGIBLE	$871

(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 2026-27 BENEFITS COST PER ELIGIBLE BASED ON MAY 2026 ESTIMATE

EXCLUDED POLICY CHANGES: 103

FISCAL REF NO.	POLICY CHANGE TITLE
2125	QAF WITHHOLD TRANSFER ADJUSTMENT
2126	QAF WITHHOLD ADJUSTMENT
3	BREAST AND CERVICAL CANCER TREATMENT
2422	HEALTH ENROLLMENT NAVIGATORS FOR CLINICS
2155	CS3 PROXY ADJUSTMENT
1595	COMMUNITY FIRST CHOICE OPTION
1791	1% FMAP INCREASE FOR PREVENTIVE SERVICES
1821	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.
1	FAMILY PACT PROGRAM
1228	CALIFORNIA COMMUNITY TRANSITIONS COSTS
2194	PHARMACY RETROACTIVE ADJUSTMENTS
1449	LITIGATION SETTLEMENTS
51	FAMILY PACT DRUG REBATES
1723	DRUG MEDI-CAL PROGRAM COST SETTLEMENT
1660	IMPERIAL AND SISKIYOU COUNTY MHP OVERPAYMENT
1713	INTERIM AND FINAL COST SETTLEMENTS - SMHS
1951	GLOBAL PAYMENT PROGRAM
2245	CALAIM ECM-COMMUNITY SUPPORTS-TRANSITIONAL RENT
1769	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG
2408	2023 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.
2504	MEDI-CAL MANAGED CARE QUALITY WITHHOLD RELEASE
1029	DENTAL MANAGED CARE (Other M/C)
2499	COMMUNITY CLINIC DIRECTED PAYMENT PROGRAM
1837	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL
1823	COUNTY CHILDREN’S HEALTH INITIATIVE PROGRAM
1797	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL
2406	2023 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ
2407	2023 MCO ENROLLMENT TAX MANAGED CARE PLANS
2063	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND
2081	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF
1784	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES
2509	PROP 35 - PROVIDER PAYMENT INCREASE FUNDING

FISCAL YEAR 2026-27 BENEFITS COST PER ELIGIBLE BASED ON MAY 2026 ESTIMATE

EXCLUDED POLICY CHANGES: 103

FISCAL REF NO.	POLICY CHANGE TITLE
2055	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS
1475	HOSPITAL QAF - FFS PAYMENTS
1761	HOSPITAL QAF - MANAGED CARE PAYMENTS
2024	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS
1071	PRIVATE HOSPITAL DSH REPLACEMENT
1073	DSH PAYMENT
1085	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
2130	PROP 56 - MEDI-CAL FAMILY PLANNING
78	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS
1078	DPH PHYSICIAN & NON-PHYS. COST
1899	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS
104	FFP FOR LOCAL TRAUMA CENTERS
82	CAPITAL PROJECT DEBT REIMBURSEMENT
1600	NDPH IGT SUPPLEMENTAL PAYMENTS
2049	PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS
1076	NDPH SUPPLEMENTAL PAYMENT
1616	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS
1038	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH
1039	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH
86	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS
2044	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS
2303	FREE CLINICS AUGMENTATION
2102	PROPOSITION 56 FUNDING
1601	IGT ADMIN. & PROCESSING FEE
1661	GEMT SUPPLEMENTAL PAYMENT PROGRAM
2415	STATE-ONLY CLAIMING ADJUSTMENTS - RETRO ADJ.
1476	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS
22	PERSONAL CARE SERVICES (Misc. Svcs.)
23	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)
2354	BEHAVIORAL HEALTH BRIDGE HOUSING
26	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)
2208	SELF-DETERMINATION PROGRAM - CDDS

FISCAL YEAR 2026-27 BENEFITS COST PER ELIGIBLE BASED ON MAY 2026 ESTIMATE

EXCLUDED POLICY CHANGES: 103

FISCAL REF NO.	POLICY CHANGE TITLE
2080	LAWSUITS/CLAIMS
2092	QAF WITHHOLD TRANSFER
2424	CYBHI - FEE SCHEDULE THIRD PARTY ADMINISTRATOR
1232	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS
2346	EQUITY & PRACTICE TRANSFORMATION PAYMENTS
2097	MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG
2439	CALAIM - PATH WPC
1975	MINIMUM WAGE INCREASE FOR HCBS WAIVERS
77	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC
2009	INFANT DEVELOPMENT PROGRAM
2550	BACKFILL LOST TITLE X FAMILY PLANNING FUNDING
1526	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS
2502	MISC. ONE-TIME PAYMENTS
2375	CYBHI - URGENT NEEDS AND EMERGENT ISSUES
27	MEDI-CAL TCM PROGRAM
2355	CALHOPE
2443	ASSET LIMIT INCREASE & ELIM. - CNTY BH FUNDING
1087	CIGARETTE AND TOBACCO SURTAX FUNDS
1760	HOSPITAL QAF - CHILDREN'S HEALTH CARE
2034	CMS DEFERRED CLAIMS
2503	MEDICAL PROVIDER INTERIM PAYMENT LOAN
2551	HR 1 - UIS EMERGENCY ACA FMAP ADJUSTMENT
2563	ELIMINATE DENTAL FOR ADULT UIS
2497	QUALITY SANCTIONS
2054	ASSISTED LIVING WAIVER EXPANSION
2010	HCBA WAIVER EXPANSION
1906	COUNTY SHARE OF OTLICP-CCS COSTS
2343	COUNTY BH RECOUPMENTS
127	BASE RECOVERIES
2558	MCP NETWORK ADEQUACY & TIMELY ACCESS SANCTIONS
2553	HR 1 - REDUCED RETROACTIVE MEDI-CAL TIMEFRAMES
2569	IMPROVEMENTS AND EFFICIENCIES

FISCAL YEAR 2026-27 BENEFITS COST PER ELIGIBLE BASED ON MAY 2026 ESTIMATE

EXCLUDED POLICY CHANGES: 103

FISCAL REF NO.	POLICY CHANGE TITLE
110	AUDIT SETTLEMENTS
2572	DMPH GME IGT ADMIN. & PROCESSING FEE
2573	GRADUATE MEDICAL EDUCATION PAYMENTS TO DMPHS
2582	OVERPAYMENTS FOR REPRODUCTIVE HEALTH
2585	2027 MCO TAX CAPITATION PAYMENTS
2586	2027 MCO TAX FUNDING ADJUSTMENT - CAPITATION
2587	2027 MCO TAX FUNDING ADJUSTMENT – GENERAL SUPPORT

TABLE OF CONTENTS

CASELOAD

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

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

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

CASELOAD GRAPHS ..... CL 1-14

STATEWIDE ELIGIBLES – INCLUDING THE IMPACT OF POLICY CHANGES ..... CL 1-7
STATEWIDE ELIGIBLES: ALL AID CATEGORIES ..... CL 1
STATEWIDE ELIGIBLES: TITLE 19 CHILDREN ..... CL 2
STATEWIDE ELIGIBLES: TITLE 19 ADULTS ..... CL 3
STATEWIDE ELIGIBLES: TITLE 21 ..... CL 4
STATEWIDE ELIGIBLES: ACA EXPANSION ..... CL 5
STATEWIDE ELIGIBLES: SPDS ..... CL 6
STATEWIDE ELIGIBLES: LTC AID CODES ..... CL 7
STATEWIDE ELIGIBLES – BASE PROJECTIONS ONLY ..... CL 8-14
STATEWIDE ELIGIBLES: ALL AID CATEGORIES ..... CL 8
STATEWIDE ELIGIBLES: TITLE 19 CHILDREN ..... CL 9
STATEWIDE ELIGIBLES: TITLE 19 ADULTS ..... CL 10
STATEWIDE ELIGIBLES: TITLE 21 ..... CL 11
STATEWIDE ELIGIBLES: ACA EXPANSION ..... CL 12
STATEWIDE ELIGIBLES: SPDS ..... CL 13
STATEWIDE ELIGIBLES: LTC AID CODES ..... CL 14

MEDI-CAL AID CATEGORY DEFINITIONS ..... CL 15

Estimated Average Monthly Certified Eligibles
May 2026 Estimate
Fiscal Years 2024-2025, 2025-2026, & 2026-2027

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

	2024-2025	2025-2026	2026-2027	24-25 To 25-26 % Change	25-26 To 26-27 % Change
ADULT	**9,906,800**	**9,624,900**	**9,170,500**	**-2.85%**	**-4.72%**
Affordable Care Act Expansion	5,032,200	4,846,000	4,545,600	-3.70%	-6.20%
Long Term Care Aid Codes	44,500	49,400	50,200	11.01%	1.62%
Seniors and Persons with Disabilities	2,431,900	2,497,800	2,477,500	2.71%	-0.81%
Title 19 Adults	2,398,200	2,231,700	2,097,200	-6.94%	-6.03%
CHILDREN	**4,965,400**	**4,762,600**	**4,677,100**	**-4.08%**	**-1.80%**
Title 19 Children	3,741,100	3,515,500	3,411,900	-6.03%	-2.95%
Title 21	1,224,300	1,247,100	1,265,200	1.86%	1.45%
Other	**7,300**	**8,700**	**8,400**	**19.18%**	**-3.45%**
Medi-Cal Access Program	7,300	8,700	8,400	19.18%	-3.45%
GRAND TOTAL	**14,879,500**	**14,396,200**	**13,856,000**	**-3.25%**	**-3.75%**

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 BCCTP Medi-Cal special program eligibles is not included above. The average monthly during FY 2024-25 is 753.
2/ Family PACT eligibles are also not included above.
3/ In N25 cycle, DHCS no longer report Tuberculosis, Dialysis, TPN and TCVAP in the footnote area.
Dialysis and TPN are part of SPDs. Tuberculosis and TCVAP are part of the Title 19 Adults aid 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 2024-25	2025-26	2026-27
COVID-19 End of Unwinding Flexibilities	Title 19 Children	0	(8,124)	(57,520)
	Title 19 Adults	0	(4,185)	(29,631)
	Title 21	0	0	0
	ACA Expansion	0	(21,625)	(132,593)
	SPDs	0	(4,645)	(35,091)
	LTC Aid Codes	0	(231)	(1,202)
	Total	**0**	**(38,810)**	**(256,037)**
Full Reinstatement of Asset Limit	SPDs	0	0	(25,547)
	LTC Aid Codes	0	0	(379)
	Total	**0**	**0**	**(25,926)**
Full-Scope Medi-Cal Expansion Enrollment Freeze	Title 19 Adults	0	(10,877)	(81,031)
	ACA Expansion	0	(12,727)	(94,814)
	SPDs	0	(1,914)	(14,258)
	Total	**0**	**(25,518)**	**(190,103)**
HR 1 - Death Master File Automation	Title 19 Adults	0	0	(245)
	Title 21	0	0	(128)
	ACA Expansion	0	0	(525)
	SPDs	0	0	(268)
	Total	**0**	**0**	**(1,166)**
HR 1 - Fed Work & Community Engagement Requirement	ACA Expansion	0	0	(42,900)
	Total	**0**	**0**	**(42,900)**
Medi-Cal Access Program Infants 266-322%	MCAP Infants	762	862	862
	Total	**762**	**862**	**862**
Medi-Cal Access Program Mothers 213-322%	MCAP Mothers	6,529	7,817	7,553
	Total	**6,529**	**7,817**	**7,553**
Medi-Cal State Inmates	SPDs	45	43	43
	Title 19 Children	3	2	2
	Title 19 Adults	3	2	2
	ACA Expansion	204	176	176
	LTC Aid Codes	1	2	2
	Total	**255**	**226**	**226**
Reinstatement of Asset Limit	SPDs	0	(6,603)	(48,760)
	LTC Aid Codes	0	(98)	(723)
	Total	**0**	**(6,701)**	**(49,482)**
Residency Verification Improvements	Title 19 Adults	0	0	(176)
	Title 21	0	0	(94)
	ACA Expansion	0	0	(380)
	SPDs	0	0	(189)
	Total	**0**	**0**	**(839)**
SB 525 Minimum Wage - Caseload Impact	Title 19 Adults	0	(514)	(4,424)
	ACA Expansion	0	(684)	(5,882)
	Total	**0**	**(1,198)**	**(10,306)**

	Budget Aid Category	2024-25	2025-26	2026-27
Total by Aid Category	Title 19 Children	3	(8,122)	(57,518)
	Title 19 Adults	3	(15,574)	(115,505)
	Title 21	0	0	(222)
	ACA Expansion	204	(34,860)	(276,918)
	SPDs	45	(13,119)	(124,069)
	LTC Aid Codes	1	(327)	(2,302)
	MCAP Infants	762	862	862
	MCAP Mothers	6,529	7,817	7,553
	Total	**7,546**	**(63,322)**	**(568,118)**

Comparison of Average Monthly Certified Eligibles
May 2026 Estimate
Fiscal Year 2025-26

(With Estimated Impact of Eligibility Policy Changes)

	Appropriaton 2025-2026	May 2026 2025-2026	Appropriation to May % Change
ADULT	**N/A**	**9,624,900**	**N/A**
Affordable Care Act Expansion	NA	4,846,000	N/A
Long Term Care Aid Codes	NA	49,400	N/A
Seniors and Persons with Disabilities	NA	2,497,800	N/A
Title 19 Adults	NA	2,231,700	N/A
CHILDREN	**N/A**	**4,762,600**	**N/A**
Title 19 Children	NA	3,515,500	N/A
Title 21	NA	1,247,100	N/A
Other	**7,000**	**8,700**	**N/A**
Medi-Cal Access Program	7,000	8,700	N/A
GRAND TOTAL	**14,873,800**	**14,396,200**	**-3.21%**

1/ The BCCTP Medi-Cal special program eligibles is not included above. The average monthly during FY 2024-25 is 753.

2/ The Appropriation for FY 2025-26 was published using 18 aid categories. Starting with the November 2025 estimate, DHCS consolidated these 18 aid categories to 6 new aid categories: Title 19 Children, Title 19 Adults, Title 21, ACA Expansion, SPDs and LTC aid codes to better align with DHCS rate setting. Due to this change, the FY 2025-26 Appropriation is not available for comparison in the new aid category format. The FY 2026-27 Appropriation will use the new aid category format.

Comparison of Average Monthly Certified Eligibles
May 2026 Estimate
Fiscal Year 2025-26 and 2026-27

(With Estimated Impact of Eligibility Policy Changes)

	November 2025 2025-2026	November 2025 2026-2027	May 2026 2025-2026	May 2026 2026-2027	% Change 2025-26	% Change 2026-27
ADULT	**9,764,700**	**9,344,200**	**9,624,900**	**9,170,500**	**-1.43%**	**-1.86%**
Affordable Care Act Expansion	4,916,800	4,591,700	4,846,000	4,545,600	-1.44%	-1.00%
Long Term Care Aid Codes	45,000	44,500	49,400	50,200	9.78%	12.81%
Seniors and Persons with Disabilities	2,545,300	2,574,400	2,497,800	2,477,500	-1.87%	-3.76%
Title 19 Adults	2,257,600	2,133,600	2,231,700	2,097,200	-1.15%	-1.71%
CHILDREN	**4,758,200**	**4,670,300**	**4,762,600**	**4,677,100**	**0.09%**	**0.15%**
Title 19 Children	3,543,000	3,458,300	3,515,500	3,411,900	-0.78%	-1.34%
Title 21	1,215,200	1,212,000	1,247,100	1,265,200	2.63%	4.39%
Other	**7,400**	**7,400**	**8,700**	**8,400**	**17.57%**	**13.51%**
Medi-Cal Access Program	7,400	7,400	8,700	8,400	17.57%	13.51%
GRAND TOTAL	**14,530,300**	**14,021,900**	**14,396,200**	**13,856,000**	**-0.92%**	**-1.18%**

Estimated Average Monthly Certified Eligibles
May 2026 Estimate
Fiscal Years 2024-2025, 2025-2026, & 2026-2027

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

	2024-2025	2025-2026	2026-2027	24-25 To 25-26 % Change	25-26 To 26-27 % Change
ADULT	**9,298,009**	**9,092,185**	**7,791,448**	**-2.21%**	**-14.31%**
Affordable Care Act Expansion	4,739,817	4,589,017	3,933,034	-3.18%	-14.29%
Long Term Care Aid Codes	40,809	45,775	40,633	12.17%	-11.23%
Seniors and Persons with Disabilities	2,289,766	2,366,676	1,986,947	3.36%	-16.04%
Title 19 Adults	2,227,618	2,090,717	1,830,835	-6.15%	-12.43%
CHILDREN	**4,649,039**	**4,505,756**	**4,308,069**	**-3.08%**	**-4.39%**
Title 19 Children	3,477,510	3,305,190	3,123,936	-4.96%	-5.48%
Title 21	1,171,529	1,200,566	1,184,133	2.48%	-1.37%
Other	**7,006**	**8,514**	**8,250**	**21.52%**	**-3.10%**
Medi-Cal Access Program	7,006	8,514	8,250	21.52%	-3.10%
GRAND TOTAL [2]	**13,954,054**	**13,606,456**	**12,107,767**	**-2.49%**	**-11.01%**
Percent of Statewide	**93.78%**	**94.51%**	**87.38%**		

[1] Eligibles enrolled or estimated to be enrolled in a medical Managed Care plan.
[2] The BCCTP Medi-Cal special program eligibles is not included above. The average monthly during FY 2024-25 is 753.

Estimated Average Monthly Certified Eligibles
May 2026 Estimate
Fiscal Years 2024-2025, 2025-2026, & 2026-2027

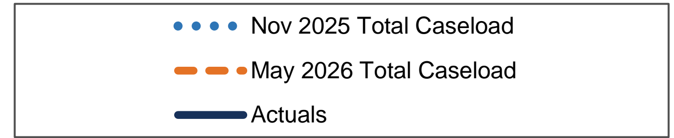
Fee-For-Service
(With Estimated Impact of Eligibility Policy Changes)**

	2024-2025	2025-2026	2026-2027	24-25 To 25-26 % Change	25-26 To 26-27 % Change
ADULT	**608,791**	**532,715**	**1,379,052**	**-12.50%**	**158.87%**
Affordable Care Act Expansion	292,383	256,983	612,566	-12.11%	138.37%
Long Term Care Aid Codes	3,692	3,625	9,567	-1.80%	163.89%
Seniors and Persons with Disabilities	142,134	131,124	490,553	-7.75%	274.11%
Title 19 Adults	170,582	140,983	266,365	-17.35%	88.93%
CHILDREN	**316,361**	**256,844**	**369,031**	**-18.81%**	**43.68%**
Title 19 Children	263,590	210,310	287,964	-20.21%	36.92%
Title 21	52,771	46,534	81,067	-11.82%	74.21%
Other	**294**	**186**	**150**	**-36.73%**	**-19.35%**
Medi-Cal Access Program	294	186	150	-36.73%	-19.35%
GRAND TOTAL	**925,446**	**789,744**	**1,748,233**	**-14.66%**	**121.37%**
Percent of Statewide	**6.22%**	**5.49%**	**12.62%**		

***** 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



Eligible Count

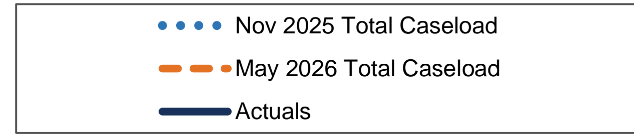
16,300,000
15,800,000
15,300,000
14,800,000
14,300,000
13,800,000
13,300,000
12,800,000

Jul 2022, Oct 2022, Jan 2023, Apr 2023, Jul 2023, Oct 2023, Jan 2024, Apr 2024, Jul 2024, Oct 2024, Jan 2025, Apr 2025, Jul 2025, Oct 2025, Jan 2026, Apr 2026, Jul 2026, Oct 2026, Jan 2027, Apr 2027

These projections reflect the impact of policy changes as displayed on page CL-B.

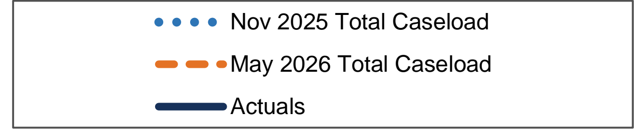
Statewide Caseload Projections, Including Impact of Policy Changes: Title 19 Children

Certified Average Monthly Eligible Count by Month



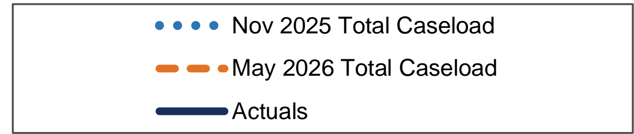
Statewide Caseload Projections, Including Impact of Policy Changes: Title 19 Adults

Certified Average Monthly Eligible Count by Month



Statewide Caseload Projections, Including Impact of Policy Changes: Title 21

Certified Average Monthly Eligible Count by Month



Eligible Count

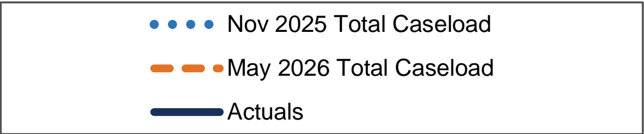
1,350,000
1,330,000
1,310,000
1,290,000
1,270,000
1,250,000
1,230,000
1,210,000
1,190,000
1,170,000
1,150,000

These projections reflect the impact of policy changes as displayed on page CL-B.

Jul 2022 | Oct 2022 | Jan 2023 | Apr 2023 | Jul 2023 | Oct 2023 | Jan 2024 | Apr 2024 | Jul 2024 | Oct 2024 | Jan 2025 | Apr 2025 | Jul 2025 | Oct 2025 | Jan 2026 | Apr 2026 | Jul 2026 | Oct 2026 | Jan 2027 | Apr 2027

Statewide Caseload Projections, Including Impact of Policy Changes: ACA Expansion

Certified Average Monthly Eligible Count by Month



Eligible Count

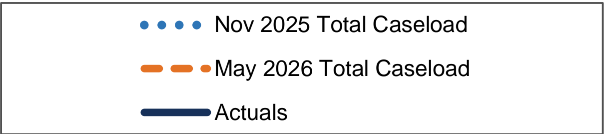
5,600,000
5,400,000
5,200,000
5,000,000
4,800,000
4,600,000
4,400,000
4,200,000
4,000,000
3,800,000
3,600,000

Jul 2022, Oct 2022, Jan 2023, Apr 2023, Jul 2023, Oct 2023, Jan 2024, Apr 2024, Jul 2024, Oct 2024, Jan 2025, Apr 2025, Jul 2025, Oct 2025, Jan 2026, Apr 2026, Jul 2026, Oct 2026, Jan 2027, Apr 2027

These projections reflect the impact of policy changes as displayed on page CL-B.

Statewide Caseload Projections, Including Impact of Policy Changes: SPDs

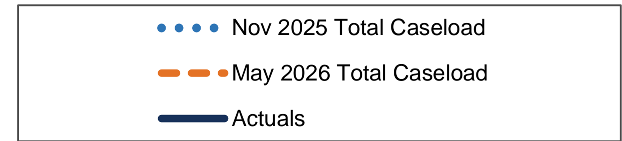
Certified Average Monthly Eligible Count by Month



These projections reflect the impact of policy changes as displayed on page CL-B.

Statewide Caseload Projections, Including Impact of Policy Changes: LTC Aid Codes

Certified Average Monthly Eligible Count by Month



Statewide Caseload Projections, Base Projection Only: All Aid Categories

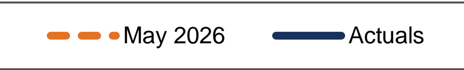
Certified Average Monthly Eligible Count by Month

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

For estimating purposes, the Medi-Cal eligibles are divided into six categories. Of these six, most can be categorized as Adults or Children.

Statewide Caseload Projections, Base Projection Only: Title 19 Children

Certified Average Monthly Eligible Count by Month



Eligible Count

4,100,000
4,000,000
3,900,000
3,800,000
3,700,000
3,600,000
3,500,000
3,400,000
3,300,000
3,200,000
3,100,000

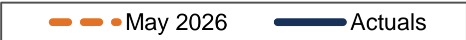
Jul 2022, Oct 2022, Jan 2023, Apr 2023, Jul 2023, Oct 2023, Jan 2024, Apr 2024, Jul 2024, Oct 2024, Jan 2025, Apr 2025, Jul 2025, Oct 2025, Jan 2026, Apr 2026, Jul 2026, Oct 2026, Jan 2027, Apr 2027

Statewide Caseload Projections, Base Projection Only: Title 19 Adults

Certified Average Monthly Eligible Count by Month

Statewide Caseload Projections, Base Projection Only: Title 21

Certified Average Monthly Eligible Count by Month



Eligible Count

1,330,000
1,310,000
1,290,000
1,270,000
1,250,000
1,230,000
1,210,000
1,190,000
1,170,000
1,150,000

Jul 2022 Oct 2022 Jan 2023 Apr 2023 Jul 2023 Oct 2023 Jan 2024 Apr 2024 Jul 2024 Oct 2024 Jan 2025 Apr 2025 Jul 2025 Oct 2025 Jan 2026 Apr 2026 Jul 2026 Oct 2026 Jan 2027 Apr 2027

Statewide Caseload Projections, Base Projection Only: ACA Expansion

Certified Average Monthly Eligible Count by Month

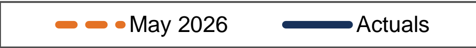
Eligible Count

5,600,000
5,400,000
5,200,000
5,000,000
4,800,000
4,600,000
4,400,000
4,200,000

Jul 2022 | Oct 2022 | Jan 2023 | Apr 2023 | Jul 2023 | Oct 2023 | Jan 2024 | Apr 2024 | Jul 2024 | Oct 2024 | Jan 2025 | Apr 2025 | Jul 2025 | Oct 2025 | Jan 2026 | Apr 2026 | Jul 2026 | Oct 2026 | Jan 2027 | Apr 2027

Statewide Caseload Projections, Base Projection Only: SPDs

Certified Average Monthly Eligible Count by Month



Statewide Caseload Projections, Base Projection Only: LTC Aid Codes

Certified Average Monthly Eligible Count by Month

MEDI-CAL AID CATEGORY DEFINITIONS

Aid Category	Aid Codes
Title 19 Children	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, 72, 74, P7, P8, 44, 48, 5F, 76, 7F, 7G, D8, D9, M0, M7, M8, M9, 47, 69, 8U, P0, P9, 01, 02, 08, 0A, 58, H7, H8, 4E, P1, P2, P3, P4, 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, 81, 86, 87, 8L, F3, F4, G3, G4, J1, J2, J3, J4, 2V, 4V, 5V, 7V, 77, 7H, I3, I5, I6
Title 19 Adults	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, 72, 74, P7, P8, 44, 48, 5F, 76, 7F, 7G, D8, D9, M0, M7, M8, M9, 47, 69, 8U, P0, P9, 01, 02, 08, 0A, 58, H7, H8, 4E, P1, P2, P3, P4, 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, 81, 86, 87, 8L, F3, F4, G3, G4, J1, J2, J3, J4, 2V, 4V, 5V, 7V, 77, 7H, I3, I5, I6
Title 21	5C, 5D, 8X, E6, H1, H2, H3, H4, H5, T0, T1, T2, T3, T4, T5, T6, T7, T8, T9, 8N, 8P, 8R, 8T, M5, M6, H0, H6, H9, I4
ACA Expansion	7U, K6, K7, L1, M1, M2, N0, N7, N8, I2
SPDs	10, 16, 1E, 14, 17, 1H, 1U, 1X, 1Y, C1, C2, 20, 26, 2E, 36, 60, 66, 6A, 6C, 6E, 6N, 6P, 24, 27, 2H, 64, 67, 6G, 6H, 6S, 6U, 6V, 6W, 6X, 6Y, 8G, C3, C4, C7, C8, K8, K9, L6, L7, 80, 71, 73, 7D
LTC Aid Codes	13, D2, D3, J5, J6, 23, 63, D4, D5, D6, D7, J7, J8, 53, 55
All Others	8H, 0L, 0M, 0N, 0P, 0R, 0T, 0U, 0V, 0W, 0X, 0Y, F1, F2, G1, G2, G9, G0, K2, K3, K4, K5, N5, N6, 0C, 0D, 0E, 0G, E7, 2C, E8

TABLE OF CONTENTS

FEE-FOR-SERVICE BASE

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

OVERVIEW OF MEDI-CAL FFS BASE EXPENDITURES..1-2

QUARTERLY OF SUMMARY OF FFS UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY 3-14

TOTAL FOR ALL SERVICES ACROSS ALL AID CATEGORIES 3
PHYSICIANS BASE ESTIMATE 4
OTHER MEDICAL BASE ESTIMATE 5
COUNTY & COMMUNITY OUTPATIENT BASE ESTIMATE 6
PHARMACY BASE ESTIMATE 7
COUNTY INPATIENT BASE ESTIMATE 8
COMMUNITY INPATIENT BASE ESTIMATE 9
NURSING FACILITIES BASE ESTIMATE 10
ICF-DD BASE ESTIMATE 11
MEDICAL TRANSPORTATION BASE ESTIMATE...12
OTHER SERVICES BASE ESTIMATE 13
HOME HEALTH BASE ESTIMATE 14

QUARTERLY OF SUMMARY OF FFS UTILIZATION AND EXPENDITURES BY AID CATEGORY 15-20

TITLE 19 CHILDREN 15
TITLE 19 ADULTS..16
TITLE 21 17
ACA EXPANSION 18
SPDS...19
LTC AID CODES 20

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 consists 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

May 2026 FFS Base Estimate

Fiscal Year		May Estimate Total Expenditure	
PY	FY 2024-25	$36,060,929,200	
CY	FY 2025-26	$39,810,216,200	10.40%
BY	FY 2026-27	$42,176,706,000	5.94%

Fiscal Year	FFS Base Expenditure		
	Nov-25	May-26	% Change
FY 2025-26	$39,751,866,100	$39,810,216,200	0.15%
FY 2026-27	$41,924,238,000	$42,176,706,000	0.60%

Overall, the May 2026 FFS Base is estimated at $39.8 billion for FY 2025-26 and $42.2 billion for FY 2026-27. The increase in the budget year is mainly from the Pharmacy service category, driven specifically by increasing average costs per pharmacy claim.

Items Impacting FFS Base Estimate

Overall Changes: Compared to the Nov 2025 estimate, the May 2026 estimate is nearly unchanged from the previous estimate. 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 MAY 2026 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
2023-24 *	1	4,696,520	3.44	$182.70	$628.86	$8,860,305,100
2023-24 *	2	4,446,690	3.11	$180.58	$561.74	$7,493,620,000
2023-24 *	3	4,689,060	3.28	$177.90	$583.11	$8,202,762,700
2023-24 *	4	4,354,280	3.02	$177.98	$537.35	$7,019,278,500
2023-24 *	TOTAL	4,546,640	3.22	$179.88	$578.74	$31,575,966,300
2024-25 *	1	4,943,880	3.47	$195.11	$677.01	$10,041,220,400
2024-25 *	2	4,775,230	3.27	$190.72	$624.24	$8,942,652,100
2024-25 *	3	4,898,530	3.24	$190.04	$616.51	$9,059,930,500
2024-25 *	4	4,492,840	3.05	$194.83	$594.81	$8,017,126,200
2024-25 *	TOTAL	4,777,620	3.26	$192.66	$628.99	$36,060,929,200
2025-26 *	1	4,975,360	3.57	$210.30	$750.56	$11,202,861,000
2025-26 *	2	4,822,660	3.36	$206.41	$694.32	$10,045,374,600
2025-26 **	3	4,796,060	3.34	$203.80	$680.54	$9,791,714,100
2025-26 **	4	4,459,210	3.22	$203.67	$655.59	$8,770,266,500
2025-26 **	TOTAL	4,763,320	3.38	$206.22	$696.47	$39,810,216,200
2026-27 **	1	4,969,180	3.74	$216.99	$811.19	$12,092,799,500
2026-27 **	2	4,867,350	3.58	$212.31	$761.12	$11,113,948,700
2026-27 **	3	4,694,730	3.20	$213.73	$682.94	$9,618,708,500
2026-27 **	4	4,487,110	3.27	$212.60	$694.68	$9,351,249,300
2026-27 **	TOTAL	4,754,590	3.45	$214.02	$739.23	$42,176,706,000

* 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 SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2026 BASE ESTIMATES)

PHYSICIANS

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2023-24 *	1	212,020	2.78	$95.25	$264.50	$168,234,300
2023-24 *	2	188,580	2.69	$94.77	$254.96	$144,244,600
2023-24 *	3	187,670	2.64	$95.79	$253.05	$142,466,000
2023-24 *	4	155,490	2.56	$102.06	$261.76	$122,102,600
2023-24 *	TOTAL	185,940	2.68	$96.63	$258.62	$577,047,400
2024-25 *	1	200,170	2.81	$104.29	$292.86	$175,863,200
2024-25 *	2	203,050	2.58	$99.98	$258.14	$157,243,900
2024-25 *	3	176,400	2.69	$104.14	$279.85	$148,099,300
2024-25 *	4	159,050	2.58	$97.21	$250.63	$119,591,800
2024-25 *	TOTAL	184,670	2.67	$101.64	$271.12	$600,798,100
2025-26 *	1	164,090	3.01	$103.58	$312.24	$153,700,600
2025-26 *	2	159,040	2.77	$101.87	$282.33	$134,705,200
2025-26 **	3	147,930	2.78	$101.96	$283.08	$125,630,200
2025-26 **	4	131,150	2.71	$101.15	$274.03	$107,818,500
2025-26 **	TOTAL	150,550	2.83	$102.24	$288.85	$521,854,500
2026-27 **	1	164,320	3.02	$103.88	$313.54	$154,556,200
2026-27 **	2	169,190	2.83	$100.73	$285.20	$144,763,600
2026-27 **	3	139,780	2.71	$100.68	$272.37	$114,217,600
2026-27 **	4	134,230	2.72	$100.79	$273.93	$110,309,600
2026-27 **	TOTAL	151,880	2.83	$101.64	$287.42	$523,847,000

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2026 BASE ESTIMATES)

OTHER MEDICAL

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2023-24 *	1	1,545,960	1.62	$203.24	$329.11	$1,526,389,500
2023-24 *	2	1,453,200	1.58	$206.81	$326.49	$1,423,341,700
2023-24 *	3	1,425,440	1.56	$217.48	$339.91	$1,453,574,100
2023-24 *	4	1,365,800	1.53	$220.47	$337.83	$1,384,208,300
2023-24 *	TOTAL	1,447,600	1.57	$211.57	$333.17	$5,787,513,700
2024-25 *	1	1,721,840	1.64	$222.87	$365.31	$1,886,993,600
2024-25 *	2	1,580,770	1.57	$235.18	$369.38	$1,751,727,600
2024-25 *	3	1,604,100	1.55	$241.32	$374.31	$1,801,298,500
2024-25 *	4	1,456,560	1.53	$241.56	$370.57	$1,619,274,700
2024-25 *	TOTAL	1,590,820	1.58	$234.66	$369.79	$7,059,294,500
2025-26 *	1	1,759,770	1.66	$249.53	$413.42	$2,182,585,600
2025-26 *	2	1,661,110	1.60	$257.09	$410.95	$2,047,900,500
2025-26 **	3	1,621,180	1.56	$256.87	$401.60	$1,953,194,100
2025-26 **	4	1,538,580	1.54	$255.35	$393.46	$1,816,097,600
2025-26 **	TOTAL	1,645,160	1.59	$254.54	$405.22	$7,999,777,800
2026-27 **	1	1,835,260	1.68	$255.44	$427.89	$2,355,851,300
2026-27 **	2	1,765,390	1.61	$256.58	$413.42	$2,189,544,900
2026-27 **	3	1,549,400	1.53	$258.59	$395.30	$1,837,441,000
2026-27 **	4	1,556,290	1.54	$255.34	$394.10	$1,840,028,000
2026-27 **	TOTAL	1,676,590	1.59	$256.42	$408.71	$8,222,865,200

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

QUARTERLY SUMMARY OF FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY (INCLUDES ACTUALS AND MAY 2026 BASE ESTIMATES)

CO. & COMM. OUTPATIENT

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2023-24 *	1	142,520	1.78	$206.55	$366.97	$156,899,100
2023-24 *	2	128,650	1.74	$208.55	$363.51	$140,300,600
2023-24 *	3	116,730	1.75	$225.91	$395.00	$138,328,600
2023-24 *	4	96,830	1.67	$230.06	$383.33	$111,352,800
2023-24 *	TOTAL	121,180	1.74	$216.27	$376.07	$546,881,100
2024-25 *	1	132,740	1.80	$246.00	$443.07	$176,442,800
2024-25 *	2	114,960	1.77	$226.06	$399.91	$137,923,600
2024-25 *	3	107,210	1.78	$257.13	$457.99	$147,310,000
2024-25 *	4	95,420	1.73	$272.90	$472.67	$135,305,900
2024-25 *	TOTAL	112,580	1.77	$249.15	$441.88	$596,982,300
2025-26 *	1	110,220	1.83	$289.54	$528.87	$174,884,200
2025-26 *	2	95,350	1.82	$305.26	$554.65	$158,660,700
2025-26 **	3	97,530	1.78	$292.25	$521.46	$152,580,300
2025-26 **	4	87,680	1.74	$292.89	$508.86	$133,847,600
2025-26 **	TOTAL	97,700	1.79	$294.82	$528.82	$619,972,800
2026-27 **	1	118,870	1.85	$287.59	$532.69	$189,961,700
2026-27 **	2	108,100	1.83	$286.73	$525.64	$170,464,100
2026-27 **	3	94,560	1.75	$296.45	$519.13	$147,273,400
2026-27 **	4	90,210	1.74	$293.58	$511.58	$138,449,000
2026-27 **	TOTAL	102,940	1.80	$290.61	$523.10	$646,148,300

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2026 BASE ESTIMATES)

PHARMACY

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2023-24 *	1	3,657,580	3.13	$142.13	$445.12	$4,884,133,300
2023-24 *	2	3,433,890	2.81	$138.69	$389.28	$4,010,220,600
2023-24 *	3	3,752,790	3.03	$139.60	$423.42	$4,767,001,800
2023-24 *	4	3,392,420	2.75	$143.49	$394.81	$4,018,114,000
2023-24 *	TOTAL	3,559,170	2.94	$140.95	$413.94	$17,679,469,700
2024-25 *	1	3,823,700	3.20	$155.50	$497.18	$5,703,183,800
2024-25 *	2	3,696,550	3.03	$153.41	$464.07	$5,146,326,400
2024-25 *	3	3,859,260	2.98	$152.96	$456.22	$5,281,971,200
2024-25 *	4	3,503,760	2.80	$161.94	$453.33	$4,765,048,700
2024-25 *	TOTAL	3,720,820	3.01	$155.74	$468.01	$20,896,530,100
2025-26 *	1	3,893,370	3.30	$175.91	$580.44	$6,779,595,600
2025-26 *	2	3,768,730	3.12	$173.74	$541.32	$6,120,317,100
2025-26 **	3	3,857,080	3.06	$167.01	$510.82	$5,910,876,900
2025-26 **	4	3,585,590	2.88	$169.35	$487.17	$5,240,362,300
2025-26 **	TOTAL	3,776,190	3.09	$171.67	$530.76	$24,051,151,900
2026-27 **	1	3,993,700	3.36	$180.74	$607.33	$7,276,504,400
2026-27 **	2	3,952,750	3.19	$178.22	$569.40	$6,752,075,500
2026-27 **	3	3,758,510	2.94	$178.05	$522.85	$5,895,377,700
2026-27 **	4	3,611,820	2.92	$180.69	$527.84	$5,719,368,500
2026-27 **	TOTAL	3,829,190	3.11	$179.44	$558.07	$25,643,326,100

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2026 BASE ESTIMATES)

COUNTY INPATIENT

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2023-24 *	1	3,580	5.86	$3,573.17	$20,940.33	$224,899,100
2023-24 *	2	3,210	5.43	$3,757.90	$20,387.86	$196,579,700
2023-24 *	3	3,120	5.85	$3,844.39	$22,477.25	$210,499,500
2023-24 *	4	2,210	5.82	$3,735.42	$21,736.31	$144,090,000
2023-24 *	TOTAL	3,030	5.73	$3,720.70	$21,334.62	$776,068,300
2024-25 *	1	2,750	5.90	$3,748.68	$22,111.28	$182,617,100
2024-25 *	2	2,400	6.04	$4,135.66	$24,997.38	$180,356,100
2024-25 *	3	2,300	6.36	$4,092.10	$26,033.72	$179,528,500
2024-25 *	4	1,760	6.41	$4,006.89	$25,670.33	$135,565,000
2024-25 *	TOTAL	2,300	6.15	$3,987.92	$24,522.32	$678,066,700
2025-26 *	1	2,330	6.34	$4,076.04	$25,846.96	$180,747,800
2025-26 *	2	1,880	6.40	$4,064.13	$26,023.57	$146,694,800
2025-26 **	3	1,930	6.66	$3,994.56	$26,610.73	$153,846,600
2025-26 **	4	1,630	6.59	$4,151.12	$27,358.07	$133,868,400
2025-26 **	TOTAL	1,940	6.49	$4,068.46	$26,396.44	$615,157,700
2026-27 **	1	2,400	6.53	$4,072.16	$26,593.98	$191,156,800
2026-27 **	2	2,230	6.49	$4,050.49	$26,280.46	$176,207,900
2026-27 **	3	1,860	6.76	$4,040.47	$27,309.15	$152,384,800
2026-27 **	4	1,720	6.59	$4,138.98	$27,263.93	$140,292,900
2026-27 **	TOTAL	2,050	6.58	$4,072.94	$26,810.72	$660,042,500

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2026 BASE ESTIMATES)

COMMUNITY INPATIENT

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2023-24 *	1	19,150	6.86	$2,507.45	$17,199.97	$988,103,700
2023-24 *	2	16,820	6.45	$2,444.66	$15,763.26	$795,587,400
2023-24 *	3	15,330	6.87	$2,460.99	$16,915.54	$778,114,800
2023-24 *	4	11,830	7.20	$2,548.56	$18,341.32	$651,006,800
2023-24 *	TOTAL	15,780	6.82	$2,488.38	$16,961.94	$3,212,812,800
2024-25 *	1	19,510	7.00	$2,492.02	$17,432.23	$1,020,134,000
2024-25 *	2	18,050	6.45	$2,443.99	$15,771.82	$853,870,700
2024-25 *	3	14,050	7.42	$2,567.55	$19,063.68	$803,762,700
2024-25 *	4	11,980	7.31	$2,539.89	$18,577.74	$667,832,600
2024-25 *	TOTAL	15,900	7.00	$2,506.59	$17,537.44	$3,345,600,000
2025-26 *	1	15,730	7.40	$2,477.56	$18,333.22	$865,053,200
2025-26 *	2	12,940	7.51	$2,664.49	$20,009.93	$776,865,400
2025-26 **	3	13,590	7.54	$2,665.37	$20,099.90	$819,736,600
2025-26 **	4	11,910	7.71	$2,704.06	$20,835.90	$744,573,700
2025-26 **	TOTAL	13,540	7.53	$2,620.27	$19,727.33	$3,206,228,900
2026-27 **	1	16,810	7.72	$2,708.83	$20,919.12	$1,054,987,700
2026-27 **	2	15,320	7.42	$2,711.22	$20,125.60	$924,785,500
2026-27 **	3	13,090	7.59	$2,748.75	$20,862.85	$819,035,200
2026-27 **	4	12,360	7.70	$2,787.17	$21,460.29	$795,884,200
2026-27 **	TOTAL	14,390	7.61	$2,735.53	$20,811.43	$3,594,692,600

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2026 BASE ESTIMATES)

NURSING FACILITIES

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2023-24 *	1	9,000	35.28	$329.65	$11,631.49	$314,224,700
2023-24 *	2	7,800	31.41	$343.33	$10,782.63	$252,259,700
2023-24 *	3	7,380	33.15	$346.02	$11,470.69	$254,041,300
2023-24 *	4	6,400	30.96	$285.98	$8,855.12	$170,044,900
2023-24 *	TOTAL	7,650	32.88	$328.36	$10,795.23	$990,570,500
2024-25 *	1	7,750	36.34	$309.31	$11,240.02	$261,386,700
2024-25 *	2	7,490	32.48	$288.06	$9,355.73	$210,316,900
2024-25 *	3	7,170	31.48	$271.19	$8,536.54	$183,578,300
2024-25 *	4	6,590	30.64	$264.02	$8,088.93	$159,910,000
2024-25 *	TOTAL	7,250	32.84	$285.25	$9,369.05	$815,191,900
2025-26 *	1	7,980	33.16	$340.71	$11,299.51	$270,555,400
2025-26 *	2	6,830	28.54	$292.75	$8,354.54	$171,243,100
2025-26 **	3	6,560	29.23	$289.18	$8,452.34	$166,240,500
2025-26 **	4	5,520	27.28	$287.33	$7,837.37	$129,857,600
2025-26 **	TOTAL	6,720	29.82	$306.71	$9,146.19	$737,896,700
2026-27 **	1	7,390	32.68	$299.55	$9,788.18	$217,105,200
2026-27 **	2	7,150	29.45	$289.00	$8,511.46	$182,576,300
2026-27 **	3	6,780	27.44	$285.65	$7,838.19	$159,537,400
2026-27 **	4	5,830	27.34	$287.23	$7,853.17	$137,429,500
2026-27 **	TOTAL	6,790	29.37	$291.06	$8,549.44	$696,648,300

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2026 BASE ESTIMATES)

ICF-DD

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2023-24 *	1	3,970	35.87	$354.24	$12,705.13	$151,140,300
2023-24 *	2	3,940	31.26	$353.36	$11,045.31	$130,456,200
2023-24 *	3	1,580	26.16	$357.81	$9,360.37	$44,358,800
2023-24 *	4	140	39.34	$352.71	$13,875.05	$5,980,100
2023-24 *	TOTAL	2,410	32.44	$354.34	$11,494.80	$331,935,400
2024-25 *	1	100	40.60	$348.68	$14,156.22	$4,275,200
2024-25 *	2	70	39.61	$452.84	$17,935.36	$3,784,400
2024-25 *	3	50	40.55	$351.56	$14,253.99	$2,195,100
2024-25 *	4	50	36.76	$354.13	$13,016.46	$1,978,500
2024-25 *	TOTAL	70	39.62	$377.00	$14,936.70	$12,233,200
2025-26 *	1	60	34.99	$376.38	$13,169.13	$2,317,800
2025-26 *	2	70	28.99	$353.11	$10,237.02	$2,201,000
2025-26 **	3	50	31.30	$363.60	$11,382.40	$1,810,400
2025-26 **	4	60	27.95	$361.32	$10,099.91	$1,818,800
2025-26 **	TOTAL	60	30.68	$363.68	$11,159.50	$8,148,000
2026-27 **	1	60	34.94	$359.58	$12,564.40	$2,262,600
2026-27 **	2	60	32.43	$358.01	$11,610.34	$2,090,800
2026-27 **	3	60	28.91	$358.01	$10,348.61	$1,863,600
2026-27 **	4	60	28.26	$361.26	$10,210.03	$1,838,600
2026-27 **	TOTAL	60	31.14	$359.19	$11,183.34	$8,055,700

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2026 BASE ESTIMATES)

MEDICAL TRANSPORTATION

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2023-24 *	1	12,690	2.07	$298.69	$617.25	$23,498,000
2023-24 *	2	11,770	2.04	$282.40	$574.72	$20,294,400
2023-24 *	3	11,670	2.07	$273.65	$566.67	$19,831,800
2023-24 *	4	7,960	1.87	$250.21	$467.29	$11,166,000
2023-24 *	TOTAL	11,020	2.02	$279.45	$565.42	$74,790,100
2024-25 *	1	12,620	1.88	$366.88	$688.01	$26,042,000
2024-25 *	2	12,150	1.86	$298.22	$555.55	$20,253,100
2024-25 *	3	9,740	1.78	$349.35	$622.49	$18,181,000
2024-25 *	4	9,090	1.85	$307.05	$567.83	$15,491,700
2024-25 *	TOTAL	10,900	1.85	$331.28	$611.39	$79,967,800
2025-26 *	1	11,520	1.78	$385.32	$686.96	$23,748,200
2025-26 *	2	10,060	1.81	$351.74	$636.08	$19,193,000
2025-26 **	3	9,530	1.81	$352.35	$638.71	$18,259,700
2025-26 **	4	8,200	1.80	$331.64	$595.58	$14,650,400
2025-26 **	TOTAL	9,830	1.80	$357.46	$643.18	$75,851,400
2026-27 **	1	11,360	1.81	$378.21	$686.09	$23,387,900
2026-27 **	2	11,000	1.85	$364.34	$672.60	$22,194,000
2026-27 **	3	9,090	1.77	$360.87	$639.89	$17,458,600
2026-27 **	4	8,310	1.80	$331.81	$596.58	$14,877,400
2026-27 **	TOTAL	9,940	1.81	$360.78	$653.08	$77,917,900

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2026 BASE ESTIMATES)

OTHER SERVICES

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2023-24 *	1	230,180	3.10	$178.76	$555.04	$383,278,100
2023-24 *	2	226,840	2.82	$180.29	$508.53	$346,066,400
2023-24 *	3	230,540	2.67	$196.76	$526.09	$363,858,200
2023-24 *	4	247,390	3.36	$148.31	$498.73	$370,146,000
2023-24 *	TOTAL	233,740	3.00	$174.03	$521.72	$1,463,348,700
2024-25 *	1	259,660	3.20	$226.28	$724.42	$564,316,600
2024-25 *	2	282,890	2.92	$179.69	$525.09	$445,625,200
2024-25 *	3	275,680	3.09	$179.52	$555.42	$459,355,900
2024-25 *	4	260,530	2.95	$159.76	$472.02	$368,928,500
2024-25 *	TOTAL	269,690	3.04	$186.77	$568.00	$1,838,226,200
2025-26 *	1	262,010	3.31	$203.97	$675.07	$530,622,000
2025-26 *	2	276,480	3.17	$165.17	$522.91	$433,722,700
2025-26 **	3	274,180	2.78	$200.55	$557.90	$458,890,000
2025-26 **	4	282,810	3.12	$157.99	$492.73	$418,046,100
2025-26 **	TOTAL	273,870	3.09	$181.20	$560.27	$1,841,280,800
2026-27 **	1	283,300	3.33	$207.13	$689.86	$586,315,700
2026-27 **	2	301,520	3.07	$184.48	$566.63	$512,560,300
2026-27 **	3	262,680	2.77	$204.14	$564.89	$445,159,100
2026-27 **	4	286,030	3.13	$157.62	$492.96	$422,999,400
2026-27 **	TOTAL	283,380	3.08	$187.81	$578.43	$1,967,034,500

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2026 BASE ESTIMATES)

HOME HEALTH

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2023-24 *	1	1,900	6.36	$1,087.78	$6,914.94	$39,505,100
2023-24 *	2	1,780	5.84	$1,097.40	$6,412.55	$34,268,600
2023-24 *	3	1,700	5.10	$1,179.76	$6,019.59	$30,687,900
2023-24 *	4	1,620	6.34	$1,009.92	$6,405.57	$31,067,000
2023-24 *	TOTAL	1,750	5.92	$1,090.18	$6,452.21	$135,528,600
2024-25 *	1	1,980	6.40	$1,053.38	$6,742.94	$39,965,400
2024-25 *	2	1,960	5.66	$1,060.08	$5,998.67	$35,224,200
2024-25 *	3	1,750	6.05	$1,089.07	$6,587.41	$34,649,800
2024-25 *	4	1,730	5.22	$1,043.98	$5,448.02	$28,198,900
2024-25 *	TOTAL	1,850	5.85	$1,061.87	$6,208.16	$138,038,300
2025-26 *	1	1,800	6.87	$1,051.58	$7,227.57	$39,050,600
2025-26 *	2	1,700	6.35	$1,046.50	$6,649.23	$33,871,200
2025-26 **	3	1,640	6.02	$1,034.40	$6,226.60	$30,648,700
2025-26 **	4	1,590	5.81	$1,055.30	$6,135.27	$29,325,500
2025-26 **	TOTAL	1,680	6.28	$1,047.09	$6,579.32	$132,896,000
2026-27 **	1	1,780	7.07	$1,075.67	$7,604.59	$40,709,900
2026-27 **	2	1,760	6.57	$1,058.68	$6,951.63	$36,685,800
2026-27 **	3	1,620	5.71	$1,047.56	$5,976.77	$28,960,000
2026-27 **	4	1,600	5.87	$1,056.61	$6,202.44	$29,772,100
2026-27 **	TOTAL	1,690	6.33	$1,060.84	$6,713.70	$136,127,900

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND MAY 2026 BASE ESTIMATES)

TITLE 19 CHILDREN

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2023-24 *	1	895,090	2.31	$205.09	$472.89	$1,269,832,600
2023-24 *	2	872,310	2.26	$189.14	$426.74	$1,116,733,800
2023-24 *	3	917,150	2.28	$182.95	$417.48	$1,148,693,300
2023-24 *	4	841,330	2.30	$176.19	$404.58	$1,021,158,000
2023-24 *	TOTAL	881,470	2.29	$188.51	$430.76	$4,556,417,700
2024-25 *	1	907,820	2.36	$215.78	$509.43	$1,387,417,000
2024-25 *	2	891,570	2.32	$203.16	$470.53	$1,258,527,200
2024-25 *	3	924,950	2.35	$191.70	$449.83	$1,248,194,000
2024-25 *	4	793,690	2.23	$200.80	$448.11	$1,066,980,000
2024-25 *	TOTAL	879,510	2.32	$202.92	$470.07	$4,961,118,200
2025-26 *	1	849,530	2.36	$229.10	$540.67	$1,377,946,500
2025-26 *	2	831,730	2.31	$224.96	$520.70	$1,299,263,000
2025-26 **	3	792,510	2.42	$223.84	$541.38	$1,287,157,600
2025-26 **	4	704,770	2.54	$215.06	$546.36	$1,155,166,300
2025-26 **	TOTAL	794,640	2.40	$223.45	$536.88	$5,119,533,400
2026-27 **	1	780,230	2.66	$242.67	$645.69	$1,511,354,000
2026-27 **	2	805,300	2.59	$231.02	$598.96	$1,447,021,300
2026-27 **	3	759,880	2.41	$231.41	$556.56	$1,268,757,200
2026-27 **	4	712,450	2.56	$222.07	$567.62	$1,213,206,900
2026-27 **	TOTAL	764,460	2.55	$232.12	$593.05	$5,440,339,300

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND MAY 2026 BASE ESTIMATES)

TITLE 19 ADULTS

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2023-24 *	1	1,113,450	2.82	$155.33	$438.67	$1,465,310,700
2023-24 *	2	1,039,940	2.57	$156.00	$401.60	$1,252,925,000
2023-24 *	3	1,113,870	2.70	$153.99	$416.22	$1,390,848,100
2023-24 *	4	1,029,230	2.45	$155.77	$382.31	$1,180,455,300
2023-24 *	TOTAL	1,074,120	2.64	$155.23	$410.38	$5,289,539,100
2024-25 *	1	1,172,790	2.82	$170.38	$479.83	$1,688,210,200
2024-25 *	2	1,112,730	2.66	$170.03	$451.91	$1,508,550,900
2024-25 *	3	1,138,920	2.63	$170.72	$448.20	$1,531,377,300
2024-25 *	4	1,039,550	2.49	$176.74	$440.04	$1,372,346,700
2024-25 *	TOTAL	1,116,000	2.65	$171.77	$455.53	$6,100,485,200
2025-26 *	1	1,138,570	2.90	$193.35	$561.14	$1,916,696,400
2025-26 *	2	1,091,760	2.75	$193.02	$529.95	$1,735,750,400
2025-26 **	3	1,077,340	2.76	$186.89	$516.42	$1,669,090,600
2025-26 **	4	991,730	2.70	$186.40	$502.37	$1,494,661,300
2025-26 **	TOTAL	1,074,850	2.78	$190.10	$528.46	$6,816,198,600
2026-27 **	1	1,114,320	3.10	$199.49	$618.89	$2,068,922,300
2026-27 **	2	1,080,950	2.98	$198.33	$590.06	$1,913,483,500
2026-27 **	3	1,053,170	2.66	$200.90	$533.74	$1,686,360,600
2026-27 **	4	998,080	2.73	$200.27	$546.65	$1,636,782,100
2026-27 **	TOTAL	1,061,630	2.87	$199.68	$573.45	$7,305,548,600

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

QUARTERLY SUMMARY OF FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY (INCLUDES ACTUALS AND MAY 2026 BASE ESTIMATES)

TITLE 21

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2023-24 *	1	257,840	2.45	$164.68	$403.13	$311,833,300
2023-24 *	2	252,740	2.40	$146.97	$352.69	$267,411,700
2023-24 *	3	267,940	2.43	$144.24	$349.92	$281,267,400
2023-24 *	4	250,550	2.48	$136.27	$337.84	$253,943,600
2023-24 *	TOTAL	257,270	2.44	$148.07	$360.99	$1,114,456,000
2024-25 *	1	271,860	2.53	$163.76	$413.83	$337,514,600
2024-25 *	2	270,950	2.49	$150.37	$373.87	$303,896,500
2024-25 *	3	281,760	2.55	$150.95	$385.38	$325,752,500
2024-25 *	4	248,450	2.44	$151.41	$368.98	$275,013,800
2024-25 *	TOTAL	268,250	2.50	$154.18	$385.88	$1,242,177,400
2025-26 *	1	267,830	2.55	$183.56	$468.53	$376,463,400
2025-26 *	2	270,380	2.51	$170.58	$427.93	$347,114,700
2025-26 **	3	275,970	2.45	$167.88	$411.36	$340,570,300
2025-26 **	4	256,960	2.50	$156.06	$390.72	$301,200,900
2025-26 **	TOTAL	267,790	2.50	$169.72	$424.89	$1,365,349,300
2026-27 **	1	278,220	2.62	$183.52	$481.52	$401,910,400
2026-27 **	2	283,620	2.61	$166.13	$432.87	$368,310,800
2026-27 **	3	270,130	2.38	$166.85	$397.48	$322,110,500
2026-27 **	4	259,050	2.53	$156.03	$394.12	$306,293,300
2026-27 **	TOTAL	272,760	2.54	$168.50	$427.31	$1,398,625,000

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND MAY 2026 BASE ESTIMATES)

ACA EXPANSION

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2023-24 *	1	1,552,400	3.91	$183.62	$718.15	$3,344,539,200
2023-24 *	2	1,444,400	3.48	$184.97	$644.33	$2,791,988,500
2023-24 *	3	1,501,100	3.79	$186.93	$708.76	$3,191,757,800
2023-24 *	4	1,400,980	3.39	$194.38	$659.63	$2,772,391,400
2023-24 *	TOTAL	1,474,720	3.65	$187.18	$683.78	$12,100,676,800
2024-25 *	1	1,620,560	4.00	$205.84	$824.03	$4,006,163,200
2024-25 *	2	1,553,430	3.76	$204.72	$768.85	$3,583,045,000
2024-25 *	3	1,576,470	3.72	$206.22	$768.14	$3,632,850,900
2024-25 *	4	1,485,510	3.45	$211.57	$730.29	$3,254,568,100
2024-25 *	TOTAL	1,558,990	3.74	$206.92	$773.82	$14,476,627,200
2025-26 *	1	1,672,480	4.11	$222.48	$913.89	$4,585,412,000
2025-26 *	2	1,612,460	3.85	$220.65	$850.08	$4,112,153,100
2025-26 **	3	1,616,610	3.78	$218.05	$824.95	$4,000,885,600
2025-26 **	4	1,523,890	3.55	$221.91	$788.21	$3,603,426,500
2025-26 **	TOTAL	1,606,360	3.83	$220.79	$845.69	$16,301,877,100
2026-27 **	1	1,713,610	4.20	$232.78	$976.84	$5,021,795,300
2026-27 **	2	1,648,610	4.04	$231.13	$934.14	$4,620,110,400
2026-27 **	3	1,591,380	3.57	$233.49	$834.17	$3,982,437,200
2026-27 **	4	1,531,250	3.61	$236.25	$853.35	$3,920,056,500
2026-27 **	TOTAL	1,621,210	3.87	$233.27	$901.81	$17,544,399,500

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND MAY 2026 BASE ESTIMATES)

SPDS

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2023-24 *	1	863,400	4.65	$188.99	$877.84	$2,273,793,200
2023-24 *	2	823,560	4.07	$188.64	$766.99	$1,894,987,600
2023-24 *	3	875,050	4.29	$182.45	$782.78	$2,054,915,700
2023-24 *	4	819,400	3.89	$178.77	$695.52	$1,709,741,300
2023-24 *	TOTAL	845,350	4.23	$184.91	$782.06	$7,933,437,800
2024-25 *	1	955,800	4.57	$191.07	$872.36	$2,501,408,000
2024-25 *	2	931,720	4.25	$185.25	$787.60	$2,201,466,300
2024-25 *	3	961,340	4.17	$186.75	$778.72	$2,245,839,200
2024-25 *	4	911,000	3.85	$188.41	$725.14	$1,981,819,700
2024-25 *	TOTAL	939,970	4.21	$187.93	$791.74	$8,930,533,200
2025-26 *	1	1,029,490	4.60	$199.81	$918.72	$2,837,438,300
2025-26 *	2	999,270	4.28	$192.82	$824.88	$2,472,829,200
2025-26 **	3	1,016,270	4.13	$192.22	$793.36	$2,418,807,100
2025-26 **	4	965,270	3.85	$193.15	$743.80	$2,153,912,000
2025-26 **	TOTAL	1,002,580	4.22	$194.70	$821.47	$9,882,986,600
2026-27 **	1	1,064,940	4.65	$201.60	$937.41	$2,994,840,700
2026-27 **	2	1,031,280	4.46	$194.91	$868.67	$2,687,543,100
2026-27 **	3	1,003,260	3.91	$194.58	$759.90	$2,287,140,200
2026-27 **	4	969,600	3.93	$193.45	$760.48	$2,212,093,500
2026-27 **	TOTAL	1,017,270	4.25	$196.43	$834.06	$10,181,617,600

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND MAY 2026 BASE ESTIMATES)

LTC AID CODES

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2023-24 *	1	14,330	17.00	$266.80	$4,536.17	$194,996,200
2023-24 *	2	13,750	14.60	$281.65	$4,111.07	$169,573,400
2023-24 *	3	13,950	12.18	$265.38	$3,232.20	$135,280,400
2023-24 *	4	12,780	9.73	$218.56	$2,127.70	$81,588,900
2023-24 *	TOTAL	13,700	13.48	$262.38	$3,535.98	$581,438,900
2024-25 *	1	15,050	11.33	$235.50	$2,668.57	$120,507,300
2024-25 *	2	14,830	9.35	$209.62	$1,959.14	$87,166,100
2024-25 *	3	15,090	8.67	$193.43	$1,677.38	$75,916,600
2024-25 *	4	14,640	8.05	$187.76	$1,512.21	$66,398,000
2024-25 *	TOTAL	14,900	9.36	$209.12	$1,957.24	$349,988,000
2025-26 *	1	17,450	9.16	$227.17	$2,080.59	$108,904,500
2025-26 *	2	17,060	7.85	$194.64	$1,528.93	$78,264,200
2025-26 **	3	17,350	7.77	$185.95	$1,444.80	$75,202,900
2025-26 **	4	16,600	7.08	$175.56	$1,243.20	$61,899,500
2025-26 **	TOTAL	17,110	7.98	$197.91	$1,578.94	$324,271,100
2026-27 **	1	17,860	9.56	$183.56	$1,754.31	$93,976,700
2026-27 **	2	17,590	8.36	$175.62	$1,468.65	$77,479,500
2026-27 **	3	16,910	7.62	$185.84	$1,417.00	$71,902,800
2026-27 **	4	16,670	7.17	$175.21	$1,255.88	$62,817,000
2026-27 **	TOTAL	17,260	8.20	$180.26	$1,478.50	$306,176,100

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

TABLE OF CONTENTS

BASE POLICY CHANGES

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

BASE POLICY CHANGES INTRODUCTION .... COVER PAGE

MEDI-CAL PROGRAM BASE POLICY CHANGES 1-122

POLICY CHANGE INDEX 1

DRUG MEDI-CAL 3

MENTAL HEALTH 12

MANAGED CARE 20

FEE-FOR-SERVICE BASE 90

OTHER...58

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 (FFS Base) Estimate consists of 11 service categories (Physicians through Home Health) which are paid on a fee-for-service basis and are described in the previous section.

The second type of base estimate has traditionally been called the Non-Fee-for-Service (Non-FFS) Base Estimate. Because some of these base estimates include services paid on a fee-for-service basis, that name is technically not correct. 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:
Fee-For-Service Base (see the Medi-Cal Fee-For-Service Base Estimate section for list of 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

MEDI-CAL PROGRAM BASE
POLICY CHANGE INDEX

FRN.	POLICY CHANGE TITLE
	DRUG MEDI-CAL
2012	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER
2320	DRUG MEDI-CAL STATE PLAN SERVICES
	MENTAL HEALTH
1780	SMHS FOR ADULTS
1779	SMHS FOR CHILDREN
	MANAGED CARE
56	TWO PLAN MODEL
57	COUNTY ORGANIZED HEALTH SYSTEMS & SINGLE PLAN
58	GEOGRAPHIC MANAGED CARE
62	PACE (OTHER M/C)
1842	REGIONAL MODEL
1029	DENTAL MANAGED CARE (OTHER M/C)
61	SENIOR CARE ACTION NETWORK (OTHER M/C)
1837	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL
1823	COUNTY CHILDREN’S HEALTH INITIATIVE PROGRAM
63	AIDS HEALTHCARE CENTERS (OTHER M/C)
1797	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL
2581	CAP PACE RATES AT LOWER BOUND
	FEE-FOR-SERVICE BASE
2540	FFS - PHARMACY
2539	FFS - OTHER MEDICAL
2543	FFS - COMMUNITY INPATIENT
2547	FFS - OTHER SERVICES
2544	FFS - NURSING FACILITIES
2542	FFS - COUNTY INPATIENT
2541	FFS - CO. & COMM. OUTPATIENT
2538	FFS - PHYSICIANS
2548	FFS - HOME HEALTH
2546	FFS - MEDICAL TRANSPORTATION
2545	FFS - ICF-DD
	OTHER
76	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS
22	PERSONAL CARE SERVICES (MISC. SVCS.)
23	HOME & COMMUNITY-BASED SVCS.-CDDS (MISC.)
1019	MEDICARE PAYMENTS - PART D PHASED-DOWN

MEDI-CAL PROGRAM BASE
POLICY CHANGE INDEX

FRN.	POLICY CHANGE TITLE
	OTHER
135	DENTAL SERVICES
32	WAIVER PERSONAL CARE SERVICES (MISC. SVCS.)
26	TARGETED CASE MGMT. SVCS. - CDDS (MISC. SVCS.)
2080	LAWSUITS/CLAIMS
77	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC
27	MEDI-CAL TCM PROGRAM
91	HIPP PREMIUM PAYOUTS (MISC. SVCS.)
127	BASE RECOVERIES

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

FISCAL REFERENCE NUMBER:2012

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$2,125,136,000**	**$1,762,233,000**
FEDERAL FUNDS	$1,636,833,550	$1,357,337,000
GENERAL FUND	$322,603,450	$132,092,000
OTHER FUNDS	$165,699,000	$272,804,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$2,125,136,000**	**$1,762,233,000**
FEDERAL FUNDS	$1,636,833,550	$1,357,337,000
GENERAL FUND	$322,603,450	$132,092,000
OTHER FUNDS	$165,699,000	$272,804,000

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

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 (HHA) 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

- 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 2025-26 and FY 2026-27, from the prior estimate, is an increase due to the following:

- Updated claims data reimbursements were higher compared to the previous projection,
- Higher estimated reimbursement rates for FY 2025-26 and FY 2026-27 based on the HHA Market Basket Index,
- Increased unpaid claims assumed for FY 2025-67 for prior year claims, and
- Updated claim lags to reflect the increase of paid expenditures in FY 2025-26.

The change in the current estimate, from FY 2025-26 to FY 2026-27, is a net decrease due to the following:

- Higher estimated reimbursement rates for FY 2026-27 services compared to FY 2025-26,
- Addition of Kings County and Madera County to the DMC-ODS waiver,
- No prior year unpaid claims assumed for FY 2026-27,
- Assuming claim lags would return to historic trends in FY 2026-27, and
- Additional funding support from the Opioid Settlements Fund (OSF) and the Behavioral Health Services Fund (BHSF) for Drug Medi-Cal Organized Delivery System.

Methodology:

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

2. A total of 40 counties have opted-in to provide waiver services:

   - Phase-In Timeline:
     - FY 2016-17: Four counties implemented the DMC-ODS waiver.
     - FY 2017-18: Seven additional counties (for a total of 11 counties) began providing waiver services.
     - FY 2018-19: 16 additional counties (for a total of 27 counties) began providing waiver services.
     - FY 2019-20: Three additional counties (for a total of 30 counties) began providing waiver services.
     - FY 2020-21: Seven additional counties (for a total of 37 counties) began providing waiver services under the Partnership Health Plan (PHP).

   - Recent Opt-Ins under the PHP:
     - July 1, 2023: Mariposa County began providing waiver services.
     - July 1, 2024: Lake County began providing waiver services.
     - December 1, 2024: Sonoma County began providing waiver services.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

3. A total of 16 counties have not opted-in to implement DMC-ODS waiver services. Madera County and Kings County are currently in the process of opting in, with projected implementation dates of July 1, 2026, respectively.

Net DMC-ODS Waiver Costs

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

(Dollars in Thousands)

DMC-ODS Waiver Net Cost	FY 2025-26	FY 2026-27
Required Services	$121,160	$100,471
Optional Services	$15,261	$12,657
Existing Services	$1,988,715	$1,649,105
Total	$2,125,136	$1,762,233

5. 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.

6. 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.

7. In FY 2026-27, $35,400,000 OSF and $100,00,000 BHSF will offset the GF in support for the Drug Medi-Cal Organized Delivery System.

8. On a cash basis, the total for waiver services costs are estimated to be $2,125,136,000 TF and $1,762,233,000 TF in FY 2025-26 and FY 2026-27 respectively.

(Dollars in Thousands)

FY 2025-26	TF	GF	IGT*	FF
Total	**$2,125,136**	**$322,603**	**$165,699**	**$1,636,834**

(Dollars in Thousands)

FY 2026-27	TF	GF	IGT*	FF	BHSF	OSF
Total	**$1,762,233**	**$132,092**	**$137,404**	**$1,357,337**	**$100,000**	**$35,400**

Funding:
100% GF (4260-101-0001)
100% Title XIX FF (4260-101-0890)
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)
100% Behavioral Health Services Fund (4260-101-3085)
Opioid Settlements Fund (4260-101-3397)

DRUG MEDI-CAL STATE PLAN SERVICES

FISCAL REFERENCE NUMBER:2320

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$49,221,000**	**$51,307,000**
FEDERAL FUNDS	$35,459,300	$34,638,700
GENERAL FUND	$3,394,700	$2,931,300
OTHER FUNDS	$10,367,000	$13,737,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$49,221,000**	**$51,307,000**
FEDERAL FUNDS	$35,459,300	$34,638,700
GENERAL FUND	$3,394,700	$2,931,300
OTHER FUNDS	$10,367,000	$13,737,000

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 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

DRUG MEDI-CAL STATE PLAN SERVICES

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

DRUG MEDI-CAL STATE PLAN SERVICES

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.

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.

DRUG MEDI-CAL STATE PLAN SERVICES

Reason for Change:
The change from the previous estimate for FY 2025-26 and FY 2026-27 are lower total expenditures due to six months of additional actuals showing lower utilization and rates.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase in total expenditures due to higher projected rates.

Methodology:
1. Expenditures are estimated using 38 quarters of cash-basis expenditure data (July 2016-December 2025) and trending the Users, Units/User, and Rate.

	FY 2025-26				FY 2026-27			
	Average Quarterly				Average Quarterly			
Type	**Users**	**Units/ User**	**Rate**	**Total**	**Users**	**Units/ User**	**Rate**	**Total**
All Others	1,513	66.9	$51.34	$20,799,600	1,634	68.4	$61.51	$27,516,600
ACA Optional	1,974	65.2	$54.06	$27,846,300	1,784	64.8	$50.17	$23,216,500
Total				**$48,645,900**				**$50,733,100**

2. Rates include Final Rate Year (RY) 2024-25 rate increases. RY 2025-26 rate increases are partially budgeted in the Drug Medi-Cal Annual Rate Adjustment PC.

3. 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.

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

5. 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 on or after July 1, 2023, counties transfer the county portion of the submitted claims before Federal Funds can be used for payment. Total estimated expenditures for DMC State Plan services are:

DRUG MEDI-CAL STATE PLAN SERVICES

Dollars in Thousands)

FY 2025-26	TF	GF	FF	IGT*
Title XIX 100%	$20,544	$0	$10,272	$10,272
100% GF	$626	$613	$0	$13
50% Title XIX / 50% GF	$0	$0	$0	$0
ACA 90% FFP/10% GF	$27,817	$2,782	$25,035	$0
Title XXI 100%	$234	$0	$152	$82
Total	**$49,221**	**$3,395**	**$35,459**	**$10,367**

(Dollars in Thousands)

FY 2026-27	TF	GF	FF	IGT*
Title XIX 100%	$27,352	$0	$13,676	$13,676
100% GF	$625	$612	$0	$13
50% Title XIX / 50% GF	$0	$0	$0	$0
ACA 90% FFP/10% GF	$23,193	$2,319	$20,874	$0
Title XXI 100%	$137	$0	$89	$48
Total	**$51,307**	**$2,931**	**$34,639**	**$13,737**

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. $573,000 captured in the 100% GF to account for the impact of the 26-49 Unsatisfactory Immigration Status (UIS) expansion for FY 2025-26 and FY 2026-27.

SMHS FOR ADULTS

FISCAL REFERENCE NUMBER:1780

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$5,958,142,000**	**$5,455,610,000**
FEDERAL FUNDS	$4,048,887,300	$3,735,626,900
GENERAL FUND	$504,458,700	$446,255,100
OTHER FUNDS	$1,404,796,000	$1,273,728,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$5,958,142,000**	**$5,455,610,000**
FEDERAL FUNDS	$4,048,887,300	$3,735,626,900
GENERAL FUND	$504,458,700	$446,255,100
OTHER FUNDS	$1,404,796,000	$1,273,728,000

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(b)(4) 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)(4) 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 plans or the fee-for-service Medi-Cal (FFS/MC) program.

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

SMHS FOR ADULTS

The following Medi-Cal SMHS are available for adults:

- Adult Residential Treatment Services
- Crisis Intervention
- Crisis Stabilization
- Crisis Residential Treatment Services
- Day Rehabilitation
- Day Treatment Intensive
- Medication Support Services
- Psychiatric Health Facility Services
- Psychiatric Inpatient Hospital Services
- Targeted Case Management
- 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 reformed behavioral health payments under the California Advancing and Innovating Medi-Cal (CalAIM) initiative. Payment reform transitioned counties from cost-based reimbursement funded via Certified Public Expenditures to fee-for-service reimbursement funded via Intergovernmental Transfers, eliminating the need for reconciliation to actual costs. In addition, SMHS services were transitioned from Healthcare Common Procedure Coding System (HCPCS) Level II coding to Level I coding, known as Current Procedural Terminology (CPT) coding, when possible. Payments to MHPs continue to be made through Short-Doyle/Medi-Cal (SD/MC) claims.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is an increase based on actual paid claims data through February 2026. The claim lags were updated to reflect the increase of paid expenditures in 2025-26.

The change in FY 2026-27, from the prior estimate, is an increase, due to higher approved claims in SD/MC for FY 2023-24 and FY 2024-25, and updated SD/MC forecasts for FY 2025-26 and FY 2026-27.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease due to reflecting higher expenditures in FY 2025-26 and assuming claim lags would return to historic trends in FY 2026-27.

Methodology:
1. The costs and clients are developed using 70 months of SD/MC and 70 months FFS/MC approved claims data, excluding disallowed claims. The SD/MC data is current as of December 31, 2025, with dates of service from December 2019 through September 2025. The FFS Inpatient data is current as of December 31, 2025, with dates of service from October 2019 through July 2025.

SMHS FOR ADULTS

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. These accrual costs are estimated below:

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2023-24	$3,968,733	$3,530,938	$437,795
FY 2024-25	$4,820,188	$4,287,777	$532,411
FY 2025-26	$5,275,673	$4,698,220	$577,453
FY 2026-27	$5,799,719	$5,176,943	$622,776

5. On a cash basis for FY 2025-26, the Department will be paying 0.68% of FY 2023-24 claims, 61.43% of FY 2024-25 claims, and 59.75% of FY 2025-26 SD/MC claims. For FFS Inpatient claims, the Department will be paying 0.95% of FY 2023-24 claims, 44.46% of FY 2024-25 claims, and 64.83% of FY 2025-26 claims. The cash amounts (rounded) for Adult's SMHS are:

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2023-24	$28,181	$24,010	$4,171
FY 2024-25	$2,870,762	$2,634,062	$236,700
FY 2025-26	$3,181,724	$2,807,370	$374,354
Total FY 2025-26	$6,080,667	$5,465,442	$615,225

6. On a cash basis for FY 2026-27, the Department will be paying 0.49% of FY 2024-25 claims, 39.41% of FY 2025-26 claims, and 59.75% of FY 2026-27 claims for SD/MC claims. For FFS Inpatient claims, the Department will be paying 0.95% of FY 2025-25 claims, and 34.22% of FY 2025-26 claims, and 64.83% of FY 2026-27 claims. The cash amounts (rounded) are:

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2024-25	$26,295	$21,223	$5,072
FY 2025-26	$2,049,055	$1,851,457	$197,598
FY 2026-27	$3,497,162	$3,093,426	$403,736
Total FY 2026-27	$5,572,512	$4,966,106	$606,406

SMHS FOR ADULTS

7. The FY 2025-26 and FY 2026-27 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 2025-26 and FY 2026-27 are as follows:

(Dollars in Thousands)

Fiscal Year	TF	FF	ACA FF	GF	GF Abate from Fund 613-0865	BH IGTF
FY 2025-26	$6,080,667	**$1,528,720**	**$2,520,168**	**$504,458**	$122,525	**$1,404,796**
FY 2026-27	$5,572,512	**$1,391,774**	**$2,343,853**	**$446,255**	$116,902	**$1,273,728**

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

FISCAL REFERENCE NUMBER:1779

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$4,861,069,000**	**$4,487,212,000**
FEDERAL FUNDS	$2,593,767,700	$2,407,560,100
GENERAL FUND	$92,988,300	$82,327,900
OTHER FUNDS	$2,174,313,000	$1,997,324,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$4,861,069,000**	**$4,487,212,000**
FEDERAL FUNDS	$2,593,767,700	$2,407,560,100
GENERAL FUND	$92,988,300	$82,327,900
OTHER FUNDS	$2,174,313,000	$1,997,324,000

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(b)(4) 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)(4) 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 plans or the fee-for-service Medi-Cal (FFS/MC) program.

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

SMHS FOR CHILDREN

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

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 reformed behavioral health payments under the California Advancing and Innovating Medi-Cal (CalAIM) initiative. Payment reform transitioned counties from cost-based reimbursement funded via Certified Public Expenditures to fee-for-service reimbursement funded via Intergovernmental Transfers, eliminating the need for reconciliation to actual costs. In addition, SMHS services were transitioned from Healthcare Common Procedure Coding System (HCPCS) Level II coding to Level I coding, known as Current Procedural Terminology (CPT) coding, when possible. Payments to MHPs continue to be made through Short-Doyle/Medi-Cal (SD/MC) claims.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is an increase based on actual paid claims data through February 2026. The claim lags were updated to reflect the increase of paid expenditures in 2025-26.

The change in FY 2026-27, from the prior estimate, is an increase, due to higher approved claims in SD/MC for FY 2023-24 and FY 2024-25, and updated SD/MC forecasts for FY 2025-26 and FY 2026-27.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease due to reflecting higher expenditures in FY 2025-26 and assuming claim lags would return to historic trends in FY 2026-27.

SMHS FOR CHILDREN

Methodology:

1. The costs and clients are developed using 70 months of SD/MC and 70 months FFS/MC approved claims data, excluding disallowed claims. The SD/MC data is current as of December 31, 2025, with dates of service from December 2019 through September 2025. The FFS Inpatient data is current as of December 31, 2025, with dates of service from October 2019 through July 2025.

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. These accrual costs are estimated below:

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2023-24	$3,423,822	$3,216,434	$207,388
FY 2024-25	$3,962,753	$3,732,670	$230,083
FY 2025-26	$4,375,705	$4,125,664	$250,041
FY 2026-27	$4,744,606	$4,474,953	$269,653

5. On a cash basis for FY 2025-26, the Department will be paying 0.39% of FY 2023-24 claims, 57.52% of FY 2024-25 claims, and 61.69% of FY 2025-26 SD/MC claims. For FFS Inpatient claims, the Department will be paying 1.97% of FY 2023-24 claims, 36.74% of FY 2024-25 claims, and 71.56% of FY 2025-26 claims. The cash amounts for Children's SMHS are:

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2023-24	$16,480	$12,392	$4,088
FY 2024-25	$2,231,408	$2,146,876	$84,532
FY 2025-26	$2,723,910	$2,544,978	$178,932
Total FY 2025-26	$4,971,798	$4,704,246	$267,552

6. On a cash basis for FY 2026-27, the Department will be paying 0.29% of FY 2024-25 claims, 37.84% of FY 2025-26 claims, and 61.69% of FY 2026-27 claims for SD/MC claims. For FFS Inpatient claims, the Department will be paying 1.97% of FY 2024-25 claims, and 26.47% of FY 2025-26 claims, and 71.56% of FY 2026-27. The cash amounts for Children's SMHS are:

SMHS FOR CHILDREN

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2024-25	$15,348	$10,812	$4,536
FY 2025-26	$1,627,385	$1,561,204	$66,181
FY 2026-27	$2,953,407	$2,760,442	$192,965
Total FY 2026-27	$4,596,140	$4,332,458	$263,682

7. The FY 2025-26 and FY 2026-27 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 2025-26 and FY 2026-27 are as follows:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF	MCHIP	ACA FF	GF Abatement from Fund 613-0865	BH IGTF
FY 2025-26	$4,971,798	**$92,988**	**$2,059,329**	**$417,985**	**$116,454**	$110,729	**$2,174,313**
FY 2026-27	$4,596,140	**$82,328**	**$1,898,471**	**$384,881**	**$124,208**	$108,928	**$1,997,324**

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

FISCAL REFERENCE NUMBER:56

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$35,773,534,000**	**$38,347,025,000**
FEDERAL FUNDS	$20,342,731,500	$21,679,113,500
GENERAL FUND	$15,430,802,500	$16,667,911,500
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$35,773,534,000**	**$38,347,025,000**
FEDERAL FUNDS	$20,342,731,500	$21,679,113,500
GENERAL FUND	$15,430,802,500	$16,667,911,500
OTHER FUNDS	$0	$0

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:
Not Applicable

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 2025-26 and FY 2026-27, is a decrease due to:

- Updated Satisfactory Immigration Status (SIS) and Unsatisfactory Immigration Status (UIS) CY 2026 and CY 2027 rates. Total member months are lower than previously estimated.
- The prior estimate assumed that enrollment would continue at levels close to those observed in July 2025 (the most recent actual month at that time). This estimate incorporates actual enrollment through January 2026 (the most recent actual month).

TWO PLAN MODEL

The incremental impact of redeterminations on managed care costs is accounted for separately in the COVID-19 End of Unwinding Flexibilities policy change.

The change in the current estimate, from FY 2025-26 to FY 2026-27, is an increase due to the dollar impact of the incremental SIS and UIS rate change from current year to budget year.

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. The last seven months of the CY 2025 rates and the first five months of the CY 2026 rates have been budgeted for FY 2025-26 on a cash basis. For FY 2026-27, the last seven months of the CY 2026 rates and the first five months of the CY 2027 rates have been budgeted on a cash basis.

3. CY 2025 rates are held constant from the previous estimate. CY 2026 rates have been updated this estimate cycle. CY rates used for FY 2026-27 include estimated capitated rate adjustments for CY 2027.

4. The member months in this PC are reflective of actuals through January 2026, inclusive of redetermination impacts. The COVID-19 End of Unwinding Flexibilities PC adjusts these base projections to account for incremental impacts of ending eligibility redetermination flexibilities on the Medi-Cal caseload and managed care enrollment.

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

6. 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.

7. As of January 1, 2025, Wellness Coach services are included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

8. The Department receives FFP of 90% for federally eligible family planning services.

9. 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.

10. Beginning October 1, 2026, HR 1 reduces the federal medical assistance percentage for UIS Federal Emergency ACA costs from 90% FF to 50% FF. The impact of this change is incorporated into the dollars of this policy change. For PC specific impacts, please see the HR 1 - UIS Emergency ACA FMAP Adjustment policy change (FRN 2551).

11. The Two-Plan Model rate growth from FY 2025-26 to FY 2026-27 is a 7.13% average rate increase on a cash basis.

TWO PLAN MODEL

12. Expenditures for Cost Based Reimbursement Clinics starting January 1, 2026, are budgeted in this PC. This was previously budgeted in the Retro MC Rate Adjustment PC (FRN 1788).

13. The impact of the Medicare Part A Buy-In, which began January 1, 2025, is captured in this PC. The impact of the Medicare Part A Buy-In phase two expansion, starting January 1, 2026, is also captured in this PC. However, the phase two expansion has been postponed indefinitely and there will be a retroactive adjustment to the CY 2026 rates to account for this. The estimated impact of this rate adjustment is captured in the Retro MC Rate Adjustment PC (FRN 1788).

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

(Dollars in Thousands)

FY 2025-26	**Member Months**	**Total**
Alpine	2,989	$1,209
El Dorado	448,822	$171,100
Fresno	5,958,064	$1,668,748
Kern	5,617,299	$1,863,001
Kings	766,416	$209,656
Los Angeles	45,419,382	$16,116,253
Madera	948,123	$250,026
Riverside	11,255,141	$4,205,668
San Bernardino	10,867,572	$4,115,506
San Francisco	2,817,021	$1,275,632
San Joaquin	3,570,359	$1,194,080
Santa Clara	5,110,770	$2,081,924
Stanislaus	2,864,268	$956,427
Tulare	3,333,902	$827,804
Total FY 2025-26	98,980,128	$34,937,034
Maternity (events)	103,008	$888,795
Total FY 2025-26 with Maternity		$35,825,829

TWO PLAN MODEL

(Dollars in Thousands)

FY 2026-27	Member Months	Total
Alpine	2,900	$1,273
El Dorado	446,476	$182,724
Fresno	5,945,264	$1,803,366
Kern	5,617,116	$2,040,180
Kings	769,404	$227,875
Los Angeles	45,026,244	$17,060,787
Madera	942,381	$267,744
Riverside	11,268,803	$4,680,545
San Bernardino	10,852,068	$4,556,827
San Francisco	2,797,082	$1,322,177
San Joaquin	3,573,547	$1,302,187
Santa Clara	5,068,982	$2,216,460
Stanislaus	2,856,411	$1,031,265
Tulare	3,312,017	$880,199
Total FY 2026-27	98,478,697	$37,573,608
Maternity (events)	108,159	$958,006
Total FY 2026-27 with Maternity		$38,531,613

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

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$19,462,950	$9,731,475	$9,731,475
65% Title XXI / 35% GF (4260-101-0001/0890)	$1,291,826	$452,139	$839,687
ACA 90% FFP/10% GF (2020 and later)	$10,792,594	$1,079,259	$9,713,335
Title XIX 100% FFP	$9,806	$0	$9,806
100% State GF (4260-101-0001)	$4,162,548	$4,162,548	$0
90% Family Planning FFP / 10% GF (4260-101-0001/0890)	$53,810	$5,381	$48,429
Total	**$35,773,534**	**$15,430,803**	**$20,342,732**

TWO PLAN MODEL

(Dollars in Thousands)

FY 2026-27	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$20,939,755	$10,469,878	$10,469,878
65% Title XXI / 35% GF (4260-101-0001/0890)	$1,393,144	$487,600	$905,544
ACA 90% FFP/10% GF (2020 and later)	$11,001,971	$1,100,197	$9,901,774
ACA UIS ER 50% FFP/50% GF	$685,611	$342,806	$342,806
Title XIX 100% FFP	$10,684	$0	$10,684
100% State GF (4260-101-0001)	$4,262,050	$4,262,050	$0
90% Family Planning FFP / 10% GF (4260-101-0001/0890)	$53,810	$5,381	$48,429
Total	**$38,347,025**	**$16,667,912**	**$21,679,114**

COUNTY ORGANIZED HEALTH SYSTEMS & SINGLE PLAN

FISCAL REFERENCE NUMBER:57

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$19,965,233,000**	**$21,305,208,000**
FEDERAL FUNDS	$11,510,441,400	$12,210,205,300
GENERAL FUND	$8,454,791,600	$9,095,002,700
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$19,965,233,000**	**$21,305,208,000**
FEDERAL FUNDS	$11,510,441,400	$12,210,205,300
GENERAL FUND	$8,454,791,600	$9,095,002,700
OTHER FUNDS	$0	$0

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:
Not Applicable

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 2025-26 and FY 2026-27, is a decrease due to:

- Updated Satisfactory Immigration Status (SIS) and Unsatisfactory Immigration Status (UIS) CY 2026 and CY 2027 rates. Total member months are lower than previously estimated.
- The prior estimate assumed that enrollment would continue at levels close to those observed in July 2025 (the most recent actual month at that time). This estimate

COUNTY ORGANIZED HEALTH SYSTEMS & SINGLE PLAN

incorporates actual enrollment through January 2026 (the most recent actual month). The incremental impact of redeterminations on managed care costs is accounted for separately in the COVID-19 End of Unwinding Flexibilities policy change.

The change in the current estimate, from FY 2025-26 to FY 2026-27, is an increase due to the dollar impact of the incremental SIS and UIS rate change from current year to budget year.

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. The last seven months of the CY 2025 rates and the first five months of the CY 2026 rates have been budgeted for FY 2025-26 on a cash basis. For FY 2026-27, the last seven months of the CY 2026 rates and the first five months of the CY 2027 rates have been budgeted on a cash basis.

3. CY 2025 rates are held constant from the previous estimate. CY 2026 rates have been updated this estimate cycle. CY rates used for FY 2026-27 include estimated capitated rate adjustments for CY 2027.

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

5. The member months in this PC are reflective of actuals through January 2026, inclusive of redetermination impacts. The COVID-19 End of Unwinding Flexibilities PC adjusts these base projections to account for incremental impacts of ending eligibility redetermination flexibilities on the Medi-Cal caseload and managed care enrollment.

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

7. 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.

8. As of January 1, 2025, Wellness Coach services are included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

9. The Department receives 90% FFP for federally eligible family planning services.

10. 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.

11. Beginning October 1, 2026, HR 1 reduces the federal medical assistance percentage for UIS Federal Emergency ACA costs from 90% FF to 50% FF. The impact of this change is incorporated into the dollars of this policy change. For PC specific impacts, please see the HR 1 - UIS Emergency ACA FMAP Adjustment policy change (FRN 2551).

COUNTY ORGANIZED HEALTH SYSTEMS & SINGLE PLAN

12. The COHS and Single Plan rate growth from FY 2025-26 to FY 2026-27 is a 5.92% average rate increase on a cash basis.

13. The impact of the Medicare Part A Buy-In, which began January 1, 2025, is captured in this PC. The impact of the Medicare Part A Buy-In, phase two expansion, starting January 1, 2026, is also captured in this PC. However, the phase two expansion has been postponed indefinitely and there will be a retroactive adjustment to the CY 2026 rates to account for this. The estimated impact of this rate adjustment is captured in the Retro MC Rate Adjustment PC (FRN 1788).

14. 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

(Dollars in Thousands)

FY 2025-26	Member Months	Total
San Luis Obispo	794,063	$318,713
Santa Barbara	2,067,528	$766,018
San Mateo	1,693,252	$724,678
Solano	1,203,759	$529,788
Santa Cruz	907,479	$357,708
Orange	10,212,024	$3,793,007
Napa	326,281	$142,411
Monterey	2,232,242	$805,562
Yolo	644,792	$281,224
Marin	545,424	$237,818
Lake	398,990	$177,173
Mendocino	480,420	$208,138
Sonoma	1,304,939	$555,969
Merced	1,758,434	$638,375
Ventura	2,847,349	$1,097,672
Humboldt	674,024	$303,553
Lassen	101,074	$43,699
Modoc	45,628	$20,148
Shasta	776,393	$347,346
Siskiyou	213,673	$97,348
Trinity	60,870	$27,775
Del Norte	146,472	$68,095
Alameda	4,750,116	$2,136,232
Contra Costa	3,127,088	$1,355,148
Imperial	1,164,955	$289,425
Partnership HP of California	3,769,351	$1,416,845
San Benito	246,657	$101,413
Mariposa	66,843	$25,613
Kaiser Foundation HP	4,176,173	$1,482,852
Total FY 2025-26	46,736,294	$18,349,745
Maternity (events)	51,126	$530,043
Total FY 2025-26 with Maternity		$18,879,789

COUNTY ORGANIZED HEALTH SYSTEMS & SINGLE PLAN

(Dollars in Thousands)

FY 2026-27	Member Months	Total
San Luis Obispo	791,509	$346,922
Santa Barbara	2,066,433	$835,757
San Mateo	1,647,631	$709,557
Solano	1,180,312	$534,728
Santa Cruz	901,178	$385,362
Orange	10,122,025	$4,082,068
Napa	322,835	$145,065
Monterey	2,220,415	$853,612
Yolo	639,019	$289,230
Marin	536,317	$239,416
Lake	397,974	$180,000
Mendocino	481,130	$213,501
Sonoma	1,290,937	$568,582
Merced	1,751,319	$688,769
Ventura	2,844,523	$1,209,227
Humboldt	670,530	$309,502
Lassen	101,569	$44,994
Modoc	45,425	$20,340
Shasta	776,898	$355,130
Siskiyou	214,092	$99,527
Trinity	60,543	$28,400
Del Norte	146,155	$69,375
Alameda	4,685,093	$2,250,833
Contra Costa	3,095,292	$1,443,348
Imperial	1,168,682	$317,274
Partnership HP of California	3,773,560	$1,488,016
San Benito	247,238	$110,209
Mariposa	66,878	$28,234
Kaiser Foundation HP	4,332,411	$1,704,133
Total FY 2026-27	46,577,922	$19,551,112
Maternity (events)	53,682	$584,669
Total FY 2026-27 with Maternity		$20,135,782

COUNTY ORGANIZED HEALTH SYSTEMS & SINGLE PLAN

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

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$10,736,766	$5,368,383	$5,368,383
65/% Title XXI / 35% GF (4260-101-0001/0890)	$866,504	$303,276	$563,228
ACA 90% FFP/10% GF (2020 and later)	$6,061,431	$606,143	$5,455,288
Title XIX 100% FFP	$96,236	$0	$96,236
100% State GF (4260-101-0001)	$2,173,955	$2,173,955	$0
90% Family Planning FFP / 10% GF (4260-101-0001/0890)	$30,341	$3,034	$27,307
Total	**$19,965,233**	**$8,454,792**	**$11,510,441**

(Dollars in Thousands)

FY 2026-27	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$11,535,177	$5,767,589	$5,767,589
65/% Title XXI / 35% GF (4260-101-0001/0890)	$928,062	$324,822	$603,240
ACA 90% FFP/10% GF (2020 and later)	$6,091,639	$609,164	$5,482,475
ACA UIS ER 50% FFP/50% GF	$423,943	$211,972	$211,972
Title XIX 100% FFP	$117,623	$0	$117,623
100% State GF (4260-101-0001)	$2,178,423	$2,178,423	$0
90% Family Planning FFP / 10% GF (4260-101-0001/0890)	$30,341	$3,034	$27,307
Total	**$21,305,208**	**$9,095,003**	**$12,210,205**

GEOGRAPHIC MANAGED CARE

FISCAL REFERENCE NUMBER:58

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$6,238,879,000**	**$6,690,671,000**
FEDERAL FUNDS	$3,728,428,950	$3,963,400,050
GENERAL FUND	$2,510,450,050	$2,727,270,950
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$6,238,879,000**	**$6,690,671,000**
FEDERAL FUNDS	$3,728,428,950	$3,963,400,050
GENERAL FUND	$2,510,450,050	$2,727,270,950
OTHER FUNDS	$0	$0

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:
Not Applicable

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 no longer provides services in Sacramento and San Diego counties. Health Net and United Healthcare Community Plan of California no longer provide services in San Diego County.

Reason for Change:
The change from the prior estimate, for FY 2025-26 and FY 2026-27, is a decrease due to:

- Updated Satisfactory Immigration Status (SIS) and Unsatisfactory Immigration Status (UIS) CY 2026 and CY 2027 rates. Total member months are lower than previously estimated.
- The prior estimate assumed that enrollment would continue at levels close to those observed in July 2025 (the most recent actual month at that time). This estimate incorporates actual enrollment through January 2026 (the most recent actual month). The incremental impact of redeterminations on managed care costs is accounted for separately in the COVID-19 End of Unwinding Flexibilities policy change.

GEOGRAPHIC MANAGED CARE

The change in the current estimate, from FY 2025-26 to FY 2026-27, is an increase due to the dollar impact of the incremental SIS and UIS rate change from the current year to the budget year.

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. The last seven months of the CY 2025 rates and the first five months of the CY 2026 rates have been budgeted for FY 2025-26 on a cash basis. For FY 2026-27, the last seven months of the CY 2026 rates and the first five months of the CY 2027 rates have been budgeted on a cash basis.

3. CY 2025 rates are held constant from the previous estimate. CY 2026 rates have been updated this estimate cycle. CY rates used for FY 2026-27 include estimated capitated rate adjustments for CY 2027.

4. The member months in this PC are reflective of actuals through January 2026, inclusive of redetermination impacts. The COVID-19 End of Unwinding Flexibilities PC adjusts these base projections to account for incremental impacts of ending eligibility redetermination flexibilities on the Medi-Cal caseload and managed care enrollment.

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

6. 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.

7. As of January 1, 2025, Wellness Coach services are included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

8. The Department receives 90% FFP for federally eligible family planning services.

9. 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.

10. Beginning October 1, 2026, HR 1 reduces the federal medical assistance percentage for UIS Federal Emergency ACA costs from 90% FF to 50% FF. The impact of this change is incorporated into the dollars of this policy change. For PC specific impacts, please see the HR 1 - UIS Emergency ACA FMAP Adjustment policy change (FRN 2551).

11. The GMC model rate growth from FY 2025-26 to FY 2026-27 is a 7.15% average rate increase on a cash basis.

12. The impact of the Medicare Part A Buy-In, which began January 1, 2025, is captured in this PC. The impact of the Medicare Part A Buy-In phase two expansion, starting January 1, 2026, is also captured in this PC. However, the phase two expansion has been postponed

GEOGRAPHIC MANAGED CARE

indefinitely and there will be a retroactive adjustment to the CY 2026 rates to account for this. The estimated impact of this rate adjustment is captured in the Retro MC Rate Adjustment PC (FRN 1788).

13. GMC dollars on an accrual basis are:

(Dollars in Thousands)

FY 2025-26	Member Months	Total
Sacramento	7,196,917	$2,218,579
San Diego	10,608,306	$3,843,796
Total FY 2025-26	17,805,223	$6,062,375
Maternity (events)	19,334	$172,640
Total FY 2025-26 with Maternity		$6,235,015

(Dollars in Thousands)

FY 2026-27	Member Months	Total
Sacramento	7,160,853	$2,385,720
San Diego	10,526,737	$4,147,607
Total FY 2026-27	17,687,591	$6,533,327
Maternity (events)	20,300	$187,001
Total FY 2026-27 with Maternity		$6,720,328

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

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$3,512,143	$1,756,072	$1,756,072
65/% Title XXI / 35% GF (4260-101-0001/0890)	$229,345	$80,271	$149,074
ACA 90% FFP/10% GF (2020 and later)	$2,013,278	$201,328	$1,811,950
Title XIX 100% FFP	$2,747	$0	$2,747
100% State GF (4260-101-0001)	$471,826	$471,826	$0
90% Family Planning FFP / 10% GF (4260-101-0001/0890)	$9,540	$954	$8,586
Total	**$6,238,879**	**$2,510,450**	**$3,728,429**

GEOGRAPHIC MANAGED CARE

(Dollars in Thousands)

FY 2026-27	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$3,798,948	$1,899,474	$1,899,474
65/% Title XXI / 35% GF (4260-101-0001/0890)	$232,007	$81,202	$150,805
ACA 90% FFP/10% GF (2020 and later)	$2,064,785	$206,479	$1,858,307
ACA UIS ER 50% FFP/50% GF	$85,518	$42,759	$42,759
Title XIX 100% FFP	$3,470	$0	$3,470
100% State GF (4260-101-0001)	$496,403	$496,403	$0
90% Family Planning FFP / 10% GF (4260-101-0001/0890)	$9,540	$954	$8,586
Total	**$6,690,671**	**$2,727,271**	**$3,963,400**

PACE (Other M/C)

FISCAL REFERENCE NUMBER:62

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$2,474,328,000**	**$3,020,768,000**
FEDERAL FUNDS	$1,159,411,600	$1,415,460,200
GENERAL FUND	$1,314,916,400	$1,605,307,800
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$2,474,328,000**	**$3,020,768,000**
FEDERAL FUNDS	$1,159,411,600	$1,415,460,200
GENERAL FUND	$1,314,916,400	$1,605,307,800
OTHER FUNDS	$0	$0

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 an integrated, managed care health care coverage model in which the Department contracts with PACE Organizations that provide a comprehensive medical/social service. Services are provided primarily through 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 Organizations are paid on a capitated basis by the Department and assume full financial risk for members' care without limits on amount, duration, or scope of services.

The Department develops actuarial rate ranges, representing a range of rates that are actuarially appropriate, in accordance with generally accepted actuarial principles and practices, and using an experience-based rate approach that leverages PACE Organizations' historical cost experience to project reasonable, appropriate, and attainable future costs. Each rate range contains a lower bound, midpoint, and upper bound. The Department selects and pays each PACE Organization capitation rates within the actuarial rate ranges, not to exceed the Amount that Would Otherwise be Paid as required by the Centers for Medicare & Medicaid Services PACE Medicaid Capitation Rate Setting Guide and federal regulation.

PACE (Other M/C)

Except as may be necessary to comply with Welfare & Institutions Code section 14301.1(n)(10), the Department will cap payments to PACE organizations beginning January 1, 2027, at the midpoint of the actuarial rate ranges, such that actual payment rates are not less than the lower bound and not greater than the midpoint.

Below is a list of new PACE organizations:

New PACE Organizations	County	Operational
WelbeHealth Sierra PACE (Stockton PACE)	Sacramento	July 1, 2025
MyPlace Health South LA PACE	Los Angeles	July 1, 2025
WelbeHealth San Bernardino PACE	Riverside	July 1, 2025
	San Bernardino	July 1, 2025
K-Day PACE	Los Angeles	July 1, 2025
North East Medical Services	Santa Clara	July 1, 2025
AltaMed	Riverside	July 1, 2025
	San Bernardino	July 1, 2025
Tungsten Health – South Los Angeles	Los Angeles	January 1, 2026
Innercare	Imperial	January 1, 2026
Innovative Integrated Health	San Joaquin	July 1, 2026
Complete Care PACE	Los Angeles	July 1, 2026
PACE of Sacramento	Sacramento	July 1, 2026
Roze Room	Los Angeles	July 1, 2026
Vista Community Clinic	Los Angeles	July 1, 2026
Asian Health Services	Alameda	January 1, 2027
Camarena Health	Los Angeles	January 1, 2027
Brandman Centers for Senior Care – Beach Cities/South Bay, LLC	Los Angeles	January 1, 2027
LGBT Center	Los Angeles	January 1, 2027
Tungsten Health – West Covina	Los Angeles	January 1, 2027
	San Bernardino	January 1, 2027
Tungsten Health – San Leandro	Alameda	January 1, 2027
	Contra Costa	January 1, 2027
United Health Centers	Fresno	January 1, 2027
	Kings	January 1, 2027
	Madera	January 1, 2027
	Tulare	January 1, 2027

Reason for Change:
The increase for FY 2025-26 and the decrease for FY 2026-27, from the prior estimate, is due to updated expenditures and member months through December 2025. The change from FY 2025-26 to FY 2026-27, in the current estimate, is a net increase due to a projected increase in enrollment and higher rates.

PACE (Other M/C)

Methodology:

1. Assume the calendar year (CY) 2025, CY 2026, and CY 2027 rates will be calculated using plan specific experienced-based data to build actuarially sound prospective rates.

2. FY 2025-26 and FY 2026-27 estimated funding is based on CY 2025 actuals and projected CY 2026 and CY 2027 rates and enrollments. Beginning January 1, 2027, except as previously indicated, PACE Organization payment rates will not exceed the midpoint of the actuarial rate ranges.

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

PACE (Other M/C)

FY 2025-26	TF Cost (Rounded)	Member Months
Centers for Elders' Independence (Alameda & Contra Costa)	$136,715,000	19,164
Sutter Senior Care (Sacramento)	$55,491,000	7,029
AltaMed Senior Care (Los Angeles & Orange)	$415,115,000	64,049
OnLok (San Francisco, Alameda, & Santa Clara)	$237,428,000	25,399
St. Paul's PACE (San Diego)	$109,337,000	17,552
Los Angeles Jewish Homes (DBA Brandman Center for Senior Care)	$37,222,000	5,908
CalOptima PACE (Orange)	$44,850,000	6,469
InnovAge (San Bernardino & Riverside)	$104,181,000	17,904
Redwood Coast (Humboldt)	$25,658,000	4,497
Innovative Integrated Health (Fresno, Kern, Tulare, & Orange)	$161,105,000	25,635
San Ysidro San Diego	$233,337,000	38,410
Stockton Sierra PACE (San Joaquin & Stanislaus)	$126,906,000	16,239
Gary & Mary West (San Diego)	$35,136,000	5,543
Family Health Centers of San Diego	$37,338,000	5,795
Central Valley (Merced, San Joaquin, & Stanislaus)	$90,983,000	10,970
LA Coast (Los Angeles)	$90,572,000	11,601
Pacific PACE (Los Angeles)	$137,420,000	17,393
Sequoia (Fresno, Kings, Tulare, & Madera)	$94,753,000	13,494
InnovAge (Sacramento, Placer, El Dorado, Sutter, San Joaquin, & Yuba)	$66,125,000	8,765
North East Medical Services (San Francisco)	$19,515,000	2,711
Neighborhood Health (Riverside & San Bernardino)	$40,756,000	6,104
AgeWell PACE (Sonoma & Marin)	$14,135,000	1,961
Providence PACE (Napa, Solano, & Sonoma)	$8,825,000	1,223
ConcertoHealth PACE (Los Angeles)	$11,743,000	1,733
my Place Health	$12,790,000	1,805
WelbeHealth Bay Area (Alameda & Santa Clara)	$34,553,000	4,142
Loma Linda University Health (Riverside & San Bernardino)	$12,671,000	2,036
Valley PACE (Fresno & Madera)	$11,942,000	1,704
Family Health Care Network (Tulare & Kings)	$9,295,000	1,473
High Desert PACE (Los Angeles & San Bernardino)	$5,893,000	1,056
Welbe Health Inland Empire PACE (Riverside & San Bernardino)	$52,538,000	7,671
Total FY 2025-26	**$2,474,328,000**	**355,435**

*Totals may differ due to rounding.

PACE (Other M/C)

FY 2026-27	TF Cost (Rounded)	Member Months
Centers for Elders' Independence (Alameda & Contra Costa)	$166,945,000	33,189
Sutter Senior Care (Sacramento)	$64,756,000	11,326
AltaMed Senior Care (Los Angeles & Orange)	$492,061,000	100,944
OnLok (San Francisco, Alameda, & Santa Clara)	$278,419,000	40,425
St. Paul's PACE (San Diego)	$134,330,000	28,382
Los Angeles Jewish Homes (DBA Brandman Center for Senior Care)	$43,219,000	9,681
CalOptima PACE (Orange)	$51,038,000	10,485
InnovAge (San Bernardino & Riverside)	$120,259,000	27,748
Redwood Coast (Humboldt)	$28,183,000	7,325
Innovative Integrated Health (Fresno, Kern, Tulare, & Orange)	$188,934,000	40,176
San Ysidro San Diego	$268,166,000	61,935
Stockton Sierra PACE (San Joaquin & Stanislaus)	$170,311,000	31,036
Gary & Mary West (San Diego)	$42,175,000	9,109
Family Health Centers of San Diego	$42,002,000	9,192
Central Valley (Merced, San Joaquin, & Stanislaus)	$128,418,000	21,537
LA Coast (Los Angeles)	$114,063,000	20,605
Pacific PACE (Los Angeles)	$178,734,000	30,963
Sequoia (Fresno, Kings, Tulare, & Madera)	$108,720,000	22,478
InnovAge (Sacramento, Placer, El Dorado, Sutter, San Joaquin, & Yuba)	$80,433,000	15,144
North East Medical Services (San Francisco)	$21,734,000	4,591
Neighborhood Health (Riverside & San Bernardino)	$60,042,000	12,133
AgeWell PACE (Sonoma & Marin)	$17,798,000	3,456
Providence PACE (Napa, Solano, & Sonoma)	$12,338,000	2,353
ConcertoHealth PACE (Los Angeles)	$14,858,000	3,047
my Place Health	$16,748,000	3,493
WelbeHealth Bay Area (Alameda & Santa Clara)	$47,863,000	8,035
Loma Linda University Health (Riverside & San Bernardino)	$18,370,000	4,018
Valley PACE (Fresno & Madera)	$17,156,000	3,490
Family Health Care Network (Tulare & Kings)	$12,795,000	2,916
High Desert PACE (Los Angeles & San Bernardino)	$2,288,000	494
Welbe Health Inland Empire PACE (Riverside & San Bernardino)	$77,612,000	15,589
Total FY 2026-27	**$3,020,768,000**	**595,295**

*Totals may differ due to rounding.

PACE (Other M/C)

Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2025-26	$2,474,328	$1,314,917	$1,159,411
FY 2026-27	$3,020,768	$1,605,308	$1,415,460

*Totals may differ due to rounding.

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

FISCAL REFERENCE NUMBER:1842

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$226,218,000**	**$246,982,000**
FEDERAL FUNDS	$143,439,300	$154,889,950
GENERAL FUND	$82,778,700	$92,092,050
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$226,218,000**	**$246,982,000**
FEDERAL FUNDS	$143,439,300	$154,889,950
GENERAL FUND	$82,778,700	$92,092,050
OTHER FUNDS	$0	$0

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:
Not Applicable

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 2025-26 and FY 2026-27, is a decrease due to:

- Updated Satisfactory Immigration Status (SIS) and Unsatisfactory Immigration Status (UIS) CY 2026 and CY 2027 rates. Total member months are lower than previously estimated.
- The prior estimate assumed that enrollment would continue at levels close to those observed in July 2025 (the most recent actual month at that time). This estimate incorporates actual enrollment through January 2026 (the most recent actual month).

REGIONAL MODEL

The incremental impact of redeterminations on managed care costs is accounted for separately in the COVID-19 End of Unwinding Flexibilities policy change.

The change in the current estimate, from FY 2025-26 to FY 2026-27, is an increase due to the dollar impact of the incremental SIS and UIS rate change from the current year to the budget year.

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. The last seven months of the CY 2025 rates and the first five months of the CY 2026 rates have been budgeted for FY 2025-26 on a cash basis. For FY 2026-27, the last seven months of the CY 2026 rates and the first five months of the CY 2027 rates have been budgeted on a cash basis.

3. CY 2025 rates are held constant from the previous estimate. CY 2026 rates have been updated this estimate cycle. CY rates used for FY 2026-27 include estimated capitated rate adjustments for CY 2027.

4. The member months in this PC are reflective of actuals through January 2026, inclusive of redetermination impacts. The COVID-19 End of Unwinding Flexibilities PC adjusts these base projections to account for incremental impacts of ending eligibility redetermination flexibilities on the Medi-Cal caseload and managed care enrollment.

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

6. 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.

7. As of January 1, 2025, Wellness Coach services are included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

8. The Department receives 90% FFP for federally eligible family planning services.

9. 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.

10. Beginning October 1, 2026, HR 1 reduces the federal medical assistance percentage for UIS Federal Emergency ACA costs from 90% FF to 50% FF. The impact of this change is incorporated into the dollars of this policy change. For PC specific impacts, please see the HR 1 - UIS Emergency ACA FMAP Adjustment policy change (FRN 2551).

REGIONAL MODEL

11. The Regional Model rate growth from FY 2025-26 to FY 2026-27 is a 6.89% average rate increase on a cash basis.

12. The impact of the Medicare Part A Buy-In, which began January 1, 2025, is captured in this PC. The impact of the Medicare Part A Buy-In phase two expansion, starting January 1, 2026, is also captured in this PC. However, the phase two expansion has been postponed indefinitely and there will be a retroactive adjustment to the CY 2026 rates to account for this. The estimated impact of this rate adjustment is captured in the Retro MC Rate Adjustment PC (FRN 1788).

13. Regional Model dollars on an accrual basis are:

(Dollars in Thousands)

FY 2025-26	**Member Months**	**Total**
Amador	103,950	$40,170
Calaveras	153,776	$58,330
Inyo	55,909	$21,059
Mono	37,105	$12,023
Tuolumne	169,634	$69,148
Total FY 2025-26	520,375	$200,730
Maternity (events)	421	$6,005
Total FY 2025-26 with Maternity		$206,735

(Dollars in Thousands)

FY 2026-27	**Member Months**	**Total**
Amador	105,223	$44,642
Calaveras	155,289	$64,251
Inyo	55,576	$22,530
Mono	37,241	$12,944
Tuolumne	171,029	$76,115
Total FY 2026-27	524,358	$220,482
Maternity (events)	442	$7,540
Total FY 2026-27 with Maternity		$228,022

REGIONAL MODEL

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

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$136,577	$68,289	$68,289
65/% Title XXI / 35% GF (4260-101-0001/0890)	$6,348	$2,222	$4,126
ACA 90% FFP/10% GF (2020 and later)	$72,192	$7,219	$64,973
Title XIX 100% FFP	$5,744	$0	$5,744
100% State GF (4260-101-0001)	$5,015	$5,015	$0
90% Family Planning FFP / 10% GF (4260-101-0001/0890)	$342	$34	$308
Total	**$226,218**	**$82,779**	**$143,439**

(Dollars in Thousands)

FY 2026-27	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$152,910	$76,455	$76,455
65/% Title XXI / 35% GF (4260-101-0001/0890)	$6,179	$2,163	$4,016
ACA 90% FFP/10% GF (2020 and later)	$75,377	$7,538	$67,839
ACA UIS ER 50% FFP/50% GF	$1,003	$502	$502
Title XIX 100% FFP	$5,770	$0	$5,770
100% State GF (4260-101-0001)	$5,401	$5,401	$0
90% Family Planning FFP / 10% GF (4260-101-0001/0890)	$342	$34	$308
Total	**$246,982**	**$92,092**	**$154,890**

DENTAL MANAGED CARE (Other M/C)

FISCAL REFERENCE NUMBER:1029

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$175,042,000**	**$180,042,000**
FEDERAL FUNDS	$96,180,200	$98,543,650
GENERAL FUND	$78,861,800	$81,498,350
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$175,042,000**	**$180,042,000**
FEDERAL FUNDS	$96,180,200	$98,543,650
GENERAL FUND	$78,861,800	$81,498,350
OTHER FUNDS	$0	$0

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 #22-20510
Health Net of California Contract #22-20511
Health Net Community Solutions, Inc. Contract #25-50057
Health Net Community Solutions, Inc. Contract #25-50060
Health Net Community Solutions, Inc. Contract #25-50063
Health Net Community Solutions, Inc. Contract #25-50066
Liberty Dental Plan of California, Inc. Contract #22-20512
Liberty Dental Plan of California, Inc. Contract #22-20513
Liberty Dental Plan of California Inc. Contract #25-50055
Liberty Health Plan of California Inc. Contract #25-50058
Liberty Dental Plan of California Inc. Contract #25-50061
Liberty Health Plan of California Inc. Contract #25-50064
California Dental Network, Inc. Contract #25-50056
California Dental Network, Inc. Contract #25-50059
California Dental Network, Inc. Contract #25-50062
California Dental Network, Inc. Contract #25-50065

Interdependent Policy Changes:
Not Applicable

DENTAL MANAGED CARE (Other M/C)

Background:
The DMC program, established in the 1990s, 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 respectively. The contracted DMC plans are licensed pursuant to the Knox-Keene Health Care Services Plan Act of 1975.

Each DMC 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. DMC covered dental services are the same as services provided under the Dental fee-for-service program.

The Medi-Cal DMC plan contracts established a single-sided risk corridor in the form of a minimum Medical Loss Ratio (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. These recoupments are budgeted in a separate policy change.

For FY 2024-25, operating DMC plans included Liberty Dental Plan of California, Health Net Community Solutions, Inc. and Access Dental Plan. New contracts were procured and awarded to three DMC Plans for the July 2025 through December 2025 time period, with calendar year term extensions intended thereafter: Liberty Dental Plan of California, California Dental Network, Inc., and Health Net Community Solutions, Inc. with Access dental Plan exiting. Each of the DMC plans for the new contract period assumed operations on July 1, 2025, in both Sacramento and Los Angeles County.

Reason for Change:
The change from the prior estimate, for FY 2025-26 and FY 2026-27, is a decrease due to updated eligible counts and rates. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to updated enrollment projections and 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. A 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.

5. There are no withholds budgeted for calendar year 2024 or calendar year 2025, but compliance withholds will resume in calendar year 2026 and performance withholds will resume in calendar year 2027.

DENTAL MANAGED CARE (Other M/C)

FY 2025-26	Total Member Months	Average Monthly Eligibles	Total Costs
Adult - GMC	4,634,404	386,200	$57,725,816
Child - GMC	2,912,952	242,746	$69,702,537
Adult - PHP	2,945,285	245,440	$32,701,091
Child - PHP	1,008,957	84,080	$15,981,174

FY 2026-27	Total Member Months	Average Monthly Eligibles	Total Costs
Adult - GMC	4,650,936	387,578	$62,598,328
Child - GMC	2,933,880	244,490	$73,949,653
Adult - PHP	2,948,424	245,702	$33,826,563
Child - PHP	1,041,180	86,765	$17,753,079

Funding:

FY 2025-26	TF	GF	FF
Regular FMAP T19	$94,468,000	$47,234,000	$47,234,000
ACA 90% FFP/10% GF (2020)	$47,304,000	$4,731,000	$42,573,000
Title 21 65% FFP/35% GF	$9,804,000	$3,431,000	$6,373,000
UIS 100% State GF	$23,466,000	$23,466,000	$0
Total	**$175,042,000**	**$78,862,000**	**$96,180,000**

FY 2026-27	TF	GF	FF
Regular FMAP T19	$96,790,000	$48,395,000	$48,395,000
ACA 90% FFP/10% GF (2020)	$48,466,000	$4,847,000	$43,619,000
Title 21 65% FFP/35% GF	$10,045,000	$3,516,000	$6,529,000
UIS 100% State GF	$24,741,000	$24,741,000	$0
Total	**$180,042,000**	**$81,499,000**	**$98,543,000**

*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)

FISCAL REFERENCE NUMBER:61

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$109,154,000**	**$117,169,000**
FEDERAL FUNDS	$54,097,000	$57,970,500
GENERAL FUND	$55,057,000	$59,198,500
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$109,154,000**	**$117,169,000**
FEDERAL FUNDS	$54,097,000	$57,970,500
GENERAL FUND	$55,057,000	$59,198,500
OTHER FUNDS	$0	$0

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 2025-26, is a decrease due to Calendar Year (CY) 2026 final rates. The change from the prior estimate, for FY 2026-27, is a decrease due to CY 2026 final rates and updated projected CY 2027 rates. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to updated projected rate growth from CY 2026 to CY 2027.

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 20,494 in FY 2025-26 and 20,915 in FY 2026-27.

SENIOR CARE ACTION NETWORK (Other M/C)

3. The CY 2025 and CY 2026 rates are final rates.

4. CY 2027 rates were projected by trending forward the CY 2026 final rates.

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

6. Assume seven months of CY 2026 rating period payments and five months of CY 2027 rating period payments are paid in FY 2026-27.

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

(Dollars in Thousands)

FY 2025-26	Costs	Member Months	Avg. Monthly Members
Los Angeles	$65,589	139,932	11,661
Riverside	$21,104	50,156	4,180
San Bernardino	$14,207	35,212	2,934
San Diego	$8,254	20,631	1,719
Total FY 2025-26	$109,154	245,931	20,494

(Dollars in Thousands)

FY 2026-27	Costs	Member Months	Avg. Monthly Members
Los Angeles	$69,453	138,257	11,521
Riverside	$23,341	53,378	4,448
San Bernardino	$15,845	37,148	3,096
San Diego	$8,529	22,197	1,850
Total FY 2026-27	$117,169	250,981	20,915

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
50% Title XIX FF / 50% GF	$108,194	$54,097	$54,097
100% GF Title XIX	$960	$960	$0
Total FY 2025-26	**$109,154**	**$55,057**	**$54,097**

(Dollars in Thousands)

FY 2026-27	TF	GF	FF
50% Title XIX FF / 50% GF	$115,941	$57,970	$57,971
100% GF Title XIX	$1,228	$1,228	$0
Total FY 2026-27	**$117,169**	**$59,198**	**$57,971**

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

FISCAL REFERENCE NUMBER:1837

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$59,467,000**	**$62,440,000**
FEDERAL FUNDS	$37,533,000	$39,409,000
GENERAL FUND	$21,934,000	$23,031,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$59,467,000**	**$62,440,000**
FEDERAL FUNDS	$37,533,000	$39,409,000
GENERAL FUND	$21,934,000	$23,031,000
OTHER FUNDS	$0	$0

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

Reason for Change:
There is an increase for FY 2025-26 and FY 2026-27, from the prior estimate, due to an increase in caseload and an increase in costs per person. There is an increase from FY 2025-26 to FY 2026-27, in the current estimate, due to anticipating the caseload and expenditure trends continuing through FY 2026-27.

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

Program Forecast	FY 2025-26	FY 2026-27
Average Monthly Caseload	7,817	7,553
Average Expected Deliveries	451	423
Per Member Per Month (PMPM)	$633.95	$688.91

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 2025-26 and FY 2026-27 are:

FY 2025-26	TF	GF	FF
65% Title XXI FFP / 35% GF	$57,742,000	$20,210,000	$37,532,000
100% GF Title XXI	$1,724,000	$1,724,000	$0
Total	**$59,467,000**	**$21,934,000**	**$37,532,000**
FY 2026-27	**TF**	**GF**	**FF**
65% Title XXI FFP / 35% GF	$60,629,000	$21,220,000	$39,409,000
100% GF Title XXI	$1,811,000	$1,811,000	$0
Total	**$62,440,000**	**$23,031,000**	**$39,409,000**

*Totals differ due to rounding.

Funding:
100% Title XXI FFP (4260-101-0890)
100% Title XXI GF (4260-101-0001)

COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM

FISCAL REFERENCE NUMBER:1823

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$16,267,000**	**$16,267,000**
FEDERAL FUNDS	$10,573,550	$10,573,550
GENERAL FUND	$5,693,450	$5,693,450
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$16,267,000**	**$16,267,000**
FEDERAL FUNDS	$10,573,550	$10,573,550
GENERAL FUND	$5,693,450	$5,693,450
OTHER FUNDS	$0	$0

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

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 2025-26 and FY 2026-27, is an increase due to projecting an increase in enrolled members. There is no change from FY 2025-26 to FY 2026-27 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 9,416 CCHIP members in FY 2025-26 and FY 2026-27.

FY 2025-26	TF	GF	FF
Benefits Title XXI 65 FF/35 GF	$16,267,000	$5,693,000	$10,574,000
Total FY 2025-26	**$16,267,000**	**$5,693,000**	**$10,574,000**
FY 2026-27	**TF**	**GF**	**FF**
Benefits Title XXI 65 FF/35 GF	$16,267,000	$5,693,000	$10,574,000
Total FY 2026-27	**$16,267,000**	**$5,693,000**	**$10,574,000**

*Totals may differ due to rounding.

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

AIDS HEALTHCARE CENTERS (Other M/C)

FISCAL REFERENCE NUMBER:63

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$12,536,000**	**$13,622,000**
FEDERAL FUNDS	$7,616,000	$8,124,200
GENERAL FUND	$4,920,000	$5,497,800
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$12,536,000**	**$13,622,000**
FEDERAL FUNDS	$7,616,000	$8,124,200
GENERAL FUND	$4,920,000	$5,497,800
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the cost of capitation rates for PHC California, the Medi-Cal managed care plan operated by AIDS Healthcare Foundation (AHF).

Authority:
Welfare & Institutions Code 14088.85
Welfare & Institutions Code 14184.208

Interdependent Policy Changes:
Not Applicable

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

Effective July 1, 2019, AHF transitioned to a full risk-managed care plan as approved by the Department. AHF provides covered health services for members who are at least 21 years old and who have had a diagnosis of stage three human immunodeficiency virus (HIV) infection.

Reason for Change:
The change from the prior estimate, for FY 2025-26, is a decrease due to CY 2025 actual cost and updated CY 2026 enrollment growth. The change from the prior estimate, for FY 2026-27, is a decrease due to updated CY 2026 and CY 2027 enrollment projections. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to CY 2026 final rates and projected CY 2027 rate growth.

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

Member Months	Dual	Medi-Cal Only
CY 2025	3,845	7,216
CY 2026	3,795	7,122
CY 2027	3,719	6,980

AIDS HEALTHCARE CENTERS (Other M/C)

2. Assume the following paid rates:

Paid Rates	Dual	Medi-Cal Only
CY 2025	$296.67	$1,530.14
CY 2026	$329.30	$1,698.46
CY 2027	$352.68	$1,819.05

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

FY 2025-26	Paid Rate	MM	TF
Dual	$310.27	3,755	$1,165,000
Medi-Cal Only	$1,600.27	7,105	$11,370,000
Total	N/A	N/A	$12,535,000

FY 2026-27	Paid Rate	MM	TF
Dual	$339.05	3,734	$1,266,000
Medi-Cal Only	$1,748.70	7,066	$12,356,000
Total	N/A	N/A	$13,622,000

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

FY 2025-26	**TF**	**GF**	**FF**
50% Title XIX FF / 50% GF	$5,278,000	$2,639,000	$2,639,000
100% GF Title XIX	$1,728,000	$1,728,000	$0
90% Title XIX FF / 50% GF	$5,530,000	$553,000	$4,977,000
Total FY 2025-26	**$12,536,000**	**$4,920,000**	**$7,616,000**

FY 2026-27	**TF**	**GF**	**FF**
50% Title XIX FF / 50% GF	$6,100,000	$3,050,000	$3,050,000
100% GF Title XIX	$1,884,000	$1,884,000	$0
90% Title XIX FF / 50% GF	$5,638,000	$563,800	$5,074,200
Total FY 2026-27	**$13,622,000**	**$5,497,800**	**$8,124,200**

Funding:
50% Title XIX FF / 50% GF (4260-101-0001/0890)
90% Title XIX FF / 50% GF (4260-101-0001/0890)
100% GF Title XIX (4620-101-0001)

MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL

FISCAL REFERENCE NUMBER:1797

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$3,051,000**	**$3,069,000**
FEDERAL FUNDS	$1,983,150	$1,994,850
GENERAL FUND	$1,067,850	$1,074,150
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$3,051,000**	**$3,069,000**
FEDERAL FUNDS	$1,983,150	$1,994,850
GENERAL FUND	$1,067,850	$1,074,150
OTHER FUNDS	$0	$0

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:
There is an increase for FY 2025-26 and FY 2026-27 from the prior estimate, and from FY 2025-26 to FY 2026-27 in the current estimate, due projecting increasing caseload and expenditure trends to continue through FY 2026-27.

MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL

Methodology:

1. The Department estimates the average monthly FFS enrollment will be 169 in FY 2025-26 and FY 2026-27, and the average monthly Medi-Cal Managed Care enrollment will be 697 in FY 2025-26 and FY 2026-27.

2. The Department estimates the weighted average PMPM cost will be $403.56 in FY 2025-26 and FY 2026-27 for FFS infants, and $269.12 in FY 2025-26 and FY 2026-27 for Medi-Cal Managed Care infants.

3. The total estimated costs for MCAIP infants in FY 2025-26 and FY 2026-27 are:

FY 2025-26	**TF**	**GF**	**FF**
Benefits	$3,051,000	$1,068,000	$1,983,000
Net Total	**$3,051,000**	**$1,068,000**	**$1,983,000**
FY 2026-27	**TF**	**GF**	**FF**
Benefits	$3,069,000	$1,074,000	$1,995,000
Net Total	**$3,069,000**	**$1,074,000**	**$1,995,000**

*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

FISCAL REFERENCE NUMBER:76

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$5,975,627,000**	**$6,548,820,000**
FEDERAL FUNDS	$2,527,028,000	$2,764,135,500
GENERAL FUND	$3,448,599,000	$3,784,684,500
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$5,975,627,000**	**$6,548,820,000**
FEDERAL FUNDS	$2,527,028,000	$2,764,135,500
GENERAL FUND	$3,448,599,000	$3,784,684,500
OTHER FUNDS	$0	$0

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 2025-26 and FY 2026-27 were revised down 0.74% and 0.65% respectively from the prior estimate based on six additional months of actual expenditures. The 2026 Part A premium increased by $2.00, and the Part B premium decreased by $3.60 as compared to the prior estimate.

Expenditures are projected to grow by 9.59% between FY 2025-26 and FY 2026-27 due to an estimated increase in the Part A premium of $27.00 and Part B premium of $15.70 between 2026 and 2027.

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

Premiums:

Calendar Year	2025	2026		2027	
	Actual	Nov 2025 Estimate	Actual	Nov 2025 Estimate	May 2026 Estimate
Part A	$518.00	$563.00	$565.00	$592.00	$592.00
Part B	$185.00	$206.50	$202.90	$218.60	$218.60

Average Monthly Beneficiaries:

FY	2024-25	2025-26		2026-27	
	Actual	Nov 2025 Estimate	May 2026 Estimate	Nov 2025 Estimate	May 2026 Estimate
Part A	197,021	268,137	268,203	268,071	268,143
Part B	1,694,494	1,770,585	1,759,677	1,808,777	1,795,901

Methodology:

1. The Centers for Medicare and Medicaid set the following premiums for 2025 and 2026.

Calendar Year	Part A	Part B
2025	$518.00	$185.00
2026	$565.00	$202.90

2. For 2026 and 2027, the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance is projecting 9.07% and 4.78% respective growth in the Medicare Part A premium. Applying this growth to the prior year Part A premium calculates as $518.00 X 1.0907 = $565.00 and $565.00 X 1.0478 = $592.00 (rounded).

3. For 2026 and 2027, the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance is projecting 9.68% and 7.74% respective growth in the Medicare Part B premium. Applying this growth to the prior year Part B premium calculates as $185.00 X 1.0968 = $202.90 and $202.90 X 1.0774 = $218.60 (rounded).

FY 2025-26	**Part A**	**Part B**
Average Monthly Members	268,203	1,759,677
Rate 07/2025-12/2025	$518.00	$185.00
Rate 01/2026-06/2026	$565.00	$202.90

FY 2026-27	**Part A**	**Part B**
Average Monthly Members	268,143	1,795,901
Rate 07/2026-12/2026	$565.00	$202.90
Rate 01/2027-06/2027	$592.00	$218.60

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

Funding:

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
Title XIX 50/50	$5,028,446	$2,514,223	$2,514,223
State GF 100%	$934,376	$934,376	$0
Title XIX 100% FFP	$12,805	$0	$12,805
Total	**$5,975,627**	**$3,448,599**	**$2,527,028**

(Dollars in Thousands)

FY 2026-27	TF	GF	FF
Title XIX 50/50	$5,499,911	$2,749,956	$2,749,955
State GF 100%	$1,034,729	$1,034,729	$0
Title XIX 100% FFP	$14,180	$0	$14,180
Total	**$6,548,820**	**$3,784,685**	**$2,764,135**

PERSONAL CARE SERVICES (Misc. Svcs.)

FISCAL REFERENCE NUMBER:22

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$4,224,145,000**	**$4,875,015,000**
FEDERAL FUNDS	$4,224,145,000	$4,875,015,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$4,224,145,000**	**$4,875,015,000**
FEDERAL FUNDS	$4,224,145,000	$4,875,015,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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, passed in 2012, 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.)

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.

Reason for Change:
There is a decrease from the prior estimate for FY 2025-26 and FY 2026-27, and an increase from FY 2025-26 to FY 2026-27 in the current estimate, due to updated expenditure data provide by CDSS.

Methodology:

1. The following estimates were provided by CDSS on an accrual basis.

(Dollars in Thousands)

FY 2025-26	TF	FF	CDSS GF/ County Share
Title XIX 100% FFP	$8,766,869	$4,383,435	$4,383,434
Total	$8,766,869	$4,383,435	$4,383,434
FY 2026-27	**TF**	**FF**	**CDSS GF/ County Share**
Title XIX 100% FFP	$9,648,317	$4,824,159	$4,824,158
Total	$9,648,317	$4,824,159	$4,824,158

*Totals may differ due to rounding.

2. The following estimates were provided by CDSS on a cash basis.

(Dollars in Thousands)

FY 2025-26	TF	FF	CDSS GF/ County Share
Title XIX 100% FFP	$8,448,291	$4,224,145	$4,224,146
Total	$8,448,291	**$4,224,145**	$4,224,146
FY 2026-27	**TF**	**FF**	**CDSS GF/ County Share**
Title XIX 100% FFP	$9,750,030	$4,875,015	$4,875,015
Total	$9,750,030	**$4,875,015**	$4,875,015

*Totals may differ due to rounding.

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

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

FISCAL REFERENCE NUMBER:23

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$4,605,030,000**	**$4,938,732,000**
FEDERAL FUNDS	$4,605,030,000	$4,938,732,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$4,605,030,000**	**$4,938,732,000**
FEDERAL FUNDS	$4,605,030,000	$4,938,732,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the federal match for the California Department of Developmental Services (CDDS) for the Home & Community Based Services (HCBS) program.

Authority:
Interagency Agreement 01-15834

Interdependent Policy Changes:
Not Applicable

Background:
CDDS, under a federal HCBS waiver, offers and arranges for non-State Plan Medicaid services via the Regional Center system. The HCBS waiver allows the State to offer these services to individuals who would otherwise require the level of care provided in a hospital, nursing facility (NF), or in an intermediate care facility for the developmentally disabled (ICF/DD). Services covered under this waiver include but are not limited to: home health aide services, habilitation, transportation, communication aides, family training, homemaker/chore services, nutritional consultation, specialized medical equipment/supplies, respite care, personal emergency response system, crisis intervention, supported employment and living services, home and vehicle modifications, prevocational services, skilled nursing, residential services, and transition/set-up expenses.

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

Reason for Change:
The change in FY 2025-26, from the prior estimate, is an increase due to the inclusion of claims for the Affordable Care Act (ACA) newly eligible population at the enhanced Federal Medical Assistance Percentage (FMAP) and higher actual expenditures.

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

The change in FY 2026-27, from the prior estimate, is an increase due to the including claims for the ACA newly population claimed at the enhanced FMAP, an estimated growth in service utilization, and updated payment timing.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to an expected increase in expenditures in FY 2026-27.

Methodology:

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

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	FF (ACA)	FF (non-ACA)	Total FF
FY 2025-26	$8,961,142	$4,356,112	$280,033	$4,324,997	**$4,605,030**
FY 2026-27	$9,778,122	$4,839,390	$111,760	$4,826,972	**$4,938,732**

Funding:

Title XIX 100% FFP (4260-101-0890)
100% ACA Title XIX FF (4260-101-0890)

MEDICARE PAYMENTS - PART D PHASED-DOWN

FISCAL REFERENCE NUMBER:1019

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$4,024,294,000**	**$4,367,207,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$4,024,294,000	$4,367,207,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$4,024,294,000**	**$4,367,207,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$4,024,294,000	$4,367,207,000
OTHER 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

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

Calendar Year	PMPM rate
2023	$155.08
2024	$167.50
2025	$181.87
2026	$189.63
2027	$215.54 (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 2022-23	$2,622,797,792	1,656,292
FY 2023-24	$3,144,217,563	1,707,898
FY 2024-25	$3,630,650,591	1,756,171

Reason for Change:

Expenditure projections for FY 2025-26 were revised lower by 0.43% from the prior estimate:

- Actual caseload data through January 2026 is lower than projected, similar to the lower enrollment seen in Medi-Cal senior & persons with disabilities caseload category.

Expenditure projections for FY 2026-27 were revised higher by 0.28% from the prior estimate:

- Projected caseload continues at the lower FY 2025-26 trend, a 2.2% change from prior Estimate.
- The lower caseload projection is offset by the estimated 2027 PMPM increase from $200.75 to $215.54.

Expenditures are projected to increase 8.52% between FY 2025-26 and FY 2026-27 in the current estimate because:

- An estimated increase in the 2027 PMPM rate of $25.91, a 13.66% year over year increase.

Methodology:

1. The 2025 growth increased 8.58% over 2024 amounts per the *Centers for Medicare & Medicaid Services*. Medi-Cal's PMPM rate for 2025 is $181.87.

2. The 2026 growth increased 4.27% over 2025 amounts per the *Centers for Medicare & Medicaid Services*. Medi-Cal's PMPM rate for 2026 is $189.63.

3. The 2027 growth is estimated to increase 13.66% over 2026 amounts per the *Centers for Medicare & Medicaid Services Advance Notice of Methodological Changes for Calendar Year (CY) 2027*. Medi-Cal's estimated PMPM rate for 2027 is $215.54.

MEDICARE PAYMENTS - PART D PHASED-DOWN

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 January 2026.

	Payment Months	Est. Ave. Monthly Members	Est. Ave. Monthly Cost	Total Cost
FY 2025-26	12	1,818,205	$335,358,000	$4,024,294,000
FY 2026-27	12	1,835,372	$363,934,000	$4,367,207,000

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

DENTAL SERVICES

FISCAL REFERENCE NUMBER:135

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$2,701,106,000**	**$2,691,090,000**
FEDERAL FUNDS	$1,426,627,100	$1,418,177,400
GENERAL FUND	$1,274,478,900	$1,272,912,600
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$2,701,106,000**	**$2,691,090,000**
FEDERAL FUNDS	$1,426,627,100	$1,418,177,400
GENERAL FUND	$1,274,478,900	$1,272,912,600
OTHER FUNDS	$0	$0

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

Reason for Change:
The change from the previous estimate for FY 2025-26 and FY 2026-27 are lower expenditures due to six months of additional actuals showing lower users, utilization and rates mainly affecting the Title XIX and XXI children aid categories.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease in total expenditures due to lower projected users.

The previous policy change overstated federal fund dollars while understating general fund dollars resulting in an increase of $138.9M GF dollars in FY 2025-26 and $157.8M in FY 2026-27 in the current estimate.

Methodology:
1. Dental expenditures are estimated using 40 months of cash-basis expenditure data (July 2022 – October 2025) 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.

Funding:
(Dollars in Thousands)

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF	$1,475,805	$737,903	$737,902
ACA 90% FFP/10% GF (2020)	$541,222	$54,122	$487,100
65% Title XXI/35% GF (10/2020)	$310,052	$108,518	$201,534
100% GF	$373,936	$373,936	$0
Title XIX 100% FFP	$91	$0	$91
Total	**$2,701,106**	**$1,274,479**	**$1,426,627**

FY 2026-27	TF	GF	FF
50% Title XIX / 50% GF	$1,467,408	$733,704	$733,704
ACA 90% FFP/10% GF (2020)	$539,253	$53,925	$485,328
65% Title XXI/35% GF (10/2020)	$306,238	$107,183	$199,055
100% GF	$378,100	$378,100	$0
Title XIX 100% FFP	$91	$0	$91
Total	**$2,691,090**	**$1,272,913**	**$1,418,177**

Note: Totals may differ due to rounding.

WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)

FISCAL REFERENCE NUMBER:32

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$525,081,000**	**$616,026,000**
FEDERAL FUNDS	$260,280,000	$305,361,000
GENERAL FUND	$264,801,000	$310,665,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$525,081,000**	**$616,026,000**
FEDERAL FUNDS	$260,280,000	$305,361,000
GENERAL FUND	$264,801,000	$310,665,000
OTHER FUNDS	$0	$0

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.)

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:
The change from the prior estimate, for FY 2025-26 and FY 2026-27, is a decrease due to the backlogged invoices being significantly less than previously estimated, which lowered the trend for both fiscal years. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase based on claims data trending slightly higher month over month.

Methodology:
1. The chart below is on a cash basis.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2025-26	$525,081	$264,801	$260,280
FY 2026-27	$616,026	$310,665	$305,361

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

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

FISCAL REFERENCE NUMBER:26

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$502,052,000**	**$518,524,000**
FEDERAL FUNDS	$502,052,000	$518,524,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$502,052,000**	**$518,524,000**
FEDERAL FUNDS	$502,052,000	$518,524,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the federal match for the California Department of Developmental Services (CDDS) for regional center targeted case management services provided to eligible developmentally disabled clients.

Authority:
Interagency Agreement (IA) 03-75284

Interdependent Policy Changes:
Not Applicable

Background:
Authorized by the Lanterman Act, the Department entered into an IA with CDDS to reimburse the Title XIX federal financial participation (FFP) for targeted case management services for Medi-Cal eligible clients. There are 21 CDDS Regional Centers statewide that provide these services. CDDS conducts a time study every three years and an annual administrative cost survey to determine each regional center's actual cost to provide Targeted Case Management (TCM). A unit of service reimbursement rate for each regional center is established annually. To obtain FFP, the federal government requires that the TCM rate be based on the regional center's cost of providing case management services to all of its consumers with developmental disabilities, regardless of whether the consumer is TCM eligible.

The General Fund is in the CDDS budget on an accrual basis. The federal funds in the Department's budget are on a cash basis.

Reason for Change:
The change in FY 2025-26 and FY 2026-27, from the prior estimate, is an increase due to the including claims for the Affordable Care Act (ACA) newly population claimed at the enhanced Federal Medical Assistance Percentage (FMAP) and higher expenditures.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to expecting an increase in expenditures in FY 2026-27.

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

Methodology:

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

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	FF (ACA)	FF (non-ACA)	Total FF
FY 2025-26	$957,689	$455,637	$52,217	$449,835	**$502,052**
FY 2026-27	$1,028,888	$510,364	$9,180	$509,344	**$518,524**

Funding:

100% Title XIX (4260-101-0890)
100% ACA Title XIX FF (4260-101-0890)

LAWSUITS/CLAIMS

FISCAL REFERENCE NUMBER:2080

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$208,519,000**	**$55,850,000**
FEDERAL FUNDS	$104,259,500	$27,925,000
GENERAL FUND	$104,259,500	$27,925,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$208,519,000**	**$55,850,000**
FEDERAL FUNDS	$104,259,500	$27,925,000
GENERAL FUND	$104,259,500	$27,925,000
OTHER FUNDS	$0	$0

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 2025-26, is an increase due to additional lawsuit settlement payments expected to be made and an update to the Anaheim Regional Medical Center, et al. v. DHCS, et al. settlement amount. There is an increase from the prior estimate for FY 2026-27 due to anticipated payments for part of a new settlement, In the Matter of Highland Outpatient Clinic. The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease due to fewer lawsuit settlement payments expected to be made.

LAWSUITS/CLAIMS

Methodology:

FY 2025-26 (rounded)	Total Amount
Provider Settlements	
Vale Operating Company, LP v. DHCS, et al.	$53,000
Total	**$53,000**
Other Attorney Fees	
Hinkle, et al. v. Kent, et al.	$1,550,000
Tesfai v. DHCS, et al.	$401,000
Total	**$1,951,000**
Other Provider Settlements	
Angel Care dba Cole Homes	$650,000
Anaheim Regional Medical Center, et al. v. DHCS, et al.	$160,000,000
In the matter of Liberty Dental Plan of California, Inc.	$870,000
Mission City Community Network, Inc. v. DHCS	$495,000
In the Matter of Highland Outpatient Clinic	$44,500,000
Total	**$206,515,000**
FY 2025-26 Total (rounded)	**$208,519,000**

FY 2025-26			
	Committed	**Balance**	**Budgeted**
Attorney Fees <$30,000	$0	$200,000	$200,000
Provider Settlements <$100,000	$53,000	$947,000	$1,000,000
Member Settlements <$10,000	$0	$150,000	$150,000
Small Claims Court	$0	$0	$0
Other Attorney Fees	$1,951,000	N/A	$1,951,000
Other Provider Settlements	$206,515,000	N/A	$206,515,000
Other Member Settlements	$0	N/A	$0
Interest Paid	$0	$0	$0
Totals (rounded)	**$208,519,000**	**$1,297,000**	**$209,816,000**

LAWSUITS/CLAIMS

FY 2026-27	
	Budgeted
Attorney Fees<$30,000;Provider Settlements<$100,000; Member Settlements<$10,000	$1,350,000
Other Attorney Fees	$0
Other Provider Settlements	$54,500,000
Other Member Settlements	$0
Interest Paid	$0
Totals (rounded)	**$55,850,000**

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

DEVELOPMENTAL CENTERS/STATE OP SMALL FAC

FISCAL REFERENCE NUMBER:77

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$18,877,000**	**$14,645,000**
FEDERAL FUNDS	$18,877,000	$14,645,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$18,877,000**	**$14,645,000**
FEDERAL FUNDS	$18,877,000	$14,645,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the federal match provided to the California Department of Developmental Services (CDDS) for the Developmental Center (DC) and the State Operated Facility (SOF).

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 one DC and one SOF. The DC is licensed as an intermediate care facility and a general acute care hospital, and the SOF is licensed as an intermediate care facility.

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 2025-26 and FY 2026-27, from the prior estimate, is a decrease due to lower estimated expenditures based on revised projections.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease due to lower expenditures estimated in FY 2026-27.

DEVELOPMENTAL CENTERS/STATE OP SMALL FAC

Methodology:

1. The following estimates, on a cash basis, have been provided by CDDS.

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	FF
FY 2025-26	$37,754	$18,877	**$18,877**
FY 2026-27	$29,290	$14,645	**$14,645**

Funding:

100% Title XIX (4260-101-0890)

MEDI-CAL TCM PROGRAM

FISCAL REFERENCE NUMBER:27

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$12,304,000**	**$9,208,000**
FEDERAL FUNDS	$12,304,000	$9,208,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$12,304,000**	**$9,208,000**
FEDERAL FUNDS	$12,304,000	$9,208,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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 from 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 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 increased

MEDI-CAL TCM PROGRAM

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 2025-26, from the prior estimate, is due to:

- Total Fund and Federal Fund are increasing due to higher actual and estimated base payments to LGAs. LGAs that withdrew from the TCM program under State Plan Amendments (SPAs) 25-0017, 25-0018, 25-0019, 25-0020, and 25-0021 finalized their submissions during the first half of FY 2025-26 rather than using the standard 12-month claiming period.
- There is no impact to the General Fund or Other State Funds, as this program reimburses only the federal share.

The change in FY 2026-27, from the prior estimate, is due to:

- Total Fund and Federal Fund are increasing due to anticipated growth in both base payments and reconciliation payments.
- There is no impact to the General Fund or Other State Funds, as this program reimburses only the federal share.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to:

- Total Fund and Federal Fund are decreasing due to a decline in actual and estimated base payments. This reduction is driven by LGAs withdrawing from the TCM program through SPAs 25-0017, 25-0018, 25-0019, 25-0020, and 25-0021, as well as the implementation of the ECM policy, which shifts the population previously eligible for TCM services to Managed Care Plans for ECM services.
- There is no impact to the General Fund or Other State Funds, as this program reimburses only the federal share.

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 amount of $13,343,000 (Regular and ACA invoices) for FY 2025-26 is based on:

   a. Actual FY 2023-24, FY 2024-25 and FY 2025-26 invoices scheduled to be paid.
   b. Estimated FY 2025-26 invoices which are based on actual claims received during FY 2025-26 Q1 and Q2. This amount incorporates the impact of the implementation of ECM related policy as of FY 2024-25. Consistent with historical trends, 30% of these invoices are expected to be paid during the same FY and the remainder to be paid during the subsequent year.

3. The projected base payment amount of $7,263,000 (Regular and ACA invoices) for FY 2026-27 is based on:
   a. The remainder of unpaid estimated invoices for FY 2025-26 and FY 2026-27.
   b. Consistent with historical trends, 30% of invoices for FY 2026-27 are expected to be paid during the same FY and the remainder anticipated to be paid during the subsequent year.

4. On a cash basis, the FFCRA Increased FMAP of $2,000 was paid in FY 2025-26.

MEDI-CAL TCM PROGRAM

5. In FY 2025-26 and FY 2026-27, the Department will complete reconciliations for FY 2020-21 through FY 2024-25. The Department expects to receive a net amount of $1,041,000 for actual and estimated audit reports during FY 2025-26 and to pay a net amount of $1,945,000 for estimated audit reports during FY 2026-27. The Department anticipates the recoupment/payment of these amounts based on previous invoice history, reimbursement history, and history of reconciliation payments.

FY 2025-26	**TF**	**FF**	**COVID-19 FF**
Base (Regular and ACA Expenditures) with ECM Impact	$13,343,000	$13,343,000	$0
FFCRA Claims	$2,000	$0	$2,000
Reconciliation			
ACA Claims	($126,000)	($126,000)	$0
FFCRA Claims	($713,000)	$0	($713,000)
Regular Claims	($202,000)	($202,000)	$0
Total FY 2025-26	**$12,304,000**	**$13,015,000**	**($711,000)**

FY 2026-27	**TF**	**FF**	**COVID-19 FF**
Base (Regular and ACA Expenditures)	$7,263,000	$7,263,000	$0
Reconciliation			
ACA Claims	$379,000	$379,000	$0
FFCRA Claims	$996,000	$0	$996,000
Regular Claims	$570,000	$570,000	$0
Total FY 2026-27	**$9,208,000**	**$8,212,000**	**$996,000**

Funding:
100% Title XIX FFP (4260-101-0890)
100% Title XIX ACA (4260-101-0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)

HIPP PREMIUM PAYOUTS (Misc. Svcs.)

FISCAL REFERENCE NUMBER:91

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$243,000**	**$255,000**
FEDERAL FUNDS	$121,500	$127,500
GENERAL FUND	$121,500	$127,500
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$243,000**	**$255,000**
FEDERAL FUNDS	$121,500	$127,500
GENERAL FUND	$121,500	$127,500
OTHER FUNDS	$0	$0

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 24-0035

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.

The Centers for Medicare and Medicaid Services (CMS) approved State Plan Amendment (SPA) 24-0035 allowing the Department to revise the eligibility criteria for the HIPP program. Previously, HIPP members and applicants were required to maintain the same Other Health Coverage (OHC) policy when they first enrolled into Medi-Cal and applicants would need to

HIPP PREMIUM PAYOUTS (Misc. Svcs.)

apply for Medicare benefits as part of the HIPP application process. Effective December 1, 2024, these two eligibility criteria have been removed to streamline the HIPP program process. The eligibility criteria revision is expected to have minimal effect on HIPP enrollment.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is due to:
- Lower actual expenditures from July 2025 through December 2025 and revised projected premiums and cost share expenses from January 2026 through June 2026.

The change in FY 2026-27, from the prior estimate, is due to:
- Lower actual expenditures and updated premiums and cost share expenses in FY 2025-26 resulted in updated projected expenditures for FY 2026-27.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to the assumption that premium and cost-sharing obligations increase by 5% in FY 2026-27 based on historical trends.

Methodology:
1. HIPP premium costs are determined by:
   - Actual premium and cost-sharing obligation expenses for July 2025 through December 2025 for the current HIPP members,
   - Using the actual amounts from FY 2025-26 to project premium and cost-sharing obligation expenses for FY 2026-27.
     - The assumption that approximately 34 of the remaining HIPP members will continue their HIPP program eligibility.
   - To project FY 2026-27 costs, the projection is based upon the assumption that:
     - Premium costs and cost-sharing 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 $596 in FY 2025-26 and $626 in FY 2026-27.

3. The average monthly HIPP enrollment is estimated to be 34 in both FY 2025-26 and FY 2026-27.

4. Costs for FY 2025-26 and FY 2026-27 are estimated to be:

   - FY 2025-26: $596 (average PMPM cost) x 34 (estimated member count) x 12 months = $243,000 TF (rounded).
   - FY 2026-27: $626 (average PMPM premium cost) x 34 (estimated member count) x 12 months = $255,000 TF (rounded).

Fiscal Year	TF	GF	FF
FY 2025-26	$243,000	$122,000	$121,000
FY 2026-27	$255,000	$128,000	$127,000

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

BASE RECOVERIES

FISCAL REFERENCE NUMBER:127

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**-$966,554,000**	**-$919,609,000**
FEDERAL FUNDS	-$730,890,700	-$695,392,310
GENERAL FUND	-$235,663,300	-$224,216,690
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**-$966,554,000**	**-$919,609,000**
FEDERAL FUNDS	-$730,890,700	-$695,392,310
GENERAL FUND	-$235,663,300	-$224,216,690
OTHER FUNDS	$0	$0

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

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increase. The phase-out occurred over Calendar Year 2023, and increased FMAP was 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 2025-26, from the prior estimate, is due to:

- Health insurance collections are projected to increase due to the recovery amounts for FY 2025-26 are assumed to be higher based on pharmacy and medical fee-for-service direct billing have continued to increase due to implemented prompt payment standards for insurance carriers and restricting denials. FY 2025-26 also increased to account for approximately five months of close-out recoveries related to the 2018 Health Management Systems contract (HMS) overlapping with new projections for the 2025 HMS contract.
- Personal injury collections are projected to be higher due to two months of one-time higher collections. Actuals have returned to expected, while slightly higher levels.
- Provider overpayments are projected lower due to lower actual recoveries through December 2025, relating to audit timelines for Diagnosis-Related Group (DRG) Private and Non designated Public Hospitals which vary throughout the year. Projections have returned to the levels observed before the recent period of lower actuals.

The change in FY 2026-27, from the prior estimate, is due to:

- Health insurance collections are projected to increase due to pharmacy and medical fee-for-service direct billing have continued to increase due to implemented prompt payment standards for insurance carriers.
- Personal injury collections are projected to be slightly higher due to an increase in settlement amounts awarded and court judgements obtained, increasing the overall trend.
- Provider overpayments are projected lower due to lower actual recoveries through December 2025, relating to audit timelines for Diagnosis-Related Group (DRG) Private and Non designated Public Hospitals which vary throughout the year. Projections have returned to the levels observed before the recent period of lower actuals.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to:

- Health insurance collections are projected to decrease in FY 2026-27 due to FY 2025-26 including close-out recoveries from the 2018 HMS contract.
- Personal injury collections are projected to be lower in FY 2026-27 based on the historical trend, absent anomalous higher collection months in FY 2025-26.
- Provider overpayments are expected to be higher in FY 2026-27 based on the historical trend, absent anomalous lower collection months in FY 2025-26.

BASE RECOVERIES

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 2022 – January 2026.

(Dollars in Thousands)

Recovery Type	FY 2025-26	FY 2026-27
Personal Injury Collections	($210,507)	($196,286)
Workers' Comp. Collections	($4,830)	($5,094)
Health Insurance Collections	($492,950)	($425,000)
General Collections	($258,267)	($293,229)
TOTAL	**($966,554)**	**($919,609)**

Funding:

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	($382,485)	($191,243)	($191,243)
100% GF (4260-101-0001)	$10,172	$10,172	$0
Title XIX 65 FF / 35 GF (4260-101-0890/0001)	($23,577)	($8,252)	($15,325)
Title XIX FFP (4260-101-0890)	($69,296)	$0	($69,296)
94% Title XIX ACA FF / 6% GF (4260-101-0890/0001)	($11,716)	($703)	($11,013)
93% Title XIX ACA FF / 7% GF (4260-101-0890/0001)	($12,677)	($887)	($11,790)
90% Title XIX ACA FF / 10% GF (4260-101-0890/0001)	($476,975)	($47,698)	($429,278)
COVID-19 Title XIX Increased FFP (4260-101-0890)	($2,356)	$0	($2,356)
COVID-19 Title XIX GF (4260-101-0001)	$2,356	$2,356	$0
COVID-19 BCCTP Title XIX Increase FFP (4260-101-0890)	($591)	$0	($591)
COVID-19 BCCTP Title XIX GF (4260-101-0001)	$591	$591	$0
TOTAL	**($966,554)**	**($235,663)**	**($730,891)**

BASE RECOVERIES

FY 2026-27	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	($363,907)	($181,954)	($181,954)
100% GF (4260-101-0001)	$9,678	$9,678	$0
Title XIX 65 FF / 35 GF (4260-101-0890/0001)	($22,432)	($7,851)	($14,581)
Title XIX FFP (4260-101-0890)	($65,931)	$0	($65,931)
94% Title XIX ACA FF / 6% GF (4260-101-0890/0001)	($11,147)	($669)	($10,478)
93% Title XIX ACA FF / 7% GF (4260-101-0890/0001)	($12,061)	($844)	($11,217)
90% Title XIX ACA FF / 10% GF (4260-101-0890/0001)	($453,809)	($45,381)	($408,428)
COVID-19 Title XIX Increased FFP (4260-101-0890)	($2,242)	$0	($2,242)
COVID-19 Title XIX GF (4260-101-0001)	$2,242	$2,242	$0
COVID-19 BCCTP Title XIX Increase FFP (4260-101-0890)	($562)	$0	($562)
COVID-19 BCCTP Title XIX GF (4260-101-0001)	$562	$562	$0
TOTAL	**($919,609)**	**($224,217)**	**($695,392)**

CAP PACE RATES AT LOWER BOUND

FISCAL REFERENCE NUMBER:2581

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**-$67,400,000**
FEDERAL FUNDS	$0	-$33,700,000
GENERAL FUND	$0	-$33,700,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**-$67,400,000**
FEDERAL FUNDS	$0	-$33,700,000
GENERAL FUND	$0	-$33,700,000
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the savings captured at the lower bound rates for 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:
PACE (Other M/C)

Background:
Existing law requires the Department to develop and pay capitation rates to PACE organizations using actuarial methods and consistent with Welfare & Institutions Code section 14301.1(n). The Department develops actuarial rate ranges, representing a range of rates that are actuarially appropriate, in accordance with generally accepted actuarial principles and practices, and using an experience-based rate approach that leverages PACE organizations' historical cost experience to project reasonable, appropriate, and attainable future costs. Each rate range contains a lower bound, midpoint, and upper bound. The Department selects and pays each PACE organization capitation rates within the actuarial rate ranges, not to exceed the Amount that Would Otherwise be Paid as required by the Centers for Medicare & Medicaid Services (CMS) PACE Medicaid Capitation Rate Setting Guide and federal regulation.

Except as may be necessary to comply with Welfare & Institutions Code section 14301.1(n)(10), the Department proposes to cap payments to PACE organizations beginning January 1, 2027, at the lower bound of the actuarial rate ranges.

Reason for Change:
This is a new policy change.

CAP PACE RATES AT LOWER BOUND

Methodology:

1. Assume the lower bound rates will be implemented on January 1, 2027.

2. The estimated impact of implementing this policy is included below.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2026-27	($67,400)	($33,700)	($33,700)

Funding:

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

FFS - PHARMACY

FISCAL REFERENCE NUMBER:2540

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$24,051,152,000**	**$25,643,326,000**
FEDERAL FUNDS	$13,802,458,000	$15,198,806,850
GENERAL FUND	$10,248,694,000	$10,444,519,150
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$24,051,152,000**	**$25,643,326,000**
FEDERAL FUNDS	$13,802,458,000	$15,198,806,850
GENERAL FUND	$10,248,694,000	$10,444,519,150
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates Fee-for-Service Base expenditures for pharmacy services.

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)
Affordable Care Act (ACA)

Interdependent Policy Changes:
Not Applicable

Background:
The Pharmacy Services Fee-For-Services Base (FFS Base) estimates expenditures for prescription drugs, medical supplies, and durable medical equipment (DME). The pharmacy benefits are administered through the FFS delivery system under the Medi-Cal Rx program.

FFS Base estimates in previous cycles showed a federal financial participation (FFP) of 50% and technical adjustments for the ACA expansion population, Children’s Health Insurance Program (CHIP) and non-emergency services for individuals who do not have satisfactory immigration status were budgeted in their own policy changes. A change was made starting with the November 2025 estimate cycle to incorporate the technical adjustment for the FFP within the FFS Base policy change.

FFS - PHARMACY

Reason for Change:

FISCAL YEAR		USERS		UTILIZATION (Days per User)		RATE (Cost per Day)		TOTAL EXPENDITURE	
PY	2024-25	3,720,820	-	3.01	-	$155.74	-	$20,896,530,100	-
CY	2025-26	3,776,190	1.5%	3.09	2.7%	$171.67	10.2%	$24,051,151,900	15.1%
BY	2026-27	3,829,190	1.4%	3.11	0.6%	$179.44	4.5%	$25,643,326,100	6.6%

Users: Users are estimated to increase by 1.5% in CY and 1.4% in BY.

Utilization: Utilization is estimated to increase by 2.7% in CY and 0.6% in BY.

Rate: Rate (average cost per claim) is projected to increase by 10.2% in CY and by 4.5% in BY, primarily due to the rising provider rate increases, including rising prices for prescription drugs and overall cost growth in the medical equipment and supplies manufacturing industry.

Total Expenditures: The total expenditures are estimated to increase by 15.1% from PY to CY and by 6.6% from CY to BY primarily due to the projected increase in rate.

Expenditures for FY 2025–26 have been revised upward by 1.0% compared to the prior estimate. This adjustment reflects the higher than estimated utilization and users, based on six additional months of actual data. The upward revision is partially offset by lower than projected rate.

(Dollars in Thousands)

FISCAL YEAR	TOTAL EXPENDITURE		
	N25	M26	% Change
2025-26	$23,807,971	$24,051,152	1.0%
2026-27	$25,658,484	$25,643,326	-0.1%

Methodology:

1. The Department used linear regressions based upon the most recent 36 months of actual paid claims data from Medi-Cal Rx for users, units per user, and dollars per unit.

2. The Department identified funds allocated to members in the ACA expansion aid categories to estimate expenditures at the 90% federal match.

3. The Department identified funds allocated to members in the CHIP aid categories to estimate expenditures at the 65% federal match.

4. California provides full-scope Medi-Cal services to individuals who do not have satisfactory immigration status; however, non-emergency services that are not pregnancy related are 100% State funded. Based on July 2025 to January 2026 FFS expenditures for non-emergency services provided to this population, the Department estimated the 100% GF expenditures.

FFS - PHARMACY

Funding:

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF	$9,301,333	$4,650,667	$4,650,667
90% Title XIX ACA FF / 10% GF	$9,822,276	$982,228	$8,840,049
65% Title XXI FF / 35% GF	$479,604	$167,861	$311,743
100% GF	$4,447,938	$4,447,938	$0
Total	**$24,051,151**	**$10,248,694**	**$13,802,459**

FY 2026-27	TF	GF	FF
50% Title XIX / 50% GF	$10,049,106	$5,024,553	$5,024,553
90% Title XIX ACA FF / 10% GF	$10,942,891	$1,094,289	$9,848,602
65% Title XXI FF / 35% GF	$501,003	$175,351	$325,652
100% GF	$4,150,326	$4,150,326	$0
Total	**$25,643,326**	**$10,444,519**	**$15,198,807**

*Totals may differ due to rounding.

FFS - OTHER MEDICAL

FISCAL REFERENCE NUMBER:2539

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$7,999,778,000**	**$8,222,865,000**
FEDERAL FUNDS	$4,072,097,950	$3,987,635,400
GENERAL FUND	$3,927,680,050	$4,235,229,600
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$7,999,778,000**	**$8,222,865,000**
FEDERAL FUNDS	$4,072,097,950	$3,987,635,400
GENERAL FUND	$3,927,680,050	$4,235,229,600
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates Fee-For-Service Base expenditures for services included in the Other Medical categories.

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)
Affordable Care Act (ACA)

Interdependent Policy Changes:
Not Applicable

Background:
The Other Medical Fee-For-Service Base (FFS Base) estimates claims paid through the Medi-Cal claims processing systems at the California Medicaid Management Information Systems (CA-MMIS) Fiscal Intermediary for clinics and specialist service providers. Payments to Federally Qualified Health Care Centers and Rural Health Centers (FQHC/RHC) are approximately 95% of expenditures in this category. A complete list of provider types can be found in the Information Only Section.

FFS Base estimates in previous cycles showed a federal financial participation (FFP) of 50% and technical adjustments for the ACA expansion population, Children's Health Insurance Program (CHIP) and non-emergency services for individuals who do not have satisfactory immigration status were budgeted in their own policy changes. A change was made starting with the November 2025 estimate cycle to incorporate the technical adjustment for the FFP within the FFS Base policy change.

FFS - OTHER MEDICAL

Reason for Change:

FISCAL YEAR		USERS		UTILIZATION (Days per User)		RATE (Cost per Day)		TOTAL EXPENDITURE	
PY	2024-25	1,590,820		1.58		$234.66		$7,059,294,500	
CY	2025-26	1,645,160	3.4%	1.59	0.6%	$254.54	8.5%	$7,999,777,800	13.3%
BY	2026-27	1,676,590	1.9%	1.59	0.0%	$256.42	0.7%	$8,222,865,200	2.8%

Users: Users are estimated to increase by 3.4% in the CY. Users are estimated to increase by 1.9% in the BY.

Utilization: Utilization is estimated to increase by 0.6% in the CY but remain unchanged in BY.

Rate: The average rate is estimated to increase by 8.5% in the CY. Rate is estimated to increase by 0.7% in the BY.

Expenditures for the CY are estimated to increase by 13.3% due to users and rates and increase by 2.8% in the BY due to users and rates.

Expenditures for FY 2025-26 are 4.9% higher than previously estimated due to an increase in users and rates. Expenditures for FY 2026-27 are 6.9% higher than previously estimated due to an increase in users and rates.

FISCAL YEAR	TOTAL EXPENDITURE		
	N25	**M26**	**% Change**
2025-26	$7,627,546,500	$7,999,777,800	4.9%
2026-27	$7,692,255,800	$8,222,865,200	6.9%

Methodology:

1. The Department used linear regressions based upon the most recent 36 months of actual paid claims data from CA-MMIS for users, units per user, and dollars per unit.

2. The Department identified funds allocated to members in the ACA expansion aid categories to estimate expenditures at the 90% federal match.

3. The Department identified funds allocated to members in the CHIP aid categories to estimate expenditures at the 65% federal match.

4. California provides full-scope Medi-Cal services to individuals who do not have satisfactory immigration status; however, non-emergency services that are not pregnancy related are 100% State funded. Based on July 2024 to July 2025 FFS expenditures for non-emergency services provided to this population, the Department estimated the 100% GF expenditures.

FFS - OTHER MEDICAL

Funding:

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF	$3,875,153	$1,937,577	$1,937,577
90% Title XIX ACA FF / 10% GF	$2,104,766	$210,477	$1,894,290
65% Title XXI FF / 35% GF	$369,587	$129,355	$240,231
100% GF	$1,650,271	$1,650,271	$0
Total	**$7,999,777**	**$3,927,680**	**$4,072,098**

FY 2026-27	TF	GF	FF
50% Title XIX / 50% GF	$3,844,358	$1,922,179	$1,922,179
90% Title XIX ACA FF / 10% GF	$2,030,312	$203,031	$1,827,280
65% Title XXI FF / 35% GF	$366,424	$128,248	$238,176
100% GF	$1,981,771	$1,981,771	$0
Total	**$8,222,865**	**$4,235,229**	**$3,987,635**

*Totals may differ due to rounding.

FFS - COMMUNITY INPATIENT

FISCAL REFERENCE NUMBER:2543

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$3,206,229,000**	**$3,594,693,000**
FEDERAL FUNDS	$2,064,920,600	$2,303,836,950
GENERAL FUND	$1,141,308,400	$1,290,856,050
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$3,206,229,000**	**$3,594,693,000**
FEDERAL FUNDS	$2,064,920,600	$2,303,836,950
GENERAL FUND	$1,141,308,400	$1,290,856,050
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates Fee-For-Service Base expenditures for acute inpatient services provided by Community Inpatient hospitals

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)
Affordable Care Act (ACA)
State Plan Amendment (SPA) 05-021

Interdependent Policy Changes:
Not Applicable

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). DPHs serve a high volume of Medi-Cal patients and receive Medi-Cal cost-based reimbursement.

FFS Base estimates in previous cycles showed a federal financial participation (FFP) of 50% and technical adjustments for the ACA expansion population, Children's Health Insurance Program (CHIP), DPHs, and non-emergency services for individuals who do not have satisfactory immigration status were budgeted in their own policy changes. A change was made starting with the November 2025 estimate cycle to incorporate the technical adjustment for the FFP within the FFS Base policy change.

FFS - COMMUNITY INPATIENT

Reason for Change:

FISCAL YEAR		USERS		UTILIZATION (Days per User)		RATE (Cost per Day)		TOTAL EXPENDITURE	
PY	2024-25	15,900		7.00		$2,506.59		$3,345,600,000	
CY	2025-26	13,540	-14.8%	7.53	7.6%	$2,620.27	4.5%	$3,206,228,900	-4.2%
BY	2026-27	14,390	6.3%	7.61	1.1%	$2,735.53	4.4%	$3,594,692,600	12.1%

Users: Users are estimated to decrease by 14.8% in CY and increase by 6.3% in BY.

Utilization: Utilization in the CY increased by 7.6% and BY is estimated to remain relatively flat.

Rate: The average rate is estimated to increase by approximately 4.5% in both CY and BY.

Expenditures for CY and BY are revised down 4.2% and 12.1% respectively from the prior estimate based on an additional six months of actuals claim data and include the effects of the end of COVID-19 public health emergency (PHE) administrative flexibilities through January 2026. Ongoing effects of the end of the administrative flexibilities are included in the COVID-19 End of Unwinding Flexibilities policy change.

FISCAL YEAR	TOTAL EXPENDITURE		
	N25	M26	% Change
2025-26	$3,330,895,200	$3,206,228,900	-3.7%
2026-27	$3,564,754,600	$3,594,692,600	-0.8%

Methodology:

1. The Department used linear regressions based upon the most recent 36 months of actual paid claims data from CA-MMIS for users, units per user, and dollars per unit.

2. The Department identified funds allocated to members in the ACA expansion aid categories to estimate expenditures at the 90% federal match.

3. The Department identified funds allocated to members in the CHIP aid categories to estimate expenditures at the 65% federal match.

4. California provides full-scope Medi-Cal services to individuals who do not have satisfactory immigration status; however, non-emergency services that are not pregnancy related are 100% State funded. Based on July 2024 to July 2025 FFS expenditures for non-emergency services provided to this population, the Department estimated the 100% GF expenditures.

5. The Department adopted flexibilities offered by the federal government to help increase administrative efficiencies in the Medi-Cal renewal process. The federal waivers ended June 30, 2025. The end of the PHE administrative flexibilities began to be observed in actuals data in August 2025 and are included in actuals through January 2026. The Estimate brings users to the last month of actuals and assumes the ongoing effects of the end of the administrative flexibilities are budgeted in the COVID-19 End of Unwinding Flexibilities policy change.

FFS - COMMUNITY INPATIENT

6. The Department identified funds for Inpatient Services rendered by District Public Hospitals(DPH's) to estimate expenditures at the 100% FFP.

Funding:

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF	$1,953,081	$976,541	$976,541
90% Title XIX ACA FF / 10% GF	$547,136	$54,714	$492,422
65% Title XXI FF / 35% GF	$120,568	$42,199	$78,369
100% GF	$67,855	$67,855	$0
100% Title XIX FF	$517,588	$0	$517,588
Total	**$3,206,228**	**$1,141,309**	**$2,064,920**

FY 2026-27	TF	GF	FF
50% Title XIX / 50% GF	$2,222,869	$1,111,435	$1,111,435
90% Title XIX ACA FF / 10% GF	$633,416	$63,342	$570,075
65% Title XXI FF / 35% GF	$134,017	$46,906	$87,111
100% GF	$69,173	$69,173	$0
100% Title XIX FF	$535,216	$0	$535,216
Total	**$3,594,691**	**$1,290,856**	**$2,303,837**

*Totals may differ due to rounding.

FFS - OTHER SERVICES

FISCAL REFERENCE NUMBER:2547

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$1,841,281,000**	**$1,967,034,000**
FEDERAL FUNDS	$942,687,750	$1,011,664,650
GENERAL FUND	$898,593,250	$955,369,350
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$1,841,281,000**	**$1,967,034,000**
FEDERAL FUNDS	$942,687,750	$1,011,664,650
GENERAL FUND	$898,593,250	$955,369,350
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates Fee-For-Service Base expenditures for services not included in other FFS categories.

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)
Affordable Care Act (ACA)

Interdependent Policy Changes:
Not Applicable

Background:
The Other Services Fee-For-Service Base (FFS Base) estimates claims paid through the Medi-Cal claims processing systems at the California Medicaid Management Information Systems (CA-MMIS) Fiscal Intermediary for provider types not included in other FFS service categories. Local Education Agency (LEA), Certified Hospice Services, Home Health Agency, and Assisted Living Waiver Services account for most of the expenditures in this service category. A complete list of provider types can be found in the Information Only Section.

FFS Base estimates in previous cycles showed a federal financial participation (FFP) of 50% and technical adjustments for the ACA expansion population, Children’s Health Insurance Program (CHIP) and non-emergency services for individuals who do not have satisfactory immigration status were budgeted in their own policy changes. A change was made starting with the November 2025 estimate cycle to incorporate the technical adjustment for the FFP within the FFS Base policy change.

FFS - OTHER SERVICES

Reason for Change:

FISCAL YEAR		USERS		UTILIZATION (Days per User)		RATE (Cost per Day)		TOTAL EXPENDITURE	
PY	2024-25	269,690	-	3.04	-	$186.77	-	$1,838,226,200	-
CY	2025-26	273,870	1.5%	3.09	1.7%	$181.20	-3.0%	$1,841,280,800	0.2%
BY	2026-27	283,380	3.5%	3.08	-0.4%	$187.81	3.6%	$1,967,034,500	6.8%

Users: LEA accounts for almost half of all users in this service category. Users are estimated to increase by 1.5% in the CY and 3.5% in the BY due to the continued upward trend in users in the LEA program, partly offset by declines in users of genetic disease testing and hospice services.

Utilization: Utilization in the CY and BY are estimated to increase 1.7% and decrease 0.4% respectively reflecting normal fluctuations in the utilization trend.

Rate: The CY rate is estimated to decrease 3.0% from the PY because of lower average rates for the Assisted Living Waiver Program (ALWP) which has a disproportionate effect on this service category because it accounts for approximately half of all expenditures. Rates for BY are projected to increase 3.6% reflecting a return to a more typical historical growth trend.

Expenditures for CY and BY were revised down 8.8% and 3.5% from the prior estimate due to system enhancements and new processes implemented by the Department to strengthen program integrity for hospice service providers resulting in significantly lower hospice service expenditures. Expenditures were also revised down because of lower average rates for ALWP based on six additional months of actuals data.

For the current estimate, expenditures are projected to remain relatively unchanged between CY and PY due to higher estimated users and utilization offset by lower estimated rates. They are projected to grow 6.8% between CY and BY due to higher projections for users and rates based on the historical trend.

FISCAL YEAR	TOTAL EXPENDITURE		
	N25	M26	% Change
2025-26	$2,019,845,200	$1,841,280,800	-8.8%
2026-27	$2,038,293,400	$1,967,034,500	-3.5%

Methodology:

1. The Department used linear regressions based upon the most recent 36 months of actual paid claims data from CA-MMIS for users, units per user, and dollars per unit.

2. The Department identified funds allocated to members in the ACA expansion aid categories to estimate expenditures at the 90% federal match.

3. The Department identified funds allocated to members in the CHIP aid categories to estimate expenditures at the 65% federal match.

FFS - OTHER SERVICES

4. California provides full-scope Medi-Cal services to individuals who do not have satisfactory immigration status; however, non-emergency services that are not pregnancy related are 100% State funded. Based on July 2025 to January 2026 FFS expenditures for non-emergency services provided to this population, the Department estimated the 100% GF expenditures.

5. The Department adopted flexibilities offered by the federal government to help increase administrative efficiencies in the Medi-Cal renewal process as part of the end of the Public Health Emergency (PHE). The federal waivers ended June 30, 2025. The end of the administrative flexibilities began to be observed in actuals data in August 2025 and are included in actuals through January 2026. The Estimate brings users to the last month of actuals and assumes the ongoing effects of the end of the administrative flexibilities are budgeted in the COVID-19 End of Unwinding Flexibilities policy change.

Funding:

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF	$1,686,185	$843,092	$843,092
90% Title XIX ACA FF / 10% GF	$73,004	$7,300	$65,704
65% Title XXI FF / 35% GF	$52,141	$18,249	$33,892
100% GF	$29,951	$29,951	$0
Total	**$1,841,281**	**$898,592**	**$942,688**

FY 2026-27	TF	GF	FF
50% Title XIX / 50% GF	$1,775,164	$887,582	$887,582
90% Title XIX ACA FF / 10% GF	$98,359	$9,836	$88,523
65% Title XXI FF / 35% GF	$54,707	$19,147	$35,559
100% GF	$38,804	$38,804	$0
Total	**$1,967,034**	**$955,369**	**$1,011,664**

*Totals may differ due to rounding.

FFS - NURSING FACILITIES

FISCAL REFERENCE NUMBER:2544

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$737,897,000**	**$696,648,000**
FEDERAL FUNDS	$405,665,300	$357,186,400
GENERAL FUND	$332,231,700	$339,461,600
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$737,897,000**	**$696,648,000**
FEDERAL FUNDS	$405,665,300	$357,186,400
GENERAL FUND	$332,231,700	$339,461,600
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates Fee-For-Service Base expenditures for nursing facilities services.

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)
Affordable Care Act (ACA)

Interdependent Policy Changes:
Not Applicable

Background:
The Nursing Facilities Fee-For-Service Base (FFS Base) estimates claims paid through the Medi-Cal claims processing systems at the California Medicaid Management Information Systems (CA-MMIS) Fiscal Intermediary for nursing facility services providing by AB 1629 facilities and other facilities. AB 1629 facilities have a Quality Assurance Fee (QAF) and Quality and Accountability Supplemental Payment (QASP). These facilities are comprised of Skilled Nursing Facilities (SNF) or Free Standing (FS) Nursing Facility Services Level B (NF-B). Other facilities service categories include Nursing Facilities Level A (NF-A), Distinct Part Nursing Facility Services (DP/NF-B), Adult and Pediatric Subacute Services, and Rural Swing Beds.

FFS Base estimates in previous cycles showed a federal financial participation (FFP) of 50% and technical adjustments for the ACA expansion population, Children's Health Insurance Program (CHIP) and non-emergency services for individuals who do not have satisfactory immigration status were budgeted in their own policy changes. A change was made starting with the November 2025 estimate cycle to incorporate the technical adjustment for the FFP within the FFS Base policy change.

FFS - NURSING FACILITIES

Reason for Change:

FISCAL YEAR		USERS		UTILIZATION (Days per User)		RATE (Cost per Day)		TOTAL EXPENDITURE	
PY	2024-25	7,250	-	32.84	-	$285.25	-	$815,191,900	-
CY	2025-26	6,720	-7.3%	29.82	-9.2%	$306.71	7.5%	$737,896,700	-9.5%
BY	2026-27	6,790	1.0%	29.37	-1.5%	$291.06	-5.1%	$696,648,300	-5.6%

Users: Compared to PY, users are estimated to decrease by 7.3% in Current Year (CY), followed by a slight increase of 1.0% in Budget Year (BY).

Utilization: Utilization is estimated to decrease by 9.2% in CY, followed by a decrease of 1.5% in BY.

Rate: The rate is projected to rise by 7.5% in the CY, driven by an increase in December 2025 across five of the six total aid categories, and then decline by 5.1% in the BY.

Total Expenditure: The CY is estimated to decrease by 9.5% due to decrease in both user and utilization estimates, and the BY projection is expected to further decrease 5.6% compared to the CY estimate.

Compared to the November 2025 estimate, total expenditures in the May 2026 estimates for FY 2025–26 and FY 2026–27 decreased by 13.2% and 14.1%, respectively. These reductions are likely attributable to the CalAIM implementation that began in January 2024, which led to declines in both users and utilization for the CY and declines in both utilization and rate in BY.

FISCAL YEAR	TOTAL EXPENDITURE		
	N25	M26	% Change
2025-26	$850,029,400	$737,896,700	-13.2%
2026-27	$810,529,700	$696,648,300	-14.1%

Methodology:

1. The Department used linear regressions based upon the most recent 36 months of actual paid claims data from CA-MMIS for users, units per user, and dollars per unit.

2. The Department identified funds allocated to members in the ACA expansion aid categories to estimate expenditures at the 90% federal match.

3. The Department identified funds allocated to members in the CHIP aid categories to estimate expenditures at the 65% federal match.

4. California provides full-scope Medi-Cal services to individuals who do not have satisfactory immigration status; however, non-emergency services that are not pregnancy related are 100% State funded. Based on July 2024 to July 2025 FFS expenditures for non-emergency services provided to this population, the Department estimated the 100% GF expenditures.

FFS - NURSING FACILITIES

Funding:

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF	$696,930	$348,465	$348,465
90% Title XIX ACA FF / 10% GF	$62,526	$6,253	$56,273
65% Title XXI FF / 35% GF	$1,426	$499	$927
100% GF	-$22,985	-$22,985	$0
Total	**$737,897**	**$332,232**	**$405,665**

FY 2026-27	TF	GF	FF
50% Title XIX / 50% GF	$639,382	$319,691	$319,691
90% Title XIX ACA FF / 10% GF	$41,704	$4,170	$37,534
65% Title XXI FF / 35% GF	-$58	-$20	-$38
100% GF	$15,621	$15,621	$0
Total	**$696,649**	**$339,462**	**$357,187**

*Totals may differ due to rounding.

FFS - COUNTY INPATIENT

FISCAL REFERENCE NUMBER:2542

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$615,158,000**	**$660,042,000**
FEDERAL FUNDS	$606,812,950	$641,008,900
GENERAL FUND	$8,345,050	$19,033,100
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$615,158,000**	**$660,042,000**
FEDERAL FUNDS	$606,812,950	$641,008,900
GENERAL FUND	$8,345,050	$19,033,100
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates Fee-For-Service Base expenditures for acute inpatient services rendered by county hospitals.

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)
Affordable Care Act (ACA)
State Plan Amendment (SPA) 05-021

Interdependent Policy Changes:
Not Applicable

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.

FFS Base estimates in previous cycles showed a federal financial participation (FFP) of 50% and technical adjustments for the ACA expansion population, Children's Health Insurance Program (CHIP), DPHs and non-emergency services for individuals who do not have satisfactory immigration status were budgeted in their own policy changes. A change was made starting with the November 2025 estimate cycle to incorporate the technical adjustments for the FFP within the FFS Base policy changes.

FFS - COUNTY INPATIENT

Reason for Change:

FISCAL YEAR		USERS		UTILIZATION (Days per User)		RATE (Cost per Day)		TOTAL EXPENDITURE	
PY	2024-25	2,300		6.15		$3,987.92		$678,066,700	
CY	2025-26	1,940	-15.7%	6.49	5.5%	$4,068.46	2.0%	$615,157,700	-9.3%
BY	2026-27	2,050	5.7%	6.58	1.4%	$4,072.94	0.1%	$660,042,500	7.3%

Users: Users are estimated to decrease by 15.7% in CY and increase by 5.7% in BY.

Utilization: Utilization in CY is expected to increase by 5.5% and 1.4% in BY.

Rate: The average rate is estimated to increase by 2% in CY and remain relatively flat in the BY.

Expenditures for FY 2025-26 are revised down 9.3% from the prior estimate based on an additional six months of actuals claim data and include the effects of the end of COVID-19 public health emergency (PHE) administrative flexibilities through January 2026. Ongoing effects of the end of the administrative flexibilities are included in the COVID-19 End of Unwinding Flexibilities policy change.

Expenditures are projected to decrease 5.6% between FY 2025-26 and FY 2026-27 due to a decrease in users.

FISCAL YEAR	TOTAL EXPENDITURE		
	N25	**M26**	**% Change**
2025-26	$651,492,500	$615,157,700	-5.6%
2026-27	$662,954,400	$660,042,500	-0.4%

Methodology:

1. The Department used linear regressions based upon the most recent 36 months of actual paid claims data from CA-MMIS for users, units per user, and dollars per unit.

2. The Department identified funds allocated to members in the ACA expansion aid categories to estimate expenditures at the 90% federal match.

3. The Department identified funds allocated to members in the CHIP aid categories to estimate expenditures at the 65% federal match.

4. California provides full-scope Medi-Cal services to individuals who do not have satisfactory immigration status; however, non-emergency services that are not pregnancy related are 100% State funded. Based on July 2025 to January 2026 FFS expenditures for non-emergency services provided to this population, the Department estimated the 100% GF expenditures.

5. The Department adopted flexibilities offered by the federal government to help increase administrative efficiencies in the Medi-Cal renewal process. The federal waivers ended June

FFS - COUNTY INPATIENT

30, 2025. The end of the PHE administrative flexibilities began to be observed in actuals data in August 2025 and are included in actuals through January 2026. The Estimate brings users to the last month of actuals and assumes the ongoing effects of the end of the administrative flexibilities are budgeted in the COVID-19 End of Unwinding Flexibilities policy change.

6. The Department identified funds for Inpatient Services rendered by District Public Hospitals (DPH's) to estimate expenditures at the 100% FFP. Although all County Inpatient hospitals are considered DPH's, the non-federal share of Medi-Cal utilizes general fund dollars.

Funding:

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF	-$55,634	-$27,817	-$27,817
90% Title XIX ACA FF / 10% GF	$22,358	$2,236	$20,122
65% Title XXI FF / 35% GF	$7,255	$2,539	$4,716
100% GF	$31,387	$31,387	$0
100% Title XIX FF	$609,792	$0	$609,792
Total	**$615,158**	**$8,345**	**$606,813**

FY 2026-27	TF	GF	FF
50% Title XIX / 50% GF	-$45,760	-$22,880	-$22,880
90% Title XIX ACA FF / 10% GF	$70,324	$7,032	$63,292
65% Title XXI FF / 35% GF	$7,322	$2,563	$4,759
100% GF	$32,318	$32,318	$0
100% Title XIX FF	$595,838	$0	$595,838
Total	**$660,042**	**$19,033**	**$641,009**

*Totals may differ due to rounding.

FFS - CO. & COMM. OUTPATIENT

FISCAL REFERENCE NUMBER:2541

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$619,973,000**	**$646,148,000**
FEDERAL FUNDS	$342,256,950	$357,354,000
GENERAL FUND	$277,716,050	$288,794,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$619,973,000**	**$646,148,000**
FEDERAL FUNDS	$342,256,950	$357,354,000
GENERAL FUND	$277,716,050	$288,794,000
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates Fee-For-Service Base expenditures for services provided by County and Community Outpatient providers.

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)
Affordable Care Act (ACA)

Interdependent Policy Changes:
Not Applicable

Background:
Fee-For-Service Base (FFS Base) County and Community Outpatient estimates claims paid through the Medi-Cal claims processing systems at the California Medicaid Management Information Systems (CA-MMIS) Fiscal Intermediary for services provided by county and community hospitals that do not require an overnight stay.

FFS Base estimates in previous cycles showed a federal financial participation (FFP) of 50% and technical adjustments for the ACA expansion population, Children’s Health Insurance Program (CHIP) and non-emergency services for individuals who do not have satisfactory immigration status were budgeted in their own policy changes. A change was made starting with the November 2025 estimate cycle to incorporate the technical adjustment for the FFP within the FFS Base policy change.

FFS - CO. & COMM. OUTPATIENT

Reason for Change:

FISCAL YEAR		USERS		UTILIZATION (Days per User)		RATE (Cost per Day)		TOTAL EXPENDITURE	
PY	2024-25	112,580	-	1.77	-	$249.15	-	$596,982,300	-
CY	2025-26	97,700	-13.2%	1.79	1.1%	$294.82	18.3%	$619,972,800	3.9%
BY	2026-27	102,940	5.4%	1.80	0.6%	$290.61	-1.4%	$646,148,300	4.2%

Users: Caseload is projected to decline by 13.2 percent in the current year followed by an increase of 5.4 percent in the budget year.

Utilization: Utilization is projected to increase by 1.1 percent in the current year and to increase by 0.6 percent in the budget year.

Rate: The rate is expected to increase by 18.3 percent in the current year, primarily driven by increased utilization of high-cost gene therapy treatments. The average rate is projected to decrease by 1.4 percent in the budget year.

Expenditures for FY 2025-26 are projected to increase by 3.9 percent from the prior year, as higher average rates—driven by increased utilization of high-cost gene therapy treatments—more than offset the decline in projected caseload.

Expenditures are projected to increase by 4.2 percent between FY 2025-26 and FY 2026-27, primarily driven by growth in projected caseload.

Reason for Change from Prior Estimate

FISCAL YEAR	TOTAL EXPENDITURE		
	N25	M26	% CHANGE
2025-26	$639,031,800	$619,972,800	-3.0%
2026-27	$654,505,600	$646,148,300	-1.3%

Expenditures for CY and BY are revised down 3 and 1.3 percent, respectively, from the prior estimate based on an additional six months of actuals claim data and include the effects of the end of COVID-19 public health emergency (PHE) administrative flexibilities through January 2026. Ongoing effects of the end of the administrative flexibilities are included in the COVID-19 End of Unwinding Flexibilities policy change.

Methodology:

1. The Department used linear regressions based upon the most recent 36 months of actual paid claims data from CA-MMIS for users, units per user, and dollars per unit.

2. The Department identified funds allocated to members in the ACA expansion aid categories to estimate expenditures at the 90% federal match.

3. The Department identified funds allocated to members in the CHIP aid categories to estimate expenditures at the 65% federal match.

FFS - CO. & COMM. OUTPATIENT

4. California provides full-scope Medi-Cal services to individuals who do not have satisfactory immigration status; however, non-emergency services that are not pregnancy related are 100% State funded. Based on July 2024 to July 2025 FFS expenditures for non-emergency services provided to this population, the Department estimated the 100% GF expenditures.

5. The Department adopted flexibilities offered by the federal government to help increase administrative efficiencies in the Medi-Cal renewal process. The federal waivers ended June 30, 2025. The end of the PHE administrative flexibilities began to be observed in actuals data in August 2025 and are included in actuals through January 2026. The Estimate brings users to the last month of actuals and assumes the ongoing effects of the end of the administrative flexibilities are budgeted in the COVID-19 End of Unwinding Flexibilities policy change.

Funding:

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF	$400,146	$200,073	$200,073
90% Title XIX ACA FF / 10% GF	$115,780	$11,578	$104,202
65% Title XXI FF / 35% GF	$58,433	$20,452	$37,982
100% GF	$45,613	$45,613	$0
Total	**$619,972**	**$277,716**	**$342,257**

FY 2026-27	TF	GF	FF
50% Title XIX / 50% GF	$418,472	$209,236	$209,236
90% Title XIX ACA FF / 10% GF	$126,084	$12,608	$113,476
65% Title XXI FF / 35% GF	$53,296	$18,654	$34,642
100% GF	$48,296	$48,296	$0
Total	**$646,148**	**$288,794**	**$357,354**

*Totals may differ due to rounding.

FFS - PHYSICIANS

FISCAL REFERENCE NUMBER:2538

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$521,854,000**	**$523,847,000**
FEDERAL FUNDS	$291,207,650	$294,234,400
GENERAL FUND	$230,646,350	$229,612,600
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$521,854,000**	**$523,847,000**
FEDERAL FUNDS	$291,207,650	$294,234,400
GENERAL FUND	$230,646,350	$229,612,600
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates Fee-For-Service Base expenditures for services included in the Physicians categories.

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)
Affordable Care Act (ACA)

Interdependent Policy Changes:
Not Applicable

Background:
The Physicians Fee-For-Service Base (FFS Base) estimates claims paid through the Medi-Cal claims processing systems at the California Medicaid Management Information Systems (CA-MMIS) Fiscal Intermediary for physicians (M.D. or D.O.) and physician groups. A complete list of provider types can be found in the Information Only Section.

FFS Base estimates in previous cycles showed a federal financial participation (FFP) of 50% and technical adjustments for the ACA expansion population, Children’s Health Insurance Program (CHIP) and non-emergency services for individuals who do not have satisfactory immigration status were budgeted in their own policy changes. A change was made starting with the November 2025 estimate cycle to incorporate the technical adjustment for the FFP within the FFS Base policy change.

FFS - PHYSICIANS

Reason for Change:

FISCAL YEAR		USERS		UTILIZATION (Days per User)		RATE (Cost per Day)		TOTAL EXPENDITURE	
PY	2024-25	184,670		2.67		$101.64		$600,798,100	
CY	2025-26	150,550	-18.5%	2.83	6.0%	$102.24	0.6%	$521,854,500	-13.1%
BY	2026-27	151,880	0.9%	2.83	0.0%	$101.64	-0.6%	$523,847,000	0.4%

Users: Users are estimated to decrease by 18.5% in the CY. Users are estimated to increase by 0.9% in the BY.

Utilization: Utilization is estimated to increase by 6.0% in the CY and remain the same in the BY.

Rate: The average rate is estimated to increase by 0.6% in the CY and decrease by 0.6% in the BY.

Expenditures for the CY are estimated to decrease by 13.1%. The BY is estimated to increase by 0.4% due to an estimated increase in users.

Expenditures for FY 2025-26 are 12.9% lower than estimated in November 2025 due to a decrease in users but partly offset by an increase in utilization. Estimated expenditures for FY 2026-27 are 14.8% lower than previously estimated due to a decrease in users but partly offset by an increase in utilization.

FISCAL YEAR	TOTAL EXPENDITURE		
	N25	M26	% Change
2025-26	$599,116,200	$521,854,500	-12.9%
2026-27	$614,676,000	$523,847,000	-14.8%

Methodology:

1. The Department used linear regressions based upon the most recent 36 months of actual paid claims data from CA-MMIS for users, units per user, and dollars per unit.

2. The Department identified funds allocated to members in the ACA expansion aid categories to estimate expenditures at the 90% federal match.

3. The Department identified funds allocated to members in the CHIP aid categories to estimate expenditures at the 65% federal match.

4. California provides full-scope Medi-Cal services to individuals who do not have satisfactory immigration status; however, non-emergency services that are not pregnancy related are 100% State funded. Based on July 2024 to July 2025 FFS expenditures for non-emergency services provided to this population, the Department estimated the 100% GF expenditures.

5. The Department adopted flexibilities offered by the federal government to help increase administrative efficiencies in the Medi-Cal renewal process. The federal waivers ended June

FFS - PHYSICIANS

30, 2025. The end of the administrative flexibilities began to be observed in actuals data in August 2025 and are included in actuals through January 2026. The Estimate brings users to the last month of actuals and assumes the ongoing effects of the end of the administrative flexibilities are budgeted in the COVID-19 End of Unwinding Flexibilities policy change.

Funding:

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF	$351,906	$175,953	$175,953
90% Title XIX ACA FF / 10% GF	$105,180	$10,518	$94,662
65% Title XXI FF / 35% GF	$31,681	$11,088	$20,593
100% GF	$33,087	$33,087	$0
Total	**$521,854**	**$230,646**	**$291,208**

FY 2026-27	TF	GF	FF
50% Title XIX / 50% GF	$346,925	$173,463	$173,463
90% Title XIX ACA FF / 10% GF	$110,113	$11,011	$99,102
65% Title XXI FF / 35% GF	$33,338	$11,668	$21,670
100% GF	$33,470	$33,470	$0
Total	**$523,846**	**$229,612**	**$294,235**

*Totals may differ due to rounding.

FFS - HOME HEALTH

FISCAL REFERENCE NUMBER:2548

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$132,896,000**	**$136,128,000**
FEDERAL FUNDS	$68,688,200	$70,393,350
GENERAL FUND	$64,207,800	$65,734,650
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$132,896,000**	**$136,128,000**
FEDERAL FUNDS	$68,688,200	$70,393,350
GENERAL FUND	$64,207,800	$65,734,650
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates Fee-For-Service Base expenditures for the Home Health service category.

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)
Affordable Care Act (ACA)

Interdependent Policy Changes:
Not Applicable

Background:
Home Health Agencies provide outpatient benefits prescribed by physicians according to a written treatment plan. These benefits are usually administered in a home setting and the plan is reviewed by the physician every 60 days. Home Health is not a medically oriented service.

FFS Base estimates in previous cycles showed a federal financial participation (FFP) of 50% and technical adjustments for the ACA expansion population, Children’s Health Insurance Program (CHIP) and non-emergency services for individuals who do not have satisfactory immigration status were budgeted in their own policy changes. A change was made starting with the November 2025 estimate cycle to incorporate the technical adjustment for the FFP within the FFS Base policy change.

FFS - HOME HEALTH

Reason for Change:

FISCAL YEAR		USERS		UTILIZATION (Days per User)		RATE (Cost per Day)		TOTAL EXPENDITURE	
PY	2024-25	1,850	-	5.85	-	$1,061.87	-	$138,038,300	-
CY	2025-26	1,680	-9.2%	6.28	7.4%	$1,047.09	-1.4%	$132,896,000	-3.7%
BY	2026-27	1,690	0.6%	6.33	0.8%	$1,060.84	1.3%	$136,127,900	2.4%

Users: Caseload is projected to decline by 9.2 percent in the current year based on an additional six months of actuals claim data and include the effects of the end of COVID-19 public health emergency (PHE) administrative flexibilities through January 2026. Caseload in the budget year are projected to increase by 0.6 percent.

Utilization: Utilization is projected to increase by 7.4 percent in the current year reflecting higher-than-anticipated service use based on later actual data. Utilization is projected to increase modestly by 0.8 percent in the budget year.

Rate: The rate is projected to decrease by 1.4 percent in the current year and to increase by 1.3 percent in the budget year.

Expenditures for FY 2025-26 are expected to decrease by 3.7 percent from the prior year with the projected decrease in caseload partially offset by an increase in utilization.

Expenditure is projected to increase by 2.4 percent in the budget year, reflecting modest increases across each component.

Reason for Change from Prior Estimate

FISCAL YEAR	TOTAL EXPENDITURE		
	N25	M26	% Change
2025-26	$132,869,000	$132,896,000	0.0%
2026-27	$133,932,700	$136,127,900	1.6%

Compared to the November 2025 estimate, total expenditure is projected to remain flat in the current year. The May 2026 estimate for total expenditure in the budget year is projected to increase by 1.6 percent.

Methodology:

1. The Department used linear regressions based upon the most recent 36 months of actual paid claims data from CA-MMIS for users, units per user, and dollars per unit.

2. The Department identified funds allocated to members in the ACA expansion aid categories to estimate expenditures at the 90% federal match.

3. The Department identified funds allocated to members in the CHIP aid categories to estimate expenditures at the 65% federal match.

FFS - HOME HEALTH

4. California provides full-scope Medi-Cal services to individuals who do not have satisfactory immigration status; however, non-emergency services that are not pregnancy related are 100% State funded. Based on July 2024 to July 2025 FFS expenditures for non-emergency services provided to this population, the Department estimated the 100% GF expenditures.

5. The Department adopted flexibilities offered by the federal government to help increase administrative efficiencies in the Medi-Cal renewal process. The federal waivers ended June 30, 2025. The end of the PHE administrative flexibilities began to be observed in actuals data in August 2025 and are included in actuals through January 2026. The Estimate brings users to the last month of actuals and assumes the ongoing effects of the end of the administrative flexibilities are budgeted in the COVID-19 End of Unwinding Flexibilities policy change.

Funding:
(Dollars in Thousands)

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF	$119,182	$59,591	$59,591
90% Title XIX ACA FF / 10% GF	$1,684	$168	$1,516
65% Title XXI FF / 35% GF	$11,664	$4,082	$7,582
100% GF	$366	$366	$0
Total	**$132,896**	**$64,207**	**$68,689**

FY 2026-27	TF	GF	FF
50% Title XIX / 50% GF	$121,746	$60,873	$60,873
90% Title XIX ACA FF / 10% GF	$1,684	$168	$1,516
65% Title XXI FF / 35% GF	$12,315	$4,310	$8,005
100% GF	$383	$383	$0
Total	**$136,128**	**$65,734**	**$70,394**

*Totals may differ due to rounding.

FFS - MEDICAL TRANSPORTATION

FISCAL REFERENCE NUMBER:2546

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$75,851,000**	**$77,918,000**
FEDERAL FUNDS	$50,839,100	$52,290,100
GENERAL FUND	$25,011,900	$25,627,900
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$75,851,000**	**$77,918,000**
FEDERAL FUNDS	$50,839,100	$52,290,100
GENERAL FUND	$25,011,900	$25,627,900
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates Fee-For-Service Base expenditures for the Medical Transportation service category.

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)
Affordable Care Act (ACA)

Interdependent Policy Changes:
Not Applicable

Background:
The Medical Transportation Fee-For-Service Base (FFS Base) estimates claims paid through the Medi-Cal claims processing systems at the California Medicaid Management Information Systems (CA-MMIS) Fiscal Intermediary for provider types emergency and non-emergency Ground Medical Transportation and Air Ambulance Transportation.

FFS Base estimates in previous cycles showed a federal financial participation (FFP) of 50% and technical adjustments for the ACA expansion population, Children's Health Insurance Program (CHIP) and non-emergency services for individuals who do not have satisfactory immigration status were budgeted in their own policy changes. A change was made starting with the November 2025 estimate cycle to incorporate the technical adjustment for the FFP within the FFS Base policy change.

FFS - MEDICAL TRANSPORTATION

Reason for Change:

FISCAL YEAR		USERS		UTILIZATION (Days per User)		RATE (Cost per Day)		TOTAL EXPENDITURE	
PY	2024-25	10,900		1.85		$331.28		$79,967,800	
CY	2025-26	9,830	-9.8%	1.80	-2.7%	$357.46	7.9%	$75,851,400	-5.1%
BY	2026-27	9,940	1.1%	1.81	0.6%	$360.78	0.9%	$77,917,900	2.7%

Users: The historical downward trend in users is assumed to continue through the CY then level out for a year over year reduction of 9.8% for the CY and a modest growth of 1.1% for the BY.

Utilization: Utilization is assumed to continue the historical downward trend, decreasing 2.7% in the CY. This trend is believed to be due to the carve-in of long-term care services into managed care and the transition of the Ground Emergency Medical Transportation (GEMT) Quality Assurance Fee (QAF) program to the Public Provider GEMT (PP-GEMT) Program. Utilization is projected to grow 0.6% in the BY.

Rate: The rate is estimated to increase 7.9% in the CY partly due to the 2024 PP-GEMT add-on increase which was effective January 2024 for the calendar year but was not implemented until 2025. The rate is projected to increase 0.9% in the BY.

Expenditures for the CY and BY are revised down 6.7% and 5.0% respectively from the prior estimate based on an additional six months of actuals claims data and include the effects of the end of public health emergency (PHE) administrative flexibilities through January 2026. Ongoing effects of the end of the administrative flexibilities are included in the COVID-19 End of Unwinding Flexibilities policy change.

Expenditures are estimated to decrease 5.1% in the CY due to fewer estimated users and utilization, partly offset by higher estimated rates. Expenditures are projected to increase 2.7% in the BY, reflecting more typical trends in users, utilization and rates.

FISCAL YEAR	TOTAL EXPENDITURE		
	N25	M26	% Change
2025-26	$81,291,000	$75,851,400	-6.7%
2026-27	$81,984,400	$77,917,900	-5.0%

Methodology:

1. The Department used linear regressions based upon the most recent 36 months of actual paid claims data from CA-MMIS for users, units per user, and dollars per unit.

2. The Department identified funds allocated to members in the ACA expansion aid categories to estimate expenditures at the 90% federal match.

3. The Department identified funds allocated to members in the CHIP aid categories to estimate expenditures at the 65% federal match.

FFS - MEDICAL TRANSPORTATION

4. California provides full-scope Medi-Cal services to individuals who do not have satisfactory immigration status; however, non-emergency services that are not pregnancy related are 100% State funded. Based on July 2025 to January 2026 FFS expenditures for non-emergency services provided to this population, the Department estimated the 100% GF expenditures.

5. The Department adopted flexibilities offered by the federal government to help increase administrative efficiencies in the Medi-Cal renewal process. The federal waivers ended June 30, 2025. The end of the administrative flexibilities began to be observed in actuals data in August 2025 and are included in actuals through January 2026. The Estimate brings users to the last month of actuals and assumes the ongoing effects of the end of the administrative flexibilities are budgeted in the COVID-19 End of Unwinding Flexibilities policy change.

Funding:

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF	$41,462	$20,731	$20,731
90% Title XIX ACA FF / 10% GF	$32,750	$3,275	$29,475
65% Title XXI FF / 35% GF	$974	$341	$633
100% GF	$665	$665	$0
Total	**$75,851**	**$25,012**	**$50,839**

FY 2026-27	TF	GF	FF
50% Title XIX / 50% GF	$42,518	$21,259	$21,259
90% Title XIX ACA FF / 10% GF	$33,723	$3,372	$30,351
65% Title XXI FF / 35% GF	$1,046	$366	$680
100% GF	$630	$630	$0
Total	**$77,917**	**$25,627**	**$52,290**

*Totals may differ due to rounding.

FFS - ICF-DD

FISCAL REFERENCE NUMBER:2545

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$8,148,000**	**$8,056,000**
FEDERAL FUNDS	$4,147,400	$4,091,000
GENERAL FUND	$4,000,600	$3,965,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$8,148,000**	**$8,056,000**
FEDERAL FUNDS	$4,147,400	$4,091,000
GENERAL FUND	$4,000,600	$3,965,000
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates Fee-For-Service Base expenditures for Intermediate Care Facility for the Developmentally Disabled (ICF-DD).

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)
Affordable Care Act (ACA)

Interdependent Policy Changes:
Not Applicable

Background:
The ICF-DD Fee-For-Service Base (FFS Base) estimates claims paid through the Medi-Cal claims processing systems at the California Medicaid Management Information Systems (CA-MMIS) Fiscal Intermediary for services provided in certain health facilities. These health facilities include those that provide 24-hour personal care, habilitation, developmental, and supportive health services and skilled nursing services for those with intermittent needs.

FFS Base estimates in previous cycles showed a federal financial participation (FFP) of 50% and technical adjustments for the ACA expansion population, Children’s Health Insurance Program (CHIP) and non-emergency services for individuals who do not have satisfactory immigration status were budgeted in their own policy changes. A change was made starting with the November 2025 estimate cycle to incorporate the technical adjustment for the FFP within the FFS Base policy change.

FFS - ICF-DD

Reason for Change:

FISCAL YEAR		USERS		UTILIZATION (Days per User)		RATE (Cost per Day)		TOTAL EXPENDITURE	
PY	2024-25	70		39.62		$377.00		$12,233,200	
CY	2025-26	60	-14.3%	30.68	-22.6%	$363.68	-3.5%	$8,148,000	-33.4%
BY	2026-27	60	0.0%	31.14	1.5%	$359.19	-1.2%	$8,055,700	-1.1%

Users: The number of users is projected to decrease from 70 in Prior Year (PY) to 60 in the Current Year (CY) across six estimated aid categories. In Budget Year (BY), the user count is expected to remain consistent with CY.

Utilization: Utilization is estimated to decline by 22.6% in CY. In BY, utilization is expected to increase slightly by 1.5%.

Rate: The average rate is projected to decline by 3.5% in CY, followed by a decrease of 1.2 % in BY.

Total Expenditure: Total expenditure is expected to decrease by 33.4% in CY, mainly driven by reduced users and utilization. In the BY, total expenditure is projected to decrease by 1.1%.

Compared to the November 2025 estimate, total expenditures in the May 2026 estimates for FY 2025–26 and FY 2026–27 decreased by 30.8% and 32.1%, respectively. These reductions are likely attributable to the CalAIM implementation that began in January 2024, which led to declines in both utilization and rates for the Current Year and Budget Year. The most significant drop is primarily due to substantial reductions in Aid Category SPDs projections between January and June 2026.

FISCAL YEAR	TOTAL EXPENDITURE		
	N25	**M26**	**% Change**
2025-26	$11,778,300	$8,148,000	-30.8%
2026-27	$11,867,600	$8,055,700	-32.1%

Methodology:

1. The Department used linear regressions based upon the most recent 36 months of actual paid claims data from CA-MMIS for users, units per user, and dollars per unit.

2. The Department identified funds allocated to members in the ACA expansion aid categories to estimate expenditures at the 90% federal match.

3. The Department identified funds allocated to members in the CHIP aid categories to estimate expenditures at the 65% federal match.

4. California provides full-scope Medi-Cal services to individuals who do not have satisfactory immigration status; however, non-emergency services that are not pregnancy related are 100% State funded. Based on July 2024 to July 2025 FFS expenditures for non-emergency services provided to this population, the Department estimated the 100% GF expenditures.

FFS - ICF-DD

Funding:

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF	$7,914	$3,957	$3,957
90% Title XIX ACA FF / 10% GF	$211	$21	$190
100% GF	$22	$22	$0
Total	**$8,147**	**$4,000**	**$4,147**

FY 2026-27	TF	GF	FF
50% Title XIX / 50% GF	$7,876	$3,938	$3,938
90% Title XIX ACA FF / 10% GF	$170	$17	$153
100% GF	$10	$10	$0
Total	**$8,056**	**$3,965**	**$4,091**

*Totals may differ due to rounding.

TABLE OF CONTENTS

REGULAR POLICY CHANGES

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

MEDI-CAL PROGRAM REGULAR POLICY CHANGES..1-458

POLICY CHANGE INDEX 1-6
ELIGIBILITY 7
AFFORDABLE CARE ACT 35
BENEFITS 44
PHARMACY 69
DRUG MEDI-CAL 105
MENTAL HEALTH 115
WAIVER-MH/UCD & BTR 137
MANAGED CARE 146
PROVIDER RATES 179
SUPPLEMENTAL PAYMENTS 227
COVID-19 309
STATE ONLY CLAIMING 314
OTHER DEPARTMENTS 317
OTHER..319

MEDI-CAL PROGRAM REGULAR
POLICY CHANGE INDEX

FRN.	POLICY CHANGE TITLE
	ELIGIBILITY
1569	MEDI-CAL STATE INMATE PROGRAMS
2529	PREMIUMS FOR ADULTS WITH UNSATIS. IMMIG. STAT.
2332	CALAIM - INMATE PRE-RELEASE PROGRAM
3	BREAST AND CERVICAL CANCER TREATMENT
2422	HEALTH ENROLLMENT NAVIGATORS FOR CLINICS
13	NON-OTLICP CHIP
1007	SCHIP FUNDING FOR PRENATAL CARE
2155	CS3 PROXY ADJUSTMENT
2237	REFUGEE MEDICAL ASSISTANCE
2029	MEDI-CAL COUNTY INMATE REIMBURSEMENT
2500	SB 525 MINIMUM WAGE - CASELOAD IMPACT
2535	REINSTATEMENT OF ASSET LIMIT
2530	FULL-SCOPE MEDI-CAL EXPANSION ENROLLMENT FREEZE
2553	HR 1 - REDUCED RETROACTIVE MEDI-CAL TIMEFRAMES
2554	HR 1 - RESTRICTED FEDERAL FUNDING FOR CERTAIN QNCS
2555	HR 1 - FED WORK & COMMUNITY ENGAGEMENT REQUIREMENT
2575	HR 1 - DEATH MASTER FILE AUTOMATION
2588	FULL REINSTATEMENT OF ASSET LIMIT
	AFFORDABLE CARE ACT
1595	COMMUNITY FIRST CHOICE OPTION
1967	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS
1791	1% FMAP INCREASE FOR PREVENTIVE SERVICES
1821	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.
	BENEFITS
25	LOCAL EDUCATION AGENCY (LEA) PROVIDERS
1	FAMILY PACT PROGRAM
1228	CALIFORNIA COMMUNITY TRANSITIONS COSTS
28	MULTIPURPOSE SENIOR SERVICES PROGRAM
2457	CYBHI WELLNESS COACH BENEFIT
1855	BEHAVIORAL HEALTH TREATMENT
2189	HEARING AID COVERAGE FOR CHILDREN PROGRAM
1562	CCT FUND TRANSFER TO CDSS
2528	UTILIZATION MANAGEMENT FOR HOSPICE
2570	MEASLES, MUMPS, RUBELLA, VARICELLA (MMRV) VACCINES
2522	ELIMINATE MEDI-CAL OPTIONAL BENEFIT - ACUPUNCTURE

MEDI-CAL PROGRAM REGULAR
POLICY CHANGE INDEX

FRN.	POLICY CHANGE TITLE
	PHARMACY
2512	CELL AND GENE THERAPY ACCESS MODEL
2194	PHARMACY RETROACTIVE ADJUSTMENTS
2124	MEDI-CAL DRUG REBATE FUND
2524	HIV/AIDS AND CANCER DRUG REBATES
1449	LITIGATION SETTLEMENTS
1433	BCCTP DRUG REBATES
51	FAMILY PACT DRUG REBATES
2519	UPDATES TO OTC COVID-19 TESTS AND OTC PRODUCTS
2526	PHARMACY UTILIZATION MANAGEMENT
2520	ELIMINATE GLP-1 COVERAGE FOR WEIGHT LOSS
2518	PRIOR AUTH. FOR CONTINUATION OF DRUG THERAPY
1181	MEDICAL SUPPLY REBATES
2527	STEP THERAPY
54	STATE SUPPLEMENTAL DRUG REBATES
55	FEDERAL DRUG REBATES
2557	PHARMACY PAYMENT METHODOLOGY - USUAL AND CUSTOMARY
2579	MEDI-CAL RX FRAUD, WASTE, & ABUSE PREVENTION
	DRUG MEDI-CAL
2278	RECOVERY INCENTIVES CONTINGENCY MANAGEMENT
1723	DRUG MEDI-CAL PROGRAM COST SETTLEMENT
1724	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT
	MENTAL HEALTH
2394	CALAIM - BH - CONNECT DEMONSTRATION
2252	MHP COSTS FOR FFPSA
1957	MHP COSTS FOR CONTINUUM OF CARE REFORM
2268	OUT OF STATE YOUTH - SMHS
1660	IMPERIAL AND SISKIYOU COUNTY MHP OVERPAYMENT
1713	INTERIM AND FINAL COST SETTLEMENTS - SMHS
2574	RETRO PAYMENTS TO COUNTIES FOR STATE-ONLY BH SVCS
	WAIVER--MH/UCD & BTR
1951	GLOBAL PAYMENT PROGRAM
2245	CALAIM ECM-COMMUNITY SUPPORTS-TRANSITIONAL RENT
1769	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG
	MANAGED CARE
2408	2023 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.

MEDI-CAL PROGRAM REGULAR POLICY CHANGE INDEX

FRN.	POLICY CHANGE TITLE
	MANAGED CARE
2061	MANAGED CARE HEALTH CARE FINANCING PROGRAM
2060	MANAGED CARE PUBLIC HOSPITAL EPP
2062	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL
2388	WORKFORCE & QUALITY INCENTIVE PROGRAM
2504	MEDI-CAL MANAGED CARE QUALITY WITHHOLD RELEASE
2437	MANAGED CARE DISTRICT HOSPITAL DIRECTED PAYMENTS
2499	COMMUNITY CLINIC DIRECTED PAYMENT PROGRAM
2448	MANAGED CARE PUBLIC DP-NF PASS-THROUGH PYMT PROG
2031	CCI-QUALITY WITHHOLD REPAYMENTS
2474	CHILDREN'S HOSPITAL SUPPLEMENTAL PAYMENT PROGRAM
2406	2023 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ
2407	2023 MCO ENROLLMENT TAX MANAGED CARE PLANS
2063	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND
1788	RETRO MC RATE ADJUSTMENTS
2558	MCP NETWORK ADEQUACY & TIMELY ACCESS SANCTIONS
2569	IMPROVEMENTS AND EFFICIENCIES
2576	MANAGED CARE RISK CORRIDORS
2577	UIS MEMBER TRANSITION TO FFS
2582	OVERPAYMENTS FOR REPRODUCTIVE HEALTH
2585	2027 MCO TAX CAPITATION PAYMENTS
2586	2027 MCO TAX FUNDING ADJUSTMENT - CAPITATION
2587	2027 MCO TAX FUNDING ADJUSTMENT – GENERAL SUPPORT
	PROVIDER RATES
88	RATE INCREASE FOR FQHCS/RHCS/CBRCS
2267	PP-GEMT IGT PROGRAM
2081	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF
1152	DPH INTERIM & FINAL RECONS
2181	NURSING FACILITY RATE ADJUSTMENTS
1329	FQHC/RHC/CBRC RECONCILIATION PROCESS
2184	GDSP NBS & PNS FEE ADJUSTMENTS
1046	LTC RATE ADJUSTMENT
96	HOSPICE RATE INCREASES
1162	DPH INTERIM RATE GROWTH
1784	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES
2509	PROP 35 - PROVIDER PAYMENT INCREASE FUNDING
1703	LABORATORY RATE METHODOLOGY CHANGE
2536	ELIMINATE PPS FOR STATE-ONLY SERVICES
1505	REDUCTION TO RADIOLOGY RATES

MEDI-CAL PROGRAM REGULAR
POLICY CHANGE INDEX

FRN.	POLICY CHANGE TITLE
	PROVIDER RATES
2458	PROP 35 - PROVIDER PAYMENT INCREASES
2591	2027 MCO TAX FUNDING ADJUSTMENT – TRI
	SUPPLEMENTAL PMNTS.
2055	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS
1475	HOSPITAL QAF - FFS PAYMENTS
1761	HOSPITAL QAF - MANAGED CARE PAYMENTS
2024	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS
1071	PRIVATE HOSPITAL DSH REPLACEMENT
1073	DSH PAYMENT
1085	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
2130	PROP 56 - MEDI-CAL FAMILY PLANNING
78	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS
1078	DPH PHYSICIAN & NON-PHYS. COST
1899	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS
104	FFP FOR LOCAL TRAUMA CENTERS
82	CAPITAL PROJECT DEBT REIMBURSEMENT
1600	NDPH IGT SUPPLEMENTAL PAYMENTS
2049	PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS
1076	NDPH SUPPLEMENTAL PAYMENT
1616	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS
1038	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH
1039	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH
86	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS
2044	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS
2303	FREE CLINICS AUGMENTATION
2102	PROPOSITION 56 FUNDING
1601	IGT ADMIN. & PROCESSING FEE
1661	GEMT SUPPLEMENTAL PAYMENT PROGRAM
2572	DMPH GME IGT ADMIN. & PROCESSING FEE
2573	GRADUATE MEDICAL EDUCATION PAYMENTS TO DMPHS
	COVID-19
2363	COVID-19 VACCINE FUNDING ADJUSTMENT
2218	COVID-19 END OF UNWINDING FLEXIBILITIES
	STATE-ONLY CLAIMING
2415	STATE-ONLY CLAIMING ADJUSTMENTS - RETRO ADJ.

MEDI-CAL PROGRAM REGULAR
POLICY CHANGE INDEX

FRN.	POLICY CHANGE TITLE
	OTHER DEPARTMENTS
1476	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS
	OTHER
2354	BEHAVIORAL HEALTH BRIDGE HOUSING
2208	SELF-DETERMINATION PROGRAM - CDDS
2329	QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES
2092	QAF WITHHOLD TRANSFER
2424	CYBHI - FEE SCHEDULE THIRD PARTY ADMINISTRATOR
1232	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS
2346	EQUITY & PRACTICE TRANSFORMATION PAYMENTS
2097	MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG
2549	PROPOSITION 36 FUNDING
2439	CALAIM - PATH WPC
1975	MINIMUM WAGE INCREASE FOR HCBS WAIVERS
2396	CARE ACT
111	INDIAN HEALTH SERVICES
2009	INFANT DEVELOPMENT PROGRAM
2550	BACKFILL LOST TITLE X FAMILY PLANNING FUNDING
1526	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS
2502	MISC. ONE-TIME PAYMENTS
2375	CYBHI - URGENT NEEDS AND EMERGENT ISSUES
2355	CALHOPE
2443	ASSET LIMIT INCREASE & ELIM. - CNTY BH FUNDING
1866	WPCS WORKERS' COMPENSATION
35	IMD ANCILLARY SERVICES
1087	CIGARETTE AND TOBACCO SURTAX FUNDS
1760	HOSPITAL QAF - CHILDREN'S HEALTH CARE
2034	CMS DEFERRED CLAIMS
2156	INDIAN HEALTH SERVICES FUNDING SHIFT
2503	MEDICAL PROVIDER INTERIM PAYMENT LOAN
2484	HEALTH CARE SVCS. FINES AND PENALTIES
2551	HR 1 - UIS EMERGENCY ACA FMAP ADJUSTMENT
2563	ELIMINATE DENTAL FOR ADULT UIS
2531	RESIDENCY VERIFICATION IMPROVEMENTS
2497	QUALITY SANCTIONS
2054	ASSISTED LIVING WAIVER EXPANSION
2010	HCBA WAIVER EXPANSION
1906	COUNTY SHARE OF OTLICP-CCS COSTS
2343	COUNTY BH RECOUPMENTS

MEDI-CAL PROGRAM REGULAR
POLICY CHANGE INDEX

FRN.	POLICY CHANGE TITLE
	OTHER
110	AUDIT SETTLEMENTS
2590	MCO TAX REVENUE TO SUPPORT MEDI-CAL

MEDI-CAL STATE INMATE PROGRAMS

FISCAL REFERENCE NUMBER:1569

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$47,616,000**	**$47,616,000**
FEDERAL FUNDS	$47,616,000	$47,616,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$47,616,000**	**$47,616,000**
FEDERAL FUNDS	$47,616,000	$47,616,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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.

Authority:
AB 1628 (Chapter 729, Statutes of 2010)
SB 184 (Chapter 47, Statutes of 2022)
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 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.

MEDI-CAL STATE INMATE PROGRAMS

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.

Reason for Change:
The change for FY 2025-26 and FY 2026-27, from the prior estimate, is an increase due to updated actuals based on current invoices from FY 2025-26. There is no change from FY 2025-26 to FY 2026-27 in the current estimate.

Methodology:

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

2. Estimated costs for FY 2025-26 and FY 2026-27 are annualized projections primarily based on actual paid claims made within FY 2025-26.

3. 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 2025-26 and FY 2026-27. The Non-Federal share for this policy change is included in CDCR’s budget and is also estimated below for display purposes.

Funding:

(Dollars in Thousands)

FY 2025-26	**TF**	**FF**	**CDCR GF**
100% Title XIX FFP (4260-101-0890)	$19,245	$9,622	$9,623
100% Title XIX ACA FF (4260-101-0890)	$42,216	$37,994	$4,222
Total FY 2025-26	$61,461	**$47,616**	$13,845
FY 2026-27	**TF**	**FF**	**CDCR GF**
100% Title XIX FFP (4260-101-0890)	$19,245	$9,622	$9,623
100% Title XIX ACA FF (4260-101-0890)	$42,216	$37,994	$4,222
Total FY 2026-27	$61,461	**$47,616**	$13,845

*Totals may differ due to rounding.

PREMIUMS FOR ADULTS WITH UNSATIS. IMMIG. STAT.

FISCAL REFERENCE NUMBER:2529

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$28,000,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$0	$28,000,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$28,000,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$0	$28,000,000
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the impact of requiring payment of a $50 per person per month premium for Medi-Cal members with unsatisfactory immigration status (UIS), excluding UIS individuals under 19 years of age, over 59 years of age, and pregnant women, beginning no sooner than July 1, 2027.

Authority:
AB 116 (Chapter 21, Statutes of 2025)

Interdependent Policy Changes:
Not Applicable

Background:
Under federal law, Medi-Cal members with certain immigration statuses are ineligible for federal funds. These members are referred to as UIS members. The state pays 100% of the costs for non-emergency and non-pregnancy services for UIS members.

Implementation of the $50 per month premium will apply to all UIS members except for individuals under 19 years of age, over 59 years of age, and pregnant women. Once implemented, members who do not pay the premium will be discontinued from full-scope coverage but will continue to have access to restricted scope (emergency and pregnancy) services.

Reason for Change:
The change from the prior estimate, for FY 2025-26, is a decrease due to operational costs now beginning in FY 2026-27. There is no change from the prior estimate for FY 2026-27. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase as costs now begin in FY 2026-27.

Methodology:
1. Assume $28 million in General Fund costs in FY 2026-27 and ongoing to procure operational resources to manage premium collection and tracking activities.

PREMIUMS FOR ADULTS WITH UNSATIS. IMMIG. STAT.

2. Fiscal impacts from collecting premiums, or from reductions in the number of individuals enrolled in full-scope coverage, will begin in FY 2027-28.

(Dollars in Thousands)

Fiscal Years	TF	GF	FF
FY 2025-26	$0	$0	$0
FY 2026-27	$28,000	$28,000	$0

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

CALAIM - INMATE PRE-RELEASE PROGRAM

FISCAL REFERENCE NUMBER:2332

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$39,297,000**	**$191,799,000**
FEDERAL FUNDS	$33,749,000	$164,724,000
GENERAL FUND	$5,548,000	$27,075,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	76.3500%	15.6400%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$9,293,700**	**$161,801,600**
FEDERAL FUNDS	$7,981,640	$138,961,170
GENERAL FUND	$1,312,100	$22,840,470
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the cost for the development, implementation, ongoing maintenance, and operation, of certain California Advancing & Innovating Medi-Cal (CalAIM) Justice-Involved Reentry Initiative.

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)
CalAIM 1115 Waiver

Interdependent Policy Change:
Not Applicable

Background:
California received 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

CALAIM - INMATE PRE-RELEASE PROGRAM

health services, both to providers in managed care networks and to county behavioral health departments.

This policy change estimates costs for CalAIM Pre-Release Services up-to-90 days prior to release. This includes the provision of a targeted set of Medi-Cal services to eligible justice-involved populations up to 90-days prior to the individual's release from a state prison, county jail, or youth correctional facility. The targeted set of pre-release services 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.

In FY 2024-25, the California Department of Corrections and Rehabilitation (CDCR) implemented pre-release services through the Justice-Involved Initiative across all state prisons, along with ten California counties. Three additional counties have gone live in FY 2025-26. There are 65 live correctional facilities across the state (31 state prisons, 22 adult jails, and 12 youth correctional facilities). Each correctional facility must submit a readiness review application to the Department for approval prior to the requested go live date. As of February 1, 2026, the Department has received readiness assessments from six additional counties for 15 adult jails and five counties for seven youth correctional facilities. The Department also worked closely with Los Angeles County's adult jails to soft-launch in April 2026, with an official go-live following before October 1, 2026. The Department anticipates receiving readiness assessments for the remaining forty-eight counties (and 90 correctional facilities), which will go-live between April 1, 2026, and October 1, 2026.

Reason for Change:
The change from the prior estimate, for FY 2025-26, is an increase due to additional counties going live sooner than previously estimated. The change from the prior estimate, for FY 2026-27, is a decrease due to estimating slightly lower costs per member. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to additional ramp up of the program continuing through FY 2026-27.

Methodology:
1. Assume Pre-Release Services up-to-90 days prior to release (including Behavioral Health Referrals/Linkages) policies implemented on October 1, 2024.

2. Total estimated costs for FY 2025-26 and FY 2026-27 are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2025-26	$39,297	$5,548	$33,749
FY 2026-27	$191,799	$27,075	$164,724

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

BREAST AND CERVICAL CANCER TREATMENT

FISCAL REFERENCE NUMBER:3

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$12,399,000**	**$17,028,000**
FEDERAL FUNDS	$6,337,650	$8,001,800
GENERAL FUND	$6,061,350	$9,026,200
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$12,399,000**	**$17,028,000**
FEDERAL FUNDS	$6,337,650	$8,001,800
GENERAL FUND	$6,061,350	$9,026,200
OTHER FUNDS	$0	$0

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)
SB 104 (Chapter 67, Statutes of 2019)
AB 133 (Chapter 143, Statutes of 2021)
SB 184 (Chapter 47, Statutes of 2022)
AB 116 (Chapter 421, Statutes of 2025)

Interdependent Policy Changes:
CCHIP, MCAP, Special Populations Admin Costs

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

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 January 1, 2020, SB 104 (Chapter 67, Statutes of 2019) granted full scope Medi-Cal to young adults who are 19-25 years of age. 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, (Chapter 47, Statutes of 2022), granted full-scope Medi-Cal to adults who are 26-49 years of age.

Effective January 1, 2026, AB 116 (Chapter 421, Statutes of 2025) implemented an enrollment freeze for the full scope Medi-Cal expansion populations ages 19 and older. This change applies to newly enrolled individuals and to individuals who have had a break in their existing full scope coverage prior to January 1, 2026. Additionally, AB 116 reinstated the asset limit test for non-MAGI Medi-Cal programs, which BCCTP falls under.

Reason for Change:
There is a decrease for FY 2025-26 and FY 2026-27 from the prior estimate, due to recent fee-for-service actuals. There is an increase from FY 2025-26 to FY 2026-27 in the current estimate, due to managed care updated caseload projections resulting from changes in state and federal law.

Methodology:

1. Assume a total of 603 members currently, of which 113 individuals are in FFS and 490 individuals are in managed care. Additionally, approximately 50 of the FFS members and 450 of the managed care members are eligible for State-Only services.

2. Assume a total of 800 members will be enrolled in FY 2025-26, of which 120 individuals will be in FFS and 680 individuals will be in managed care. Additionally, approximately 100 of the FFS members and 900 of the managed care members are eligible for State-Only services.

3. Assume a total of 1,500 members will be enrolled in FY 2026-27, of which 420 individuals will be in FFS and 1,080 individuals will be in managed care. Additionally, approximately 225 of the FFS members and 1,275 of the managed care members are eligible for State-Only services.

4. Assume none of the members were in accelerated enrollment.

5. Assume the State will pay Medicare and other health coverage premiums for an average of 163 members monthly in FY 2025-26 and in FY 2026-27. Assume an average monthly premium cost per member of $66.67.

6. Assume 45% of members will require a third year of treatment, and 20% of those members will require a fourth year of treatment.

7. Assume Managed Care costs associated with the BCCTP are budgeted in this policy change. Assume an average, weighted monthly costs of $926.45 in FY 2025-26 and $986.24 in FY 2026-27 for Managed Care members.

BREAST AND CERVICAL CANCER TREATMENT

8. FFS and Managed Care costs are estimated as follows:

FY 2025-26	TF	GF	FF
Full Scope Costs	$6,419,000	$2,260,000	$4,159,000
FFS State-Only Services	$415,000	$415,000	$0
FFS State-Only Premiums	$131,000	$131,000	$0
Full Scope Managed Care Costs	$4,333,000	$2,155,000	$2,178,000
Managed Care State-Only Services	$1,101,000	$1,101,000	$0
Total	**$12,399,000**	**$6,062,000**	**$6,337,000**

FY 2026-27	TF	GF	FF
Full Scope Costs	$5,711,000	$2,016,000	$3,695,000
FFS State-Only Services	$442,000	$442,000	$0
FFS State-Only Premiums	$131,000	$131,000	$0
Full Scope Managed Care Costs	$8,567,000	$4,260,000	$4,307,000
Managed Care State-Only Services	$2,177,000	$2,177,000	$0
Total	**$17,028,000**	**$9,026,000**	**$8,002,000**

* Totals differ due to rounding.

Funding:

FY 2025-26	TF	GF	FF
100% General Fund (4260-101-0001)	$1,647,000	$1,647,000	$0
50% Title XIX FFP / 50% GF (4260-101-0890/0001)	$4,341,000	$2,171,000	$2,170,000
65% Title XIX FFP/ 35% GF (4260-101-0890/0001)	$6,411,000	$2,244,000	$4,167,000
Total	**$12,399,000**	**$6,062,000**	**$6,337,000**

FY 2026-27	TF	GF	FF
100% General Fund (4260-101-0001)	$2,750,000	$2,750,000	$0
50% Title XIX FFP / 50% GF (4260-101-0890/0001)	$8,526,000	$4,263,000	$4,263,000
65% Title XIX FFP/ 35% GF (4260-101-0890/0001)	$5,752,000	$2,013,000	$3,739,000
Total	**$17,028,000**	**$9,026,000**	**$8,002,000**

* Totals differ due to rounding.

HEALTH ENROLLMENT NAVIGATORS FOR CLINICS

FISCAL REFERENCE NUMBER:2422

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$8,244,000**	**$0**
FEDERAL FUNDS	$4,122,000	$0
GENERAL FUND	$4,122,000	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$8,244,000**	**$0**
FEDERAL FUNDS	$4,122,000	$0
GENERAL FUND	$4,122,000	$0
OTHER FUNDS	$0	$0

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 helped 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 2025-26, is a decrease due to a slightly smaller final payment. There is no change from the prior estimate for FY 2026-27. The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease due to all payments being completed in FY 2025-26.

Methodology:
1. A prime contractor implementation occurred on October 1, 2023.

HEALTH ENROLLMENT NAVIGATORS FOR CLINICS

2. Assume local CHCs and RCAs conducted outreach, enrollment, and retention activities in their applicable area and received supplemental funding.

3. Implementation started in December 2023, and ended June 2025. Close-out will occur through June 2026. The final close-out payment was issued in November 2025.

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	$11,452	$5,726	$5,726
Estimated in FY 2025-26	$8,244	$4,122	$4,122
Total Estimated Remaining	$304	$152	$152

*Federal funds authority is newly requested for the fiscal year in which funds are anticipated to be expended.

5. Total estimated costs for FY 2025-26 are:

(Dollars in Thousands)

FY 2025-26	TF	GF	FF*
Appropriation Year 2023-24	$8,244	$4,122	$4,122
Total FY 2025-26	**$8,244**	**$4,122**	**$4,122**

*Federal funds authority is newly requested for the fiscal year in which funds are anticipated to be expended.
**Totals may differ due to rounding.

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

NON-OTLICP CHIP

FISCAL REFERENCE NUMBER:13

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$126,430,800	$123,190,200
GENERAL FUND	-$126,430,800	-$123,190,200
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$126,430,800	$123,190,200
GENERAL FUND	-$126,430,800	-$123,190,200
OTHER FUNDS	$0	$0

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.

- Medicaid Expansion: This CHIP population exceeds the Medicaid FPL limit and are below the OTLICP FPL (aid codes M5, M6).

- 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 2025-26 and FY 2026-27, is a General Fund (GF) savings increase due to an increase in estimated expenditures. The change from FY 2025-26 to FY 2026-27, in the current estimate, is a slight GF savings decrease due to a decrease in estimated expenditures.

NON-OTLICP CHIP

Methodology:

1. It is assumed the estimated costs of the HPE and Medicaid Expansion aid codes will be $842,872,000 TF in FY 2025-26 and $821,268,000 TF in FY 2026-27.

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 2025-26 and FY 2026-27 are:

FY 2025-26	TF	GF
HPE	$8,685,000	($1,303,000)
Medicaid Expansion	$834,187,000	($125,128,000)
Total Cost	**$842,872,000**	**($126,431,000)**

FY 2026-27	TF	GF
HPE	$8,325,000	($1,248,000)
Medicaid Expansion	$812,943,000	($121,942,000)
Total Cost	**$821,268,000**	**($123,190,000)**

Funding:

FY 2025-26	TF	GF	FF
50% Title XIX FF/50% GF (4260-101-0890/0001)	($842,872,000)	($421,436,000)	($421,436,000)
65% Title XXI FF/35% GF (4260-101-0890/0001)	$842,872,000	$295,005,000	$547,867,000
Net Impact (rounded)	**$0**	**($126,431,000)**	**$126,431,000**

FY 2026-27	TF	GF	FF
50% Title XIX FF / 50% GF (4260-101-0890/0001)	($821,268,000)	($410,634,000)	($410,634,000)
65% Title XXI FF / 35% GF (4260-101-0890/0001)	$821,268,000	$287,444,000	$533,824,000
Net Impact (rounded)	**$0**	**($123,190,000)**	**$123,190,000**

SCHIP FUNDING FOR PRENATAL CARE

FISCAL REFERENCE NUMBER:1007

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$80,347,150	$80,575,300
GENERAL FUND	-$80,347,150	-$80,575,300
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$80,347,150	$80,575,300
GENERAL FUND	-$80,347,150	-$80,575,300
OTHER FUNDS	$0	$0

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 2025-26 and FY 2026-27, is an increase in General Fund (GF) savings due to a projected increase in prenatal costs. There is a slight GF savings increase from FY 2025-26 to FY 2026-27, in the current estimate, due to projecting a slight increase in prenatal costs in FY 2026-27.

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

(Dollars in Thousands)

FY 2025-26	$123,611
FY 2026-27	$123,962

Funding:
(Dollars in Thousands)

FY 2025-26	Fund Number	TF	GF	FF
100% State GF	4260-101-0001	($123,611)	($123,611)	$0
Title XXI 65% FF / 35% GF	4260-101-0890/0001	$123,611	$43,264	$80,347
Net Impact		**$0**	**($80,347)**	**$80,347**
FY 2026-27	**Fund Number**	**TF**	**GF**	**FF**
100% State GF	4260-101-0001	($123,962)	($123,962)	$0
Title XXI 65% FF / 35% GF	4260-101-0890/0001	$123,962	$43,387	$80,575
Net Impact		**$0**	**($80,575)**	**$80,575**

CS3 PROXY ADJUSTMENT

FISCAL REFERENCE NUMBER:2155

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$113,512,600	$114,308,700
GENERAL FUND	-$113,512,600	-$114,308,700
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$113,512,600	$114,308,700
GENERAL FUND	-$113,512,600	-$114,308,700
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the technical adjustment in funding for the Non-Optional Targeted Low Income Children's Program (OTLICP) population of the Children's Health Insurance Program (CHIP) as described below. Expenditures are adjusted from Title XIX 50% federal financial participation (FFP) to enhanced Title XXI FFP.

Authority:
SB 903 (Chapter 624, Statutes of 1997)
42 CFR 435.907(e)

Interdependent Policy Changes:
Not Applicable

Background:
Medi-Cal has multiple CHIP eligibility categories. The largest is OTLICP which is budgeted throughout the Estimate.

California was granted a proxy methodology (CS3-Proxy) to claim enhanced 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.

Reason for Change:
The change for FY 2025-26 and FY 2026-27, from the prior estimate, is a General Fund (GF) savings increase due to updated actuals based on recent adjustment memos. The change from FY 2025-26 to FY 2026-27, in the current estimate, is a slight GF savings increase due to projecting higher memos in FY 2026-27.

Methodology:
1. Effective FY 2020-21, assume a two-quarter adjustment lag.

CS3 PROXY ADJUSTMENT

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. Total estimated costs for FY 2025-26 and FY 2026-27 are:

(Dollars in Thousands)

Fiscal Years	TF	GF	FF
FY 2025-26	**$0**	**($113,512)**	**$113,512**
FY 2026-27	**$0**	**($114,309)**	**$114,309**

* Totals may differ due to rounding

Funding:
(Dollars in Thousands)

FY 2025-26	Fund Number	TF	GF	FF
50% Title XIX / 50% GF	4260-101-0890/0001	($502,504)	($251,252)	($251,252)
65% Title XXI / 35% GF	4260-101-0890/0001	$502,504	$175,877	$326,627
Title XIX FF	4260-101-0890	($127,124)	$0	($127,124)
Title XIX GF	4260-101-0001	$127,124	$127,124	$0
Title XXI FF	4260-101-0890	$165,261	$0	$165,261
Title XXI GF	4260-101-0001	($165,261)	($165,261)	$0
Net Impact (rounded)		**$0**	**($113,512)**	**$113,512**

* Totals may differ due to rounding

(Dollars in Thousands)

FY 2026-27	Fund Number	TF	GF	FF
50% Title XIX / 50% GF	4260-101-0890/0001	($496,438)	($248,219)	($248,219)
65% Title XXI / 35% GF	4260-101-0890/0001	$496,438	$173,753	$322,685
Title XIX FF	4260-101-0890	($132,810)	$0	($132,810)
Title XIX GF	4260-101-0001	$132,810	$132,810	$0
Title XXI FF	4260-101-0890	$172,653	$0	$172,653
Title XXI GF	4260-101-0001	($172,653)	($172,653)	$0
Net Impact (rounded)		**$0**	**($114,309)**	**$114,309**

* Totals may differ due to rounding

REFUGEE MEDICAL ASSISTANCE

FISCAL REFERENCE NUMBER:2237

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$47,000	-$47,000
OTHER FUNDS	$47,000	$47,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$47,000	-$47,000
OTHER FUNDS	$47,000	$47,000

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 (RMA) (aid code 02) during their first four 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 $624,000 annual reimbursement cap under the grant for these services.

Reason for Change:
The change from the prior estimate, for FY 2025-26, is a decrease due to updated actuals that are lower than previously estimated. The change from the prior estimate, for FY 2026-27, is a decrease due to updated projections based on actuals. There is no change from FY 2025-26 to FY 2026-27 in the current estimate.

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

2. The total reimbursable amounts are estimated to be:

Fiscal Year	TF	GF	GF Reimbursement
FY 2025-26	$0	($47,000)	$47,000
FY 2026-27	$0	($47,000)	$47,000

Funding:
100% GF (4260-101-0001)
Reimbursement GF (4260-601-0995)

MEDI-CAL COUNTY INMATE REIMBURSEMENT

FISCAL REFERENCE NUMBER:2029

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$2,436,000	-$2,513,000
OTHER FUNDS	$2,436,000	$2,513,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$2,436,000	-$2,513,000
OTHER FUNDS	$2,436,000	$2,513,000

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 medical

MEDI-CAL COUNTY INMATE REIMBURSEMENT

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 2025-26 is an increase and for FY 2026-27 is a decrease due to capturing more recent paid claims data. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to updated claims data projecting an increase for FY 2026-27.

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

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 2025-26 and FY 2026-27 will be:

FY 2025-26	**GF**	**Reimbursement**
Non ACA	$850,000	$875,000
ACA	$1,501,000	$1,464,000
Juvenile	$67,000	$92,000
Compassionate Release – Non ACA	$3,000	$4,000
Compassionate Release - ACA	$1,000	$1,000
Total	$2,422,000	**$2,436,000**

FY 2026-27	**GF**	**Reimbursement**
Non ACA	$892,000	$882,000
ACA	$1,576,000	$1,557,000
Juvenile	$70,000	$69,000
Compassionate Release – Non ACA	$4,000	$4,000
Compassionate Release - ACA	$1,000	$1,000
Total	$2,543,000	**$2,513,000**

*Totals may differ due to rounding.

Funding:
100% GF (4260-101-0001)
Reimbursement GF (4260-610-0995)

SB 525 MINIMUM WAGE - CASELOAD IMPACT

FISCAL REFERENCE NUMBER:2500

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**-$188,536,000**	**-$239,621,000**
FEDERAL FUNDS	-$113,121,600	-$143,772,500
GENERAL FUND	-$75,414,400	-$95,848,500
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	97.4100%	81.9500%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**-$4,883,100**	**-$43,251,600**
FEDERAL FUNDS	-$2,929,850	-$25,950,940
GENERAL FUND	-$1,953,230	-$17,300,650
OTHER FUNDS	$0	$0

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. In general, wages for affected workers are scheduled to reach $25 per hour over several years.

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:
There is no change from the prior estimate for FY 2025-26 and FY 2026-27. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase in savings due to further increases in the minimum wage pursuant to SB 525.

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 to SB 525 implementation.

SB 525 MINIMUM WAGE - CASELOAD IMPACT

2. As SB 525 implementation is rolling out, assume that a monthly average loss of 46,300 Medi-Cal members during FY 2025-26, growing to 57,100 Medi-Cal members in FY 2026-27.

3. Assume an average cost per member per month of $339 in FY 2025-26 and $349 in FY 2026-27.

4. The estimated impact of SB 525 related to reduced caseload is:

Fiscal Years	TF	GF	FF
FY 2025-26	($188,536,000)	($75,414,000)	($113,122,000)
FY 2026-27	($239,621,000)	($95,849,000)	($143,772,000)

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

REINSTATEMENT OF ASSET LIMIT

FISCAL REFERENCE NUMBER:2535

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**-$113,411,000**	**-$862,813,000**
FEDERAL FUNDS	-$56,705,500	-$431,406,500
GENERAL FUND	-$56,705,500	-$431,406,500
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	7.6900%	4.5700%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**-$104,689,700**	**-$823,382,400**
FEDERAL FUNDS	-$52,344,850	-$411,691,220
GENERAL FUND	-$52,344,850	-$411,691,220
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the impact of reinstituting the Medi-Cal Asset Limit to consider resources, including property and other assets, when determining Medi-Cal eligibility for applicants or members whose eligibility is not based on modified adjusted gross income (MAGI) financial methods.

Authority:
AB 116 (Chapter 21, Statutes of 2025)
SPA 25-0037

Interdependent Policy Changes:
Full Reinstatement of Asset Limit

Background:
The Medi-Cal program's asset limits have historically aligned with those of the federal Supplemental Security Income (SSI) program. However, in 2021, California passed Assembly Bill (AB) 133 (Chapter 143, Statutes of 2021) to modify these limits through a two-phased approach: Phase I increased the asset limits, and Phase II eliminated them entirely.

To implement these changes, the Department sought federal approval to disregard up to $130,000 in nonexempt property for a single-member household, and an additional $65,000 for each additional household member, up to a maximum of ten members, effective July 1, 2022. Beginning January 1, 2024, all assets were fully disregarded in determining Medi-Cal eligibility.

Pursuant to the Budget Act of 2025, the Department sought federal approval to reinstate asset limits to disregard up to $130,000 in nonexempt property for a single-member household, and an additional $65,000 for each additional household member, with an effective date of no sooner than January 1, 2026. The Centers for Medicare and Medicaid Services approved California’s State Plan Amendment to implement the asset limits, effective January 1, 2026. The implementation was conditioned on the Director of Health Care Services determining that systems had been programmed and they communicated that determination in writing to the Department of Finance, and no sooner than January 1, 2026. This determination of system readiness was made and communicated to the Department of Finance on December 19, 2025.

REINSTATEMENT OF ASSET LIMIT

Reason for Change:
The change from the prior estimate, for FY 2025-26 and FY 2026-27, is a General Fund (GF) savings increase due to a projected increase in costs. The change from FY 2025-26 to FY 2026-27, in the current estimate, is a GF savings increase as FY 2025-26 only has six-months of savings. Additionally, ramp-up for the program is expected to finish in FY 2027-28.

Methodology:

1. Assume implementation began January 1, 2026.

2. The impact of reinstating the Medi-Cal Asset limit is shown below:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2025-26	($113,411)	($56,706)	($56,705)
FY 2026-27	($862,813)	($431,407)	($431,406)

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

FULL-SCOPE MEDI-CAL EXPANSION ENROLLMENT FREEZE

FISCAL REFERENCE NUMBER:2530

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**-$94,693,000**	**-$865,510,000**
FEDERAL FUNDS	-$11,311,050	-$122,968,300
GENERAL FUND	-$83,381,950	-$742,541,700
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	4.7600%	0.6700%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**-$90,185,600**	**-$859,711,100**
FEDERAL FUNDS	-$10,772,640	-$122,144,410
GENERAL FUND	-$79,412,970	-$737,566,670
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the impact of freezing new enrollment for individuals that otherwise would qualify for full-scope coverage under the previous young adult expansion (19-25), Age 26-49 Adult expansion, or Age 50+ expansion for individuals regardless of immigration status.

Authority:
AB 116 (Chapter 21, Statutes of 2025)

Interdependent Policy Changes:
Not Applicable

Background:
In May 2016, the state expanded full-scope eligibility to otherwise eligible undocumented children. In January 2020, the state expanded full-scope eligibility to undocumented young adults aged 19 through 25. In May 2022, the state expanded full-scope eligibility to undocumented adults aged 50 and older. In January 2024, the state expanded full-scope eligibility to undocumented adults aged 26 through 49.

Under federal law, full-scope services (other than emergency and pregnancy-related services) are not eligible for federal funding. The state pays the full cost of non-emergency and non-pregnancy services for these populations.

In view of the state's General Fund condition, the Budget Act assumes a freeze on new enrollment for state funded full-scope coverage under the expansions listed above for individuals aged 19 and older whom the Department expanded state funded full scope benefits, not pregnant or in their one-year postpartum, or a foster youth/former foster youth up to age 26. Currently enrolled members will not be immediately affected. No sooner than January 1, 2026, individuals aged 19 or older, who are otherwise eligible, seeking to obtain full-scope coverage under these previous expansions will not be enrolled in full-scope coverage, but may receive restricted scope (emergency and pregnancy) services.

FULL-SCOPE MEDI-CAL EXPANSION ENROLLMENT FREEZE

Reason for Change:
There is no change from the prior estimate for FY 2025-26 and FY 2026-27. The change from FY 2025-26 to FY 2026-27, in the current estimate, is a General Fund savings increase due to the program continuing to ramp up through FY 2026-27.

Methodology:

1. After accounting for individuals that cure reasons for discontinuance, assume that approximately 15,000 individuals that otherwise would have been enrolled in full-scope coverage each month will not be enrolled.

2. Assume that the total number of individuals not enrolled that otherwise would have been enrolled will reach approximately 90,000 by the end of FY 2025-26 and continue to grow thereafter.

3. The estimated impact of the enrollment freeze in FY 2025-26 and FY 2026-27 is shown below:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2025-26	**($94,693)**	**($83,382)**	**($11,311)**
FY 2026-27	**($865,510)**	**($742,542)**	**($122,968)**

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

COMMUNITY FIRST CHOICE OPTION

FISCAL REFERENCE NUMBER:1595

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$11,410,654,000**	**$12,068,334,000**
FEDERAL FUNDS	$11,410,654,000	$12,068,334,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$11,410,654,000**	**$12,068,334,000**
FEDERAL FUNDS	$11,410,654,000	$12,068,334,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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

Reason for Change:
There is an increase from the prior estimate for FY 2025-26 and FY 2026-27, and from FY 2025-26 to FY 2026-27 in the current estimate, 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 2025-26 and FY 2026-27 are in the table below.

(Dollars in Thousands)

FY 2025-26	TF	FF	CDSS GF/ County Share
Title XIX 100% FFP (4260-101-0890)	$20,146,817	$11,282,217	$8,864,600
Total	$20,146,817	$11,282,217	$8,864,600
FY 2026-27	**TF**	**FF**	**CDSS GF/ County Share**
Title XIX 100% FFP (4260-101-0890)	$22,719,399	$12,722,863	$9,996,536
Total	$22,719,399	$12,722,863	$9,996,536

*Totals may differ due to rounding.

3. The estimated costs CDSS provided on a cash basis for FY 2025-26 and FY 2026-27 in the table below.

(Dollars in Thousands)

FY 2025-26	TF	FF	CDSS GF/ County Share
Title XIX 100% FFP (4260-101-0890)	$20,376,168	$11,410,654	$8,965,514
Total	$20,376,168	**$11,410,654**	$8,965,514
FY 2026-27	**TF**	**FF**	**CDSS GF/ County Share**
Title XIX 100% FFP (4260-101-0890)	$21,550,597	$12,068,334	$9,482,263
Total	$21,550,597	**$12,068,334**	$9,482,263

*Totals may differ due to rounding.

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

HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS

FISCAL REFERENCE NUMBER:1967

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$13,572,000**	**$17,844,000**
FEDERAL FUNDS	$13,572,000	$17,844,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$13,572,000**	**$17,844,000**
FEDERAL FUNDS	$13,572,000	$17,844,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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 a decrease for FY 2025-26, from the prior estimate, due to adding two quarters of actuals lower than previously projected. There is no change for FY 2026-27 from the prior estimate. There is an increase from FY 2025-26 to FY 2026-27, in the current estimate, due to capturing two quarters of actual expenditures in FY 2025-26 that are lower than the estimated average expenditures for the remaining quarters through FY 2026-27.

HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS

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 based on the average expenditures of the most recent three years of available data.

3. The estimated pass-through costs are included in the chart below.

(Dollars in Thousands)

FY 2025-26	TF	FF
FY 2024-25 Q3	$189	$189
FY 2024-25 Q4	$0	$0
FY 2025-26 Q1	$8,922	$8,922
FY 2025-26 Q2	$4,461	$4,461
Net Impact	**$13,572**	**$13,572**

FY 2026-27	TF	FF
FY 2025-26 Q3	$4,461	$4,461
FY 2025-26 Q4	$4,461	$4,461
FY 2026-27 Q1	$4,461	$4,461
FY 2026-27 Q2	$4,461	$4,461
Net Impact	**$17,844**	**$17,844**

Funding:
ACA 100% FFP (4260-101-0890)

1% FMAP INCREASE FOR PREVENTIVE SERVICES

FISCAL REFERENCE NUMBER:1791

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$6,154,000	$6,050,000
GENERAL FUND	-$6,154,000	-$6,050,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$6,154,000	$6,050,000
GENERAL FUND	-$6,154,000	-$6,050,000
OTHER FUNDS	$0	$0

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

Reason for Change:
The change in FY 2025-26 and FY 2026-27, from the prior estimate, is a net increase in General Fund savings due to the following:

- Decreased FFS savings based on updated actual data through June 2025; and
- Increased managed care savings based on updated Calendar Year (CY) 2025 actual data.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to lower projected FFS and managed care savings in FY 2026-27.

Methodology:

1. The 1% FMAP savings will include the following periods of savings in FY 2025-26:
   - FFS – July 1, 2024 through June 30, 2025
   - Managed Care – January 1, 2025 through December 31, 2025

2. FY 2026-27 will include the following periods of savings:
   - FFS – July 1, 2025 through June 30, 2026
   - Managed Care – January 1, 2026 through December 31, 2026

3. Total savings for the 1% FMAP increase for preventive services are as follows:

FY 2025-26	**TF**	**GF**	**FF**
FFS:			
FY 2024-25 Savings	$0	($455,000)	$455,000
Total FFS	$0	($455,000)	$455,000
Managed Care:			
FY 2024-25 Savings (Jan 2025 to Jun 2025)	$0	($2,869,000)	$2,869,000
FY 2025-26 Savings (Jul 2025 to Dec 2025)	$0	($2,830,000)	$2,830,000
Total Managed Care	$0	($5,699,000)	$5,699,000
Total FY 2025-26	**$0**	**($6,154,000)**	**$6,154,000**

FY 2026-27	**TF**	**GF**	**FF**
FFS:			
FY 2025-26 Savings	$0	($424,000)	$424,000
Total FFS	$0	($424,000)	$424,000
Managed Care:			
FY 2025-26 Savings (Jan 2026 to Jun 2026)	$0	($2,813,000)	$2,813,000
FY 2026-27 Savings (Jul 2026 to Dec 2026)	$0	($2,813,000)	$2,813,000
Total Managed Care	$0	($5,626,000)	$5,626,000
Total FY 2026-27	**$0**	**($6,050,000)**	**$6,050,000**

1% FMAP INCREASE FOR PREVENTIVE SERVICES

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

HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.

FISCAL REFERENCE NUMBER:1821

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$36,025,600	$33,763,200
GENERAL FUND	-$36,025,600	-$33,763,200
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$36,025,600	$33,763,200
GENERAL FUND	-$36,025,600	-$33,763,200
OTHER FUNDS	$0	$0

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) SPA 20-0024
SPA 23-0002 (Pending)

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 temporarily expanded the HPE Program to include the aged (65 years of age and older), disabled, and blind population, or the HPE Expansion Group. Authority under SPA 20-0024 was valid through the end of the Public Health Emergency (PHE).

HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.

The Department will submit SPA 23-0002 for short-term authority to cover the HPE Expansion Group through April 2026, as system changes will take effect in May 2026 and enrollment will be discontinued. This policy revision is driven by several factors, including compliance requirements under House Resolution 1, the reinstatement of the asset limits for the aged, blind and disabled population, and other complexities that were not originally anticipated.

In the first quarter of 2026, the Department submitted a new SPA that seeks to establish the Department authority to operate the HPE program as it functioned prior to the PHE, retaining all existing Modified Adjusted Gross Income (MAGI) coverage groups and eligibility requirements; and clarify new policy that the HPE program will no longer cover non-MAGI coverage groups.

Reason for Change:
The change in FY 2025-26 and FY 2026-27, from the prior estimate, is an increase in GF savings due to adding three quarters of actuals higher than previously projected. The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease in GF savings due to lower projected quarters based on the most recent actuals and enrollment 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. Estimated costs are developed using the four most recent quarters of actual claims.

4. The chart below includes the estimated funding adjustment to shift claims from Title XIX 50/50 FMAP to the enhanced Title XIX ACA FMAP.

FY 2025-26	TF	GF	FF
50% Title XIX FF / 50% GF	($90,064,000)	($45,032,000)	($45,032,000)
90% Title XIX FF / 10% GF	$90,064,000	$9,006,000	$81,058,000
Net Impact	**$0**	**($36,026,000)**	**$36,026,000**

FY 2026-27	TF	GF	FF
50% Title XIX FF / 50% GF	($84,408,000)	($42,204,000)	($42,204,000)
90% Title XIX FF / 10% GF	$84,408,000	$8,441,000	$75,967,000
Net Impact	**$0**	**($33,763,000)**	**$33,763,000**

*Totals may not add due to rounding

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

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

FISCAL REFERENCE NUMBER:25

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$976,828,000**	**$678,367,000**
FEDERAL FUNDS	$976,828,000	$678,367,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$976,828,000**	**$678,367,000**
FEDERAL FUNDS	$976,828,000	$678,367,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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, public charter schools, community colleges, California State University campuses, or University of California 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 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.

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

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, 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 back-casting 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.

The LEA BOP seeks to amend the State Plan to enhance access to school-based health services for Medi-Cal enrolled students through the LEA BOP. This amendment aims to expand the scope of covered services, establish appropriate interim reimbursement rates, include additional qualified practitioner types, and refine existing language for clarity and alignment with federal guidance. LEA BOP seeks an effective date of July 1, 2026, for this amendment.

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.

Reason for Change:

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

The change in FY 2025-26, from the prior estimate, is an increase due to:

- An increase in final settlements amounts to be processed and paid.

The change in FY 2026-27, from the prior estimate, is due to:

- No significant changes

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a net decrease due to:

- A decrease in final settlements to be processed and paid and that all submitted back-casting settlements will be completed in FY 2025-26.

Methodology:

1. For FY 2025-26, the estimated interim reimbursement is based on the average of the preceding two FYs of actual paid claims data.

2. For FY 2026-27, the estimated interim reimbursement is based on the average of the preceding two FYs of paid and estimated claims data.

3. FY 2025-26 and FY 2026-27 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. Approximately 100% of the FY 2023-24 and FY 2024-25 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.

5. 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.

6. 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 98.88% submitted CRCS reports FY 2015-16 through FY 2018-19 are expected to be completed in FY 2025-26.

7. 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.

8. The LEA BOP will be submitting a SPA to expand services and practitioners and to update language clarifying specific policy and removing participation barriers specific to institutions of higher learning with an effective date of July 1, 2026.

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

FY 2025-26	TF	Title XIX FFP	Title XXI FFP	COVID-19 FF
Est. Interim Reimbursement	$176,338,000	$139,969,000	$36,369,000	$0
Reduction due to CYBHI Impact	($295,000)	($235,000)	($60,000)	$0
Interim Settlements	$289,512,000	$225,291,000	$59,090,000	$5,131,000
Final Settlements	$380,794,000	$278,163,000	$75,019,000	$27,612,000
Back-casting	$130,479,000	$103,568,000	$26,911,000	$0
Total	**$976,828,000**	**$746,756,000**	**$197,329,000**	**$32,743,000**

FY 2026-27	TF	Title XIX FFP	Title XXI FFP	COVID-19 FF
Est. Interim Reimbursement	$188,993,000	$150,014,000	$38,979,000	$0
Rate Inflation (1.95%)	$3,693,000	$2,931,000	$762,000	$0
Reduction due to CYBHI Impact – Interim Reimbursement (Claims)	($421,000)	($334,000)	($87,000)	$0
Interim Settlements	$291,322,000	$231,238,000	$60,084,000	$0
Reduction due to CYBHI Impact – Interim Settlement	($1,255,000)	($996,000)	($259,000)	$0
Final Settlements	$195,120,000	$153,350,000	$40,033,000	$1,737,000
SPA Fiscal Impact	$915,000	$726,000	$189,000	$0
Total	**$678,367,000**	**$536,929,000**	**$139,701,000**	**$1,737,000**

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

FISCAL REFERENCE NUMBER:1

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$105,766,000**	**$140,721,000**
FEDERAL FUNDS	$78,983,600	$105,318,400
GENERAL FUND	$26,782,400	$35,402,600
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$105,766,000**	**$140,721,000**
FEDERAL FUNDS	$78,983,600	$105,318,400
GENERAL FUND	$26,782,400	$35,402,600
OTHER FUNDS	$0	$0

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

Enacted July 4, 2025, House Resolution 1 (H.R. 1) (Public Law No. 119-21), Section 71113 "Federal Payments to Prohibited Entities," prohibits using federal Medicaid funds for payments to a prohibited entity during the 1-year period beginning on July 4, 2025. Litigation is ongoing, but H.R. 1 Section 71113 is currently in effect.

Reason for Change:
The change in FY 2025-26 and FY 2026-27, from the prior estimate, is a decrease due to a projected rate and user reduction for the Family PACT program. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to a projected growth in FPACT rates in FY 2026-27.

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.

Fiscal Years	TF	GF	FF
FY 2025-26	$105,766,000	$26,782,000	$78,984,000
FY 2026-27	$140,721,000	$35,403,000	$105,318,000

*Totals may differ due to rounding.

Funding:

FY 2025-26	TF	GF	FF
90% Family Planning / 10% GF (4260-101-0890/0001)	$85,109,000	$8,511,000	$76,598,000
50% Title XIX / 50% GF (4260-101-0890/0001)	$4,771,000	$2,385,000	$2,385,000
100% GF (4260-101-0001)	$15,886,000	$15,886,000	$0
Total	**$105,766,000**	**$26,782,000**	**$78,984,000**

FY 2026-27	TF	GF	FF
90% Family Planning / 10% GF (4260-101-0890/0001)	$113,486,000	$11,349,000	$102,137,000
50% Title XIX / 50% GF (4260-101-0890/0001)	$6,362,000	$3,181,000	$3,181,000
100% GF (4260-101-0001)	$20,873,000	$20,873,000	$0
Total	**$140,721,000**	**$35,403,000**	**$105,318,000**

*Totals may differ due to rounding.

CALIFORNIA COMMUNITY TRANSITIONS COSTS

FISCAL REFERENCE NUMBER:1228

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$111,759,000**	**$127,913,000**
FEDERAL FUNDS	$86,973,000	$99,562,000
GENERAL FUND	$24,786,000	$28,351,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$111,759,000**	**$127,913,000**
FEDERAL FUNDS	$86,973,000	$99,562,000
GENERAL FUND	$24,786,000	$28,351,000
OTHER FUNDS	$0	$0

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, Section 14196.6
CMS Notice of Award Number: 1LICMS300149-01-27

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 of 2019 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

The Consolidated Appropriations Act of 2021 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 (Chapter 300, Statutes of 2020) 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.

AB 133 (Chapter 143, Statues of 2021) aligned state law with federal MFP requirements, by removing barriers to the Department’s implementation of the state-only CCT program and 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.

On March 31, 2022, CMS issued a Memorandum to state 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, SB 281 (Chapter 898, Statutes of 2022) was approved and amended California Welfare and Institutions Code 14196.2 to extend the CCT-like program’s end date from December 31, 2023, to December 31, 2026. On January 1, 2026, the Department ceased member enrollment into the program. On January 1, 2027, the Department shall cease to provide services for the temporary State-Funded CCT–Like Program. Additionally, per SB 281, California Welfare and Institutions Code 14196.2 - 14196.6 was amended to authorize for the repeal of the State-Funded CCT–Like Program on January 1, 2028.

The Consolidated Appropriations Act of 2023 appropriated 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 December 31, 2031.

Reason for Change:
The change from the prior estimate, for FY 2025-26 and FY 2026-27, is a decrease due to lower enrollment and the average cost for CCT being lower than previously estimated. These changes are primarily due to ongoing waitlists for waiver programs, such as the Assisted Living Waiver, and members shifting from CCT/Waiver programs to the managed care delivery system to gain access to Enhanced Care Management and Community Supports. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to additional enrollments for members occurring in FY 2026-27.

CALIFORNIA COMMUNITY TRANSITIONS COSTS

Methodology:

1. Assume estimated cost of waiver impacted services for members residing year-round in Nursing Facility (NF)-Bs is $109,754 in FY 2025-26 and $102,593 in FY 2026-27. The savings from moving members from NF-Bs to the waiver are 50% FF and 50% GF.

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 499 members will transition from an inpatient facility to the CCT program in FY 2025-26 and 516 in FY 2026-27.

5. Assume 231 ALW members in FY 2025-26 and FY 2026-27 who transition from an institution to a community setting qualify to draw down post-transition Qualified Home and Community-Based Services.

6. Assume $43,541,000 was awarded for CY 2025, which allowed CCT transitions to continue through December 31, 2025.

7. Assume the federal government will issue a new grant award in CY 2026 at least equal to the current grant awarded, which will allow CCT transitions to continue through December 31, 2026.

8. Below is the estimated impact of the CCT Demonstration project in FY 2025-26 and FY 2026-27.

FY 2025-26	**TF**	**GF**	**FF**
CCT Costs PC:			
Regular CCT Population	$98,078,000	$22,021,000	$76,057,000
State-Funded CCT Population	$273,000	$70,000	$203,000
ALW Transition Costs	$13,408,000	$2,695,000	$10,713,000
Total Costs	**$111,759,000**	**$24,786,000**	**$86,973,000**
CCT Savings:			
Total GF savings and Total FFP	($30,512,000)	($15,884,000)	($14,627,000)
CCT Fund Transfer to CDSS PC:	$736,000	$0	$736,000
CCT Outreach - Admin costs PC:	$364,000	$0	$364,000
Total of CCT PCs including savings	$82,347,000	$8,902,000	$73,446,000

*The savings are included in the total, however, they are fully reflected in the base estimates.

CALIFORNIA COMMUNITY TRANSITIONS COSTS

FY 2026-27	TF	GF	FF
CCT Costs PC:			
Regular CCT Population	$114,505,000	$25,655,000	$88,850,000
ALW Transition Costs	$13,408,000	$2,696,000	$10,712,000
Total Cost	**$127,913,000**	**$28,351,000**	**$99,562,000**
CCT Savings:			
Total GF savings and Total FFP	($79,869,000)	($41,580,000)	($38,289,000)
CCT Fund Transfer to CDSS PC:	$736,000	$0	$736,000
CCT Outreach - Admin costs PC:	$364,000	$0	$364,000
Total of CCT PCs including savings	$49,144,000	($13,229,000)	$62,373,000

*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

FISCAL REFERENCE NUMBER:28

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$63,951,000**	**$63,951,000**
FEDERAL FUNDS	$31,736,500	$31,736,500
GENERAL FUND	$32,214,500	$32,214,500
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$63,951,000**	**$63,951,000**
FEDERAL FUNDS	$31,736,500	$31,736,500
GENERAL FUND	$32,214,500	$32,214,500
OTHER FUNDS	$0	$0

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 60 and older who are "at risk" of needing nursing facility placement but who wish to remain in the community. The program provides services under a federal 1915(c) home and community-based services (HCBS) waiver.

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

The MSSP renewal application was submitted to CMS on March 29, 2024. Following the renewal application submission, CMS issued three rounds of subsequent requests for additional information and granted a 90-day extension through September 28, 2024. The Department provided responses to all requests for additional information, and on September 26, 2024, the Department and the California Department of Aging received CMS' approval of the renewed 1915(c) HCBS waiver, effective July 1, 2024, through June 30, 2029.

Reason for Change:
There is no change in totals funds from the prior estimate for FY 2025-26 or FY 2026-27. There is a slight increase in General Fund (GF) for FY 2025-26 and FY 2026-27 due to an increase in the adjustment for the Unsatisfactory Immigration Status population. There is no change from FY 2025-26 to FY 2026-27 in the current estimate.

Methodology:
1. Assume the MSSP has 11,940 slots at a rate of $5,356 per slot for FY 2025-26 and FY 2026-27.

2. The estimates below were provided on a cash basis.

Fiscal Years	TF	GF	FF
FY 2025-26	$63,951,000	$32,214,000	$31,737,000
FY 2026-27	$63,951,000	$32,214,000	$31,737,000

*Totals may differ due to rounding.

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

CYBHI WELLNESS COACH BENEFIT

FISCAL REFERENCE NUMBER:2457

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$99,000**	**$32,000**
FEDERAL FUNDS	$56,000	$18,000
GENERAL FUND	$43,000	-$5,086,000
OTHER FUNDS	$0	$5,100,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$99,000**	**$32,000**
FEDERAL FUNDS	$56,000	$18,000
GENERAL FUND	$43,000	-$5,086,000
OTHER FUNDS	$0	$5,100,000

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:
State Plan Amendment (SPA) 25-0014
AB 133 (Chapter 143, Statutes of 2021)

Interdependent Policy Changes:
Not Applicable

Background:
The Department, in partnership with HCAI is implementing the Certified Wellness Coach Medi-Cal benefit (SPA 25-0014, approved by CMS on June 25, 2025, with an effective date of January 1, 2025) to improve access to services and support to Medi-Cal members with existing and emerging behavioral health needs. This benefit is 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 Coach services are preventive services, as defined in 42 CFR 440.130(c), to support behavioral health needs and promote physical and mental health. Certified Wellness Coach services are recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under state law.

CYBHI WELLNESS COACH BENEFIT

Certified Wellness Coaches operate as part of a care team to provide the following services 1) Wellness promotion and education, 2) Screening not requiring a licensed provider, 3) Care coordination including navigation services, 4) Individual and group behavioral health coaching, including wellness education, coping skills, goal setting and planning, teaching life skills, stress management, and problem solving, 5) Crisis referral, including identifying potential risk, providing emotional support, and engaging in warm handoffs with licensed, credentialed, or associate behavioral health providers.

The Budget Act of 2021 authorized the Children and Youth Behavioral Health Initiative (CYBHI), a multi-year investment package 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.

Reason for Change:
The change in FY 2025-26 and FY 2026-27, from the prior estimate, is a decrease due to updated fee-for-service and managed care costs.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease due to updated fee-for-service and managed care costs. In addition, the Department estimates to receive reimbursement funding through an interagency agreement with the Department of Health Care Access and Information (HCAI) to help support this benefit in FY 2026-27.

Methodology:
1. Assume the effective date of the benefit is January 2025.

2. Assume FFS payments began in August 2025. Managed care payments began in February 2025 and are fully captured in the managed care base capitation rates.

3. Assume that an Erroneous Payment Correction (EPC) for the January 2025 through July 2025 period will be implemented no sooner than February 1, 2026.

4. The before percent in base impact of the estimated FFS and managed care costs, on a cash basis, for FY 2025-26 and FY 2026-27 are:

FY 2025-26	**TF**	**GF**	**FF**
FFS (Lagged)	$101,000	$43,000	$58,000
FFS (EPC)	$76,000	$33,000	$43,000
Managed Care	$12,312,000	$5,292,000	$7,020,000
Total	**$12,489,000**	**$5,368,000**	**$7,121,000**

FY 2026-27	**TF**	**GF**	**FF**
FFS (Lagged)	$121,000	$52,000	$69,000
Managed Care	$11,805,000	$5,074,000	$6,731,000
Total	**$11,925,000**	**$5,126,000**	**$6,800,000**

CYBHI WELLNESS COACH BENEFIT

5. Assume $5,100,000 reimbursement from the IA with HCAI will be received to offset GF costs in FY 2026-27.

6. The after percent in base impact of the estimated FFS costs and GF offset, on a cash basis, for FY 2025-26 and FY 2026-27 are:

FY 2025-26	TF	GF	FF
FFS (Lagged)	$23,000	$10,000	$13,000
FFS (EPC)	$76,000	$33,000	$43,000
Total	**$99,000**	**$43,000**	**$56,000**

FY 2026-27	TF	GF	FF	Reimbursement
FFS (Lagged)	$32,000	$14,000	$18,000	$0
GF Offset	$0	-$5,100,000	$0	$5,100,000
Total	**$32,000**	**-$5,086,000**	**$18,000**	**$5,100,000**

Funding:
100% Title XIX FF (4260-101-0890)
100% GF (4260-101-0001)
Reimbursement (4260-601-0995)

BEHAVIORAL HEALTH TREATMENT

FISCAL REFERENCE NUMBER:1855

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$7,792,000**	**$6,334,000**
FEDERAL FUNDS	$3,896,000	$3,167,000
GENERAL FUND	$3,896,000	$3,167,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$7,792,000**	**$6,334,000**
FEDERAL FUNDS	$3,896,000	$3,167,000
GENERAL FUND	$3,896,000	$3,167,000
OTHER FUNDS	$0	$0

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 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).

BEHAVIORAL HEALTH TREATMENT

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 2025-26 and FY 2026-27, from the prior estimate, is a net increase based on updated expenditure data and the assumed timing of invoice payments.

The change in the current estimate, from FY 2025-26 to FY 2026-27, is due to more prior year payments being estimated for FY 2025-26 than for FY 2026-27.

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 $5,915,000 TF for FY 2025-26 and FY 2026-27 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 are no longer included in this policy change.

7. On a cash basis, FFS reimbursements are estimated to be paid as follows:

Behavioral Health Treatment	Accrual	FY 2025-26	FY 2026-27
FY 2023-24 claims	$11,481,000	$314,000	$0
FY 2024-25 claims	$6,040,000	$2,740,000	$228,000
FY 2025-26 claims	$5,915,000	$4,738,000	$1,177,000
FY 2026-27 claims	$5,915,000	$0	$4,929,000
Total		$7,792,000	$6,334,000

BEHAVIORAL HEALTH TREATMENT

(Dollars in Thousands)

Behavioral Health Treatment	TF	GF	FF
FY 2025-26	$7,792	$3,896	$3,896
FY 2026-27	$6,334	$3,167	$3,167

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

HEARING AID COVERAGE FOR CHILDREN PROGRAM

FISCAL REFERENCE NUMBER:2189

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$1,552,000**	**$2,621,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$1,552,000	$2,621,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	9.6800%	5.7300%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$1,401,800**	**$2,470,800**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$1,401,770	$2,470,820
OTHER 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 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. 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 recent pandemic that resulted in school closures and increased adoption of 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

Reason for Change:
There is no change from the prior estimate for FY 2025-26 and FY 2026-27.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to the continuation of enrollment ramp-up in FY 2026-27.

Methodology:
1. HACCP began on July 1, 2021. Claim reimbursement payments began in December 2021.

2. Annual costs are estimated to be $1,650,000 in FY 2025-26 and $2,738,000 in FY 2026-27.

3. The hearing aid costs in this policy change are budgeted without the impact of the Medi-Cal provider rate increases.

4. FY 2025-26 and FY 2026-27 lagged payments for HACCP claims are estimated to be:

(Dollars in Thousands)

Hearing Aid Coverage for Children Program	TF	GF
FY 2025-26 (Lagged)	$1,552	$1,552
FY 2026-27 (Lagged)	$2,621	$2,621

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

CCT FUND TRANSFER TO CDSS

FISCAL REFERENCE NUMBER:1562

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$736,000**	**$736,000**
FEDERAL FUNDS	$736,000	$736,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$736,000**	**$736,000**
FEDERAL FUNDS	$736,000	$736,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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
CMS Notice of Award Number: 1LICMS300149-01-27

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.

The Consolidated Appropriations Act of 2021 included an extension of the MFP grant through FFY 2023 and appropriated funding through FFY 2023. Under the Act, the CCT Program

CCT FUND TRANSFER TO CDSS

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.

The Consolidated Appropriations Act of 2023 appropriated 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 2025-26 and FY 2026-27, is an increase due to a methodology change using actual adjustment memos. There is no change from FY 2025-26 to FY 2026-27 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. Assume $43,541,000 TF was awarded for calendar year (CY) 2025, which allowed CCT transitions to continue through December 31, 2025.

5. Assume the federal government will issue a new grant award in CY 2026 at least equal to the current grant awarded, which will allow CCT transitions to continue through December 31, 2026.

6. Below is the overall impact of the CCT Demonstration project in FY 2025-26 and FY 2026-27.

CCT FUND TRANSFER TO CDSS

FY 2025-26	TF	GF	FF
CCT Costs PC:			
Regular CCT Population	$98,078,000	$22,021,000	$76,057,000
State-Funded CCT Population	$273,000	$70,000	$203,000
ALW Transition Costs	$13,408,000	$2,695,000	$10,713,000
Total Costs	$111,759,000	$24,786,000	$86,973,000
CCT Savings:			
Total GF savings and Total FFP	($30,512,000)	($15,884,000)	($14,627,000)
CCT Fund Transfer to CDSS PC:	**$736,000**	**$0**	**$736,000**
CCT Outreach - Admin costs PC:	$364,000	$0	$364,000
Total of CCT PCs including savings	$82,347,000	$8,902,000	$73,446,000

*The savings are included in the total, however, they are fully reflected in the base estimates.

FY 2026-27	TF	GF	FF
CCT Costs PC:			
Regular CCT Population	$114,505,000	$25,655,000	$88,850,000
ALW Transition Costs	$13,408,000	$2,696,000	$10,712,000
Total Cost	$127,913,000	$28,351,000	$99,562,000
CCT Savings:			
Total GF savings and Total FFP	($79,869,000)	($41,580,000)	($38,289,000)
CCT Fund Transfer to CDSS PC:	**$736,000**	**$0**	**$736,000**
CCT Outreach - Admin costs PC:	$364,000	$0	$364,000
Total of CCT PCs including savings	$49,144,000	($13,229,000)	$62,373,000

*The savings are included in the total, however, they are fully reflected in the base estimates.

Funding:
MFP Federal Grant (4260-106-0890)

UTILIZATION MANAGEMENT FOR HOSPICE

FISCAL REFERENCE NUMBER:2528

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**-$100,000,000**	**-$110,171,000**
FEDERAL FUNDS	-$61,730,450	-$68,009,000
GENERAL FUND	-$38,269,550	-$42,162,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	93.0000%	64.0800%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**-$7,000,000**	**-$39,573,400**
FEDERAL FUNDS	-$4,321,130	-$24,428,830
GENERAL FUND	-$2,678,870	-$15,144,590
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the savings from Fee-for-Service (FFS) system enhancements and utilization management requirements for hospice services.

Authority:
AB 116 (Chapter 21, Statutes of 2025)

Interdependent Policy Changes:
Not Applicable

Background:
The Department implemented changes to the Medi-Cal Hospice program to strengthen program integrity.

Effective June 1, 2025, the Department implemented new FFS system enhancements designed to prospectively validate Medi-Cal member election of hospice services and strengthen program integrity by using a unique hospice indicator code. In addition, a new online process was introduced for submitting the Medi-Cal Hospice Program Attestation Form which is intended to improve oversight and streamline validation of information by allowing the Department to receive and review key information up front, such as terminal illness certification and hospice provider demographics, such license number, legal address, and the name of the Medical Director.

Effective July 1, 2026, pursuant to AB 116, the Department will implement utilization management requirements for hospice services.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is due to the incorporation of savings from the new FFS systems enhancements for the hospice program. A portion of the FY 2025-26 savings are reflected in the FFS base estimate as actual hospice expenditures have decreased.

The change in FY 2026-27, from the prior estimate, is due to an updated estimate of the total hospice program savings to include savings from the hospice program updates that occurred in FY 2025-26. The additional savings for the utilization management requirements for hospice

UTILIZATION MANAGEMENT FOR HOSPICE

services are additive to the FY 2025-26 savings but the annual savings for utilization management are now reduced as most of the hospice program savings are estimated to occur with the FY 2025-26 hospice program changes.

The change in the current estimate, from FY 2025-26 to FY 2026-27, is due to the additional savings in FY 2026-27 associated with utilization management requirements.

Methodology:

1. Annual savings for the hospice services FFS system enhancements are estimated at $100 million TF and was implemented on June 1, 2025. These savings are estimated to be 93% in the Fee-for-Service (FFS) base estimate in FY 2025-26 and 70.6% in the FFS Base estimate using actual expenditure data through January 2026.

Hospice Program Updates	**TF**	**TF**
(Dollars in Thousands)	**FY 2025-26**	**FY 2026-27**
Annual Savings	($100,000)	($100,000)
% in FFS Base	93.0%	70.6%
Total savings in PC	($7,000)	($29,400)

2. Utilization management requirements for hospice services are assumed to be implemented no sooner than July 1, 2026. Savings from the utilization management implementation is estimated to be an additional $10.171 million savings starting in FY 2026-27.

3. Managed care impacts of this policy are considered in the base managed care policy changes. The CY 2026 managed care rates included a downward adjustment to hospice costs for rate cells where significantly higher cost experience was observed. The CY 2027 rates are being developed.

4. Total estimated savings for FY 2025-26 and FY 2026-27, before percent in base is applied, on a cash basis, are as follows:

(Dollars in Thousands)

Fiscal Year	**TF**	**GF**	**FF**
FY 2025-26	**($100,000)**	**($38,270)**	**($61,730)**
FY 2026-27	**($110,171)**	**($42,162)**	**($68,009)**

Funding:

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)

CELL AND GENE THERAPY ACCESS MODEL

FISCAL REFERENCE NUMBER:2512

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$18,110,000**	**$19,321,000**
FEDERAL FUNDS	$9,055,000	$9,660,500
GENERAL FUND	$9,055,000	$9,660,500
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$18,110,000**	**$19,321,000**
FEDERAL FUNDS	$9,055,000	$9,660,500
GENERAL FUND	$9,055,000	$9,660,500
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the cost of Medi-Cal members participating in the federal Cell and Gene Therapy (CGT) Access Model for sickle cell disease (SCD).

Authority:
State Plan Amendment 24-0009

Interdependent Policy Changes:
Not Applicable

Background:
The CGT Access Model was developed in response to former President Biden's Executive Order 14087, "Lowering Prescription Drug Costs for Americans." The CGT Access Model tests whether a Centers for Medicare & Medicaid Services (CMS) led approach to developing and administering outcomes-based agreements (OBAs) for CGT therapies improves Medicaid members' access to innovative treatment, improves their health outcomes, and reduces health care costs and burdens on state Medicaid programs. The CGT Access Model consists of eleven performance years (PYs).

The initial focus of the model is on cell and gene therapies to treat SCD a rare genetic blood disorder that disproportionately affects Black Americans. The model includes coverage of the cell and gene therapy treatment, a defined scope of fertility preservation services, and supports for ancillary services, including travel expenses, case management, and behavioral health services.

Under the CGT Access Model, manufacturers will be obligated to provide states with supplemental rebates. The negotiated rebate structure includes a statutory (federal) rebate, a guaranteed rebate that is CGT Access Model specific and negotiated by CMS based on percent of sickle cell disease Medicaid members residing in California, and an outcomes based (value based) rebate that will materialize in later years if agreed upon outcome measures are not achieved.

CELL AND GENE THERAPY ACCESS MODEL

The Department applied for participation in CMS' CGT Access Model on March 11, 2025. The Department received formal approval from CMS and was accepted into the CGT Access Model for Medi-Cal as of March 25, 2025. In alignment with CMS requirements, Medi-Cal coverage includes the following therapies:

- CASGEVY™ by Vertex Pharmaceuticals, Inc. - effective October 1, 2025.
- LYFGENIA™ by bluebird bio, Inc. - effective July 1, 2025.

Reason for Change:
There is no change in FY 2025-26 and FY 2026-27, from the prior estimate.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to the application of a payment lag factor in FY 2025-26 and assuming there is no payment lag adjustment in FY 2026-27.

Methodology:

1. Assume participation in the CGT Access Model is effective July 1, 2025, for LYFGENIA™ and October 1, 2025, for CASGEVY™..

2. Assume the two SCD gene therapies offered with the CGT Access Model (LYFGENIA™ from bluebird bio, Inc. and CASGEVY™ from Vertex Pharmaceuticals) are carved out of the managed care capitation and Fee-for-Service (FFS) inpatient Diagnosis Related Group (DRG) bundled payments and will be paid through the Medi-Cal FFS delivery system.

3. Assume the SCD gene therapies will be provided to twelve Medi-Cal members per year for CASGEVY™ and twelve Medi-Cal members per year for LYFGENIA™.

4. Assume the cost of the SCD gene therapies is post statutory drug rebates and post guaranteed drug rebates paid by the drug manufacturers.

5. Assume the annual total cost is $19,321,000 TF ($9,660,000 GF).

6. Assume the total cost of participation in the CGT Access Model is:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2025-26	$18,110	$9,055	$9,055
FY 2026-27	$19,321	$9,660	$9,661

CELL AND GENE THERAPY ACCESS MODEL

Funding:

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF	$18,110	$9,055	$9,055
Total	**$18,110**	**$9,055**	**$9,055**

(Dollars in Thousands)

FY 2026-27	TF	GF	FF
50% Title XIX / 50% GF	$19,321	$9,660	$9,661
Total	**$19,321**	**$9,660**	**$9,661**

PHARMACY RETROACTIVE ADJUSTMENTS

FISCAL REFERENCE NUMBER:2194

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$800,000**	**$0**
FEDERAL FUNDS	-$30,949,250	$0
GENERAL FUND	$31,749,250	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$800,000**	**$0**
FEDERAL FUNDS	-$30,949,250	$0
GENERAL FUND	$31,749,250	$0
OTHER FUNDS	$0	$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

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 canceled the retroactive recoupments for independent pharmacy providers.

Reason for Change:
There is no change in FY 2025-26 and FY 2026-27 from the prior estimate.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to the completion of the remaining payment adjustment in FY 2025-26.

Methodology:

1. Federal Repayment:
   Assume the retroactive recoupments for independent pharmacy providers will not be collected.

2. Remaining Payments:
   Assume the remaining net payment to independent pharmacies (estimated at $800,000) will occur in FY 2025-26.

3. Assume the Remaining Payments from FY 2023-24 and FY 2024-25 require an adjustment as these payments were made past the two-year CMS claiming limit. This adjustment will be completed in FY 2025-26.

4. On a cash basis, the net impact in FY 2025-26 is estimated to be:

FY 2025-26	TF	GF	FF
Remaining Payments	$800,000	$286,000	$514,000
Remaining Payment Adjustment	$0	$31,463,000	($31,463,000)
Total	**$800,000**	**$31,749,000**	**($30,949,000)**

PHARMACY RETROACTIVE ADJUSTMENTS

Funding:

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF	$490,000	$245,000	$245,000
90% Title XIX/ 10% GF	$269,000	$27,000	$242,000
65% Title XXI / 35% GF	$41,000	$14,000	$27,000
100% Title XIX FF (4260-101-0890)	($29,874,000)	$0	($29,874,000)
100% Title XIX GF (4260-101-0001)	$29,874,000	$29,874,000	$0
100% Title XXI FF (4260-101-0890)	($1,589,000)	$0	($1,589,000)
100% Title XXI GF (4260-101-0001)	$1,589,000	$1,589,000	$0
Total	**$800,000**	**$31,749,000**	**($30,949,000)**

MEDI-CAL DRUG REBATE FUND

FISCAL REFERENCE NUMBER:2124

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$2,386,754,000	-$2,846,543,000
OTHER FUNDS	$2,386,754,000	$2,846,543,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$2,386,754,000	-$2,846,543,000
OTHER FUNDS	$2,386,754,000	$2,846,543,000

Purpose:
This policy change estimates the transfer of the non-federal share of drug rebate collections from the Medicaid Drug Rebate Program (MDRP) and the California specific non-Medicaid drug rebate collections from the Medi-Cal Drug Rebate Fund to the General Fund (GF).

Authority:
SB 78 (Chapter 38, Statues of 2019)
Budget Act of 2025

Interdependent Policy Changes:
Not Applicable

Background:
SB 78 established the Medi-Cal Drug Rebate Fund, effective July 1, 2019. The non-federal share of federal and state supplemental Medi-Cal rebate collections from the MDRP 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.

The Budget Act of 2025 permitted the Department to enter into a contract with a rebate aggregator, Prime Therapeutics (the Contractor), to negotiate and execute contracts to allow Medi-Cal to collect California specific, non-Medicaid drug rebates for covered drugs provided through Medi-Cal Rx to Medi-Cal members with Unsatisfactory Immigrant Status (UIS) and those enrolled in California Children’s Services (CCS) State-Only and Genetically Handicapped

MEDI-CAL DRUG REBATE FUND

Persons Program (GHPP) State-Only. The Contractor's administrative costs will be a percentage of the total California specific, non-Medicaid drug rebates collected, and the estimated savings reflected in this policy change reflect the net total (i.e., less the Contractor's administrative costs) of UIS state drug rebates. These rebates collected through the Medi-Cal Rx Rebate Aggregator will also be deposited into the Medi-Cal Drug Rebate Fund and transferred to offset the GF. These savings were previously included in the Medi-Cal Rx Rebate Aggregator Policy Change. The savings net of the Contractor's administrative costs for CCS State-Only rebates and GHPP State-Only rebates can be found in the Family Health Local Assistance Estimate, CCS State-Only Rx Rebate Aggregator policy change and GHPP State-Only Rx Rebate Aggregator policy change.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is due to:

- Estimating a decrease in the MDRP GF rebate collections due to updated Federal Fund Participation (FFP) and GF splits for actual and estimated MDRP rebate collections resulting in more FF rebate collections and less GF rebate collections, and
- Including non-Medicaid UIS state drug rebates in this policy change.

The change in FY 2026-27, from the prior estimate, is due to:

- Estimating an increase in MDRP GF rebate collections, and
- Including non-Medicaid UIS state drug rebates in this policy change.

The change from FY 2025-26 to FY 2026-27 in the current estimate, is due to:

- Estimating higher MDRP GF rebate collections in FY 2026-27, and
- Estimating that quarterly non-Medicaid UIS state drug rebate amounts will increase from FY 2025-26, and three quarters of state drug rebates will be collected in FY 2026-27

Methodology:

1. In FY 2025-26, it is estimated that $2.2 billion collected for the MDRP will be transferred from the Medi-Cal Drug Rebate Fund to the GF and $2.4 billion collected for the MDRP will be transferred from the Medi-Cal Drug Rebate Fund to the GF in FY 2026-27.

2. A balance of $129.92 million was in the Medi-Cal Drug Rebate Fund as of July 2025. In FY 2025-26 and FY 2026-27 all rebate collections will be transferred to the GF leaving no reserve in the Medi-Cal Drug Rebate Fund.

3. Assume implementation of the state drug rebates for UIS will be no sooner than October 1, 2025. State drug rebates are invoiced quarterly and due seven months after the quarter ends. A one-time exception will occur with the first invoiced quarter, October-December 2025, which is assumed to be collected in May 2026. Assume one quarter of state drug rebates will be collected in FY 2025-26, and three quarters of state drug rebates will be collected in FY 2026-27.

MEDI-CAL DRUG REBATE FUND

4. The summary of the non-federal share and federal share of the estimated FY 2025-26 and FY 2026-27 rebates and the estimated reserve for each respective fiscal year are:

(Dollars in Thousands)

FY 2025-26 Summary of Drug Rebates	TF	Fund 3331	FF
Federal Drug Rebates	($9,091,360)	($1,880,484)	($7,210,876)
State Supplemental Drug Rebates	($893,631)	($255,825)	($637,806)
Family PACT Drug Rebates	($2,836)	($359)	($2,477)
BCCTP Drug Rebates	($1,937)	($617)	($1,320)
Subtotal MDRP Rebates	($9,989,764)	($2,137,285)	($7,852,479)
Non-Medicaid UIS Drug Rebates	($119,552)	($119,552)	
FY 2024-25 Fund Balance		($129,917)	
Medi-Cal Drug Rebate Fund Transfer		**($2,386,754)**	

(Dollars in Thousands)

FY 2026-27 Summary of Drug Rebates	TF	Fund 3331	FF
Federal Drug Rebates	($9,161,102)	($2,178,948)	($6,982,154)
State Supplemental Drug Rebates	($826,561)	($231,770)	($594,791)
Family PACT Drug Rebates	($2,245)	($284)	($1,961)
BCCTP Drug Rebates	($1,828)	($541)	($1,287)
Subtotal MDRP Rebates	($9,991,736)	($2,411,543)	($7,580,193)
Non-Medicaid UIS Drug Rebates	($435,000)	($435,000)	
Medi-Cal Drug Rebate Fund Transfer		**($2,846,543)**	

5. The estimated transfers from the Medi-Cal Drug Rebate Fund to GF are:

(Dollars in Thousands)

FY 2025-26	TF	GF	SF
MDRP Rebates Transfers	$0	($2,267,202)	$2,267,202
Non-Medicaid UIS Drug Rebates Transfer	$0	($119,552)	$119,552
Total Drug Rebates Transfer	**$0**	**($2,386,754)**	**$2,386,754**

MEDI-CAL DRUG REBATE FUND

(Dollars in Thousands)

FY 2026-27	TF	GF	SF
MDRP Rebates Transfers	$0	($2,411,543)	$2,411,543
Non-Medicaid UIS Drug Rebates Transfer	$0	($435,000)	$435,000
Total Drug Rebates Transfer	**$0**	**($2,846,543)**	**$2,846,543**

Funding:

(Dollars in Thousands)

FY 2025-26	TF	GF	SF
Medi-Cal Drug Rebate Fund (4260-601-3331)	$2,386,754	$0	$2,386,754
100% GF (4260-101-0001)	($2,386,754)	($2,386,754)	$0
Total	**$0**	**($2,386,754)**	**$2,386,754**

(Dollars in Thousands)

FY 2026-27	TF	GF	SF
Medi-Cal Drug Rebate Fund (4260-601-3331)	$2,846,543	$0	$2,846,543
100% GF (4260-101-0001)	($2,846,543)	($2,846,543)	$0
Total	**$0**	**($2,846,543)**	**$2,846,543**

HIV/AIDS AND CANCER DRUG REBATES

FISCAL REFERENCE NUMBER:2524

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**-$300,000,000**
FEDERAL FUNDS	$0	-$150,000,000
GENERAL FUND	$0	-$150,000,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**-$300,000,000**
FEDERAL FUNDS	$0	-$150,000,000
GENERAL FUND	$0	-$150,000,000
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the savings from modifying the rebate percentages for human immunodeficiency virus (HIV)/ acquired immunodeficiency syndrome (AIDS) and cancer drugs.

Authority:
AB 116 (Chapter 21, Statutes of 2025)

Interdependent Policy Changes:
Not Applicable

Background:
The Department is implementing various initiatives to enhance Medi-Cal Rx coverage and reimbursement policy to promote continued access to high-quality pharmacy benefits while ensuring more effective and efficient use of state and federal resources, to promote greater cost savings, and to protect against fraud, waste, and abuse.

AB 116 modifies the rebate percentages for HIV/AIDS and cancer drugs. If the mandatory rebate from the Centers for Medicare and Medicaid Services (CMS) is less than 50%, then the minimum rebate will increase to not less than 20%. If the mandatory CMS rebate is greater than 50% then the minimum will be not less than 15%.

Reason for Change:
There is no change in FY 2025-26 and FY 2026-27, from the prior estimate.

The change from FY 2025-26 to FY 2026-27, in the current estimate is due to estimating that the rebates invoiced using the increased rebate percentage will be collected beginning in FY 2026-27.

HIV/AIDS AND CANCER DRUG REBATES

Methodology:
1. Annual savings are estimated at $300 million TF ($150 million GF).

2. Assume implementation will be no sooner than January 1, 2026.

3. Rebates are invoiced quarterly and payments occur six months after the conclusion of each quarter.

4. Assume four quarters of rebate collections with the increased rebate percentage in FY 2026-27.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2026-27	($300,000)	($150,000)	($150,000)

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

LITIGATION SETTLEMENTS

FISCAL REFERENCE NUMBER:1449

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**-$6,000**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$6,000	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**-$6,000**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$6,000	$0
OTHER 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:
There is no change from the prior estimate for both FY 2025-26 and FY 2026-27. The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease due to only being able to budget for current year settlement amounts.

LITIGATION SETTLEMENTS

Methodology:
The following settlements are expected to be received in FY 2025-26:

Settlement Name	FY 2025-26
Progenity Inc.	($6,000)
Total GF Savings	**($6,000)**

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

BCCTP DRUG REBATES

FISCAL REFERENCE NUMBER:1433

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**-$1,320,000**	**-$1,287,000**
FEDERAL FUNDS	-$1,320,000	-$1,287,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**-$1,320,000**	**-$1,287,000**
FEDERAL FUNDS	-$1,320,000	-$1,287,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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 2025-26, from the prior estimate, is an increase in savings due to including two additional quarters of actual rebate collection data through the quarter ending December 2025.

The change in FY 2026-27, from the prior estimate, is an increase in savings due to an increase in estimated BCCTP pharmacy expenditures for the applicable expenditure period.

BCCTP DRUG REBATES

The change from FY 2025-26 to FY 2026-27, in the current estimate, is an decrease in rebate savings due to two high quarters of actual rebate collections in FY 2025-26.

Methodology:

1. Payments began in January 2010.

2. Rebates are invoiced quarterly.

3. The estimated rebates to collect are $1,937,000 in FY 2025-26 and $1,828,000 in FY 2026-27.

4. Assume, of the total BCCTP rebates collected, the ACA offset for BCCTP is $174,000 TF in FY 2025-26 and $281,000 TF in FY 2026-27.

5. The Department estimates $617,000 and $541,000 BCCTP drug rebates to be collected and transferred to the Medi-Cal Drug Rebate Fund in FY 2025-26 and FY 2026-27, respectively.

FY 2025-26	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	($1,146,000)	($1,146,000)	($617,000)
ACA Offset	($174,000)	($174,000)	$0
Total	**($1,320,000)**	**($1,320,000)**	($617,000)

FY 2026-27	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	($1,006,000)	($1,006,000)	($541,000)
ACA Offset	($281,000)	($281,000)	$0
Total	**($1,287,000)**	**($1,287,000)**	($541,000)

*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

FISCAL REFERENCE NUMBER:51

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**-$2,477,000**	**-$1,961,000**
FEDERAL FUNDS	-$2,477,000	-$1,961,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**-$2,477,000**	**-$1,961,000**
FEDERAL FUNDS	-$2,477,000	-$1,961,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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

Reason for Change:
The change from the prior estimate, for FY 2025-26, is an increase in rebates savings due to:

- Including two additional quarters of actual rebate collection data through quarter ending December 2025, and
- An increase in the estimated FPACT pharmacy expenditures for the applicable expenditure period.

The change from the prior estimate, for FY 2026-27, is an increase in rebates savings due to an increase in the estimated FPACT pharmacy expenditures for the applicable expenditure period.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease in rebate savings due to an estimated decrease in FPACT pharmacy expenditures from FY 2025-26 to FY 2026-27.

Methodology:

1. The regular Federal Medical Assistance Percentage (FMAP) percentage is applied to 9.31% of the FPACT rebates to account for the purchase of non-family planning drugs, and the family planning percentage (90% FFP) is applied to 90.69% of the FPACT rebates.
2. Assume the ACA offset is $225,000 TF for FY 2025-26 and $181,000 TF for FY 2026-27.
3. Actual data from July 2013 to December 2025 is used to project rebates.
4. The Department estimates $359,000 and $284,000 FPACT rebate collections to be collected and transferred to the Medi-Cal Drug Rebate Fund in FY 2025-26 and FY 2026-27, respectively.

Funding:

FY 2025-26	TF	FF	Fund 3331 Transfer
100% Title XIX FF	($2,252,000)	($2,252,000)	($359,000)
ACA Offset	($225,000)	($225,000)	$0
Total	**($2,477,000)**	**($2,477,000)**	($359,000)

FY 2026-27	TF	FF	Fund 3331 Transfer
100% Title XIX FF	($1,780,000)	($1,780,000)	($284,000)
ACA Offset	($181,000)	($181,000)	$0
Total	**($1,961,000)**	**($1,961,000)**	($284,000)

*The Fund 3331 Transfer column is for informational purposes only. See Methodology #4.

UPDATES TO OTC COVID-19 TESTS AND OTC PRODUCTS

FISCAL REFERENCE NUMBER:2519

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**-$4,360,000**	**-$12,000,000**
FEDERAL FUNDS	-$2,531,100	-$7,027,100
GENERAL FUND	-$1,828,900	-$4,972,900
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**-$4,360,000**	**-$12,000,000**
FEDERAL FUNDS	-$2,531,100	-$7,027,100
GENERAL FUND	-$1,828,900	-$4,972,900
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the savings from updating coverage for over-the-counter (OTC) COVID-19 tests and restrictions on coverage for specific OTC products.

This policy change was previously titled “Eliminate COVID-19 Tests & OTC Drugs.”

Authority:
AB 116 (Chapter 21, Statutes of 2025)

Interdependent Policy Changes:
Not Applicable

Background:
The Department is proposing various initiatives to enhance Medi-Cal Rx coverage and reimbursement policy to promote continued access to high-quality pharmacy benefits while ensuring more effective and efficient use of state and federal resources, to promote greater cost savings, and to protect against fraud, waste, and abuse.

The Department proposes to update coverage and introduce restrictions for the following drug classes/therapies:

- OTC COVID-19 tests
  - Prior authorizations will be required for all OTC COVID-19 tests effective January 1, 2026.
  - OTC COVID-19 test coverage will be eliminated effective October 1, 2027.
- OTC multivitamin combination products
  - Remove coverage for members 21 years of age and older.
- OTC single-ingredient vitamins
  - Limit coverage for members under 21 years.
  - PA will be required for members 21 years and older, except for Vitamin D and B preparations.

UPDATES TO OTC COVID-19 TESTS AND OTC PRODUCTS

- OTC first- and second-generation antihistamines.
  - For members 21 years of age and older, coverage is restricted to generic formulations only.
  - Fexofenadine and Allegra brand name products are PA only.
- OTC dry eye products
  - For all members 21 years of age and older, coverage is restricted PA only.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is due to an implementation delay and an updated payment lag.

There is no change in FY 2026-27 from the prior estimate.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to FY 2026-27 reflecting a full year's savings.

Methodology:
1. Annual savings are estimated at $12 million TF.

2. Assume implementation will be no sooner than February 1, 2026.

3. Total estimated savings for updates to coverage of OTC COVID-19 tests and specific OTC products, on a cash basis, are as follows:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2025-26	**($4,360)**	**($1,829)**	**($2,531)**
FY 2026-27	**($12,000)**	**($4,973)**	**($7,027)**

Funding:

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	($1,694)	($847)	($847)
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	($1,812)	($181)	($1,631)
65% Title XXI FF / 35% GF (4260-101-0001/0890)	($82)	($29)	($53)
100% GF (4260-101-0001)	($772)	($772)	$0
Total	**($4,360)**	**($1,829)**	**($2,531)**

UPDATES TO OTC COVID-19 TESTS AND OTC PRODUCTS

(Dollars in Thousands)

FY 2026-27	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	($4,527)	($2,263)	($2,264)
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	($5,147)	($515)	($4,632)
65% Title XXI FF / 35% GF (4260-101-0001/0890)	($202)	($71)	($131)
100% GF (4260-101-0001)	($2,124)	($2,124)	$0
Total	**($12,000)**	**($4,973)**	**($7,027)**

PHARMACY UTILIZATION MANAGEMENT

FISCAL REFERENCE NUMBER:2526

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**-$17,860,000**	**-$80,632,000**
FEDERAL FUNDS	-$10,369,150	-$47,218,500
GENERAL FUND	-$7,490,850	-$33,413,500
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	10.3500%	3.0500%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**-$16,011,500**	**-$78,172,700**
FEDERAL FUNDS	-$9,295,940	-$45,778,340
GENERAL FUND	-$6,715,550	-$32,394,390
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the savings from implementing updates to utilization management (UM) controls and prior authorization (PA) requirements for pharmacy benefits.

Authority:
AB 116 (Chapter 21, Statutes of 2025)

Interdependent Policy Changes:
Not Applicable

Background:
The Department is proposing various initiatives to enhance Medi-Cal Rx coverage and reimbursement policy to promote continued access to high-quality pharmacy benefits while ensuring more effective and efficient use of state and federal resources, to promote greater cost savings, and to protect against fraud, waste, and abuse.

The Department proposes to make modifications of UM controls and PA requirements to align with the current state of the program.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is due to a phased implementation of savings with the impact being realized later than originally anticipated.

The change in FY 2026-27, from the prior estimate, is due to an implementation delay to January 1, 2027.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to 12 months of re-coded drugs savings and the additional implementation of the Prime system starting January 1, 2027.

Methodology:
1. Effective January 1, 2026, the re-coding of several utilized drugs is estimated to result in annual savings of $40 million TF.

PHARMACY UTILIZATION MANAGEMENT

2. Assume implementation will continue with Prime systems changes beginning no sooner than January 1, 2027 and is estimated to result in annual savings of $91 million TF.

3. Total estimated savings for pharmacy utilization management, on a cash basis, are as follows:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2025-26	($17,860)	($7,491)	($10,369)
FY 2026-27	($80,632)	($33,414)	($47,219)

Funding:

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	($6,936)	($3,468)	($3,468)
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	($7,426)	($743)	($6,683)
65% Title XXI FF / 35% GF (4260-101-0001/0890)	($335)	($117)	($218)
100% GF (4260-101-0001)	($3,163)	($3,163)	$0
Total	**($17,860)**	**($7,491)**	**($10,369)**

(Dollars in Thousands)

FY 2026-27	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	($30,422)	($15,211)	($15,211)
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	($34,586)	($3,459)	($31,127)
65% Title XXI FF / 35% GF (4260-101-0001/0890)	($1,354)	($474)	($880)
100% GF (4260-101-0001)	($14,270)	($14,270)	$0
Total	**($80,632)**	**($33,414)**	**($47,219)**

ELIMINATE GLP-1 COVERAGE FOR WEIGHT LOSS

FISCAL REFERENCE NUMBER:2520

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**-$86,567,000**	**-$365,144,000**
FEDERAL FUNDS	-$212,000	-$964,000
GENERAL FUND	-$86,355,000	-$364,180,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	10.3500%	2.9100%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**-$77,607,300**	**-$354,518,300**
FEDERAL FUNDS	-$190,060	-$935,950
GENERAL FUND	-$77,417,260	-$353,582,360
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the savings from eliminating coverage for glucagon-like peptide-1 (GLP-1) drugs for weight loss indications.

Authority:
AB 116 (Chapter 21, Statutes of 2025)

Interdependent Policy Changes:
Not Applicable

Background:
The Department is proposing various initiatives to enhance Medi-Cal Rx coverage and reimbursement policy to promote continued access to high-quality pharmacy benefits while ensuring more effective and efficient use of state and federal resources, to promote greater cost savings, and to protect against fraud, waste, and abuse.

The Department proposes to eliminate coverage for all GLP-1 drugs for weight loss indications.

Reason for Change:
There is no change in FY 2025-26 and FY 2026-27 from the prior estimate.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to the additional ramp up of savings estimated in FY 2026-27.

Methodology:
1. The coverage for all GLP-1 drugs for weight loss indications was eliminated effective January 1, 2026.

ELIMINATE GLP-1 COVERAGE FOR WEIGHT LOSS

2. Total estimated savings, on cash basis, are as follows:

Fiscal Year	TF	GF	FF
FY 2025-26	($86,567,000)	($86,355,000)	($212,000)
FY 2026-27	($365,144,000)	($364,180,000)	($964,000)

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

PRIOR AUTH. FOR CONTINUATION OF DRUG THERAPY

FISCAL REFERENCE NUMBER:2518

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**-$111,625,000**	**-$250,000,000**
FEDERAL FUNDS	-$64,803,100	-$146,399,600
GENERAL FUND	-$46,821,900	-$103,600,400
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	10.3500%	6.1400%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**-$100,071,800**	**-$234,650,000**
FEDERAL FUNDS	-$58,095,980	-$137,410,660
GENERAL FUND	-$41,975,830	-$97,239,340
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the savings from discontinuing the current continuation of therapy policy which looks to see if members' claims data shows a history of prior use within 100 days and make continued coverage subject to prior authorization (PA).

Authority:
AB 116 (Chapter 21, Statutes of 2025)

Interdependent Policy Changes:
Not Applicable

Background:
The Department is proposing various initiatives to enhance Medi-Cal Rx coverage and reimbursement policy to promote continued access to high-quality pharmacy benefits while ensuring more effective and efficient use of state and federal resources, to promote greater cost savings, and to protect against fraud, waste, and abuse.

The Department intends to remove the 100-day look back for drugs that are removed from the Contract Drug List (CDL). Members on drugs that have been removed from the Medi-Cal Rx CDL will require a Prior Authorization to continue therapy and will no longer be granted automatic coverage based on prior use.

Reason for Change:
There is no change in FY 2025-26 and FY 2026-27 from the prior estimate.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to FY 2026-27 reflecting a full year's savings.

PRIOR AUTH. FOR CONTINUATION OF DRUG THERAPY

Methodology:

1. Annual savings are estimated at $250 million TF.

2. Implementation is effective January 1, 2026.

3. There is no managed care impact outside of the base.

4. Total estimated savings from discontinuing the current continuation of therapy policy, on a cash basis, are as follows:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2025-26	**($111,625)**	**($46,822)**	**($64,803)**
FY 2026-27	**($250,000)**	**($103,600)**	**($146,400)**

Funding:

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	($43,360)	($21,680)	($21,680)
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	($46,408)	($4,641)	($41,767)
65% Title XXI FF / 35% GF (4260-101-0001/0890)	($2,086)	($730)	($1,356)
100% GF (4260-101-0001)	($19,771)	($19,771)	$0
Total	**($111,625)**	**($46,822)**	**($64,803)**

(Dollars in Thousands)

FY 2026-27	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	($94,326)	($47,163)	($47,163)
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	($107,231)	($10,723)	($96,508)
65% Title XXI FF / 35% GF (4260-101-0001/0890)	($4,198)	($1,469)	($2,729)
100% GF (4260-101-0001)	($44,245)	($44,245)	$0
Total	**($250,000)**	**($103,600)**	**($146,400)**

MEDICAL SUPPLY REBATES

FISCAL REFERENCE NUMBER:1181

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**-$153,000,000**	**-$204,000,000**
FEDERAL FUNDS	-$76,500,000	-$142,008,200
GENERAL FUND	-$76,500,000	-$61,991,800
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**-$153,000,000**	**-$204,000,000**
FEDERAL FUNDS	-$76,500,000	-$142,008,200
GENERAL FUND	-$76,500,000	-$61,991,800
OTHER FUNDS	$0	$0

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 2025-26, from the prior estimate, is an increase in savings due to revised projections based on updated actual rebate collection data.

The change in FY 2026-27, from the prior estimate, is an increase in savings due to revised projections based on updated actual rebate collection data.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase 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 four quarters of rebates to be collected in FY 2026-27 compared to three quarters in FY 2025-26.

MEDICAL SUPPLY REBATES

Methodology:

1. Assume the average FFS quarterly collections for medical supply rebates are $51,000,000.

2. There is a one quarter lag for medical supply rebate collections under the current manual process.

3. 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 quarters of rebates collected in FY 2025-26.

4. Assume the total rebates collected are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2025-26	($153,000)	($76,500)	($76,500)
FY 2026-27	($204,000)	($61,992)	($142,008)

Funding:

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF	($153,000)	($76,500)	($76,500)
Total	**($153,000)**	**($76,500)**	**($76,500)**

(Dollars in Thousands)

FY 2026-27	TF	GF	FF
50% Title XIX / 50% GF	($100,312)	($50,156)	($50,156)
90% Title XIX / 10% GF	($97,820)	($9,782)	($88,038)
65% Title XXI / 35% GF	($5,868)	($2,054)	($3,814)
Total	**($204,000)**	**($61,992)**	**($142,008)**

STEP THERAPY

FISCAL REFERENCE NUMBER:2527

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**-$156,275,000**	**-$350,000,000**
FEDERAL FUNDS	-$90,724,200	-$204,959,650
GENERAL FUND	-$65,550,800	-$145,040,350
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	10.3500%	6.1400%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**-$140,100,500**	**-$328,510,000**
FEDERAL FUNDS	-$81,334,240	-$192,375,130
GENERAL FUND	-$58,766,290	-$136,134,870
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the savings from implementing step therapy protocols for pharmacy drugs.

Authority:
AB 116 (Chapter 21, Statutes of 2025)

Interdependent Policy Changes:
Not Applicable

Background:
The Department is proposing various initiatives to enhance Medi-Cal Rx coverage and reimbursement policy to promote continued access to high-quality pharmacy benefits while ensuring more effective and efficient use of state and federal resources, to promote greater cost savings, and to protect against fraud, waste, and abuse.

Step therapy is a strategy used in utilization management based on clinical guidelines to control prescription drug costs. This approach establishes a specific order for which medications are covered by a health benefits plan. The Department would administer a step therapy program to develop, create, update, and maintain a specific list of step-therapy drugs and apply specific step-therapy clinical guidelines and Medi-Cal net cost criteria developed by the Department. These step-therapy clinical guidelines and cost criteria will apply in addition to Prior Authorizations (PA) review for medical necessity for drugs not listed on the Contract Drug List (CDL).

For drugs included in the Medi-Cal step therapy program, members would be required to first try one or more medications from the CDL in a specific order determined by the Department. Only after these first-line or second-line therapy drugs have been attempted and found to be ineffective can a drug that is not included in the CDL and prescribed by the member’s physician be eligible for a prior authorization (PA) review. This review will assess the medical necessity of the prescribed drug on a case-by-case basis.

STEP THERAPY

Reason for Change:
There is no change in FY 2025-26 and FY 2026-27 from the prior estimate.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to FY 2026-27 reflecting a full year’s savings.

Methodology:
1. Annual savings are estimated at $350 million TF.
2. Implementation is effective January 1, 2026.
3. There is no managed care impact outside of the base.
4. Total estimated savings for step therapy protocols, on a cash basis, are as follows:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2025-26	($156,275)	($65,551)	($90,724)
FY 2026-27	($350,000)	($145,040)	($204,960)

Funding:

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	($60,702)	($30,351)	($30,351)
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	($64,971)	($6,497)	($58,474)
65% Title XXI FF / 35% GF (4260-101-0001/0890)	($2,922)	($1,023)	($1,899)
100% GF (4260-101-0001)	($27,680)	($27,680)	$0
Total	**($156,275)**	**($65,551)**	**($90,724)**

(Dollars in Thousands)

FY 2026-27	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	($132,056)	($66,028)	($66,028)
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	($150,124)	($15,012)	($135,112)
65% Title XXI FF / 35% GF (4260-101-0001/0890)	($5,877)	($2,057)	($3,820)
100% GF (4260-101-0001)	($61,943)	($61,943)	$0
Total	**($350,000)**	**($145,040)**	**($204,960)**

STATE SUPPLEMENTAL DRUG REBATES

FISCAL REFERENCE NUMBER:54

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**-$637,806,000**	**-$594,791,000**
FEDERAL FUNDS	-$637,806,000	-$594,791,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**-$637,806,000**	**-$594,791,000**
FEDERAL FUNDS	-$637,806,000	-$594,791,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the revenues collected from the State Supplemental Drug rebates.

Authority:
Welfare & Institutions Code 14105.33
SB 78 (Chapter 38, Statues of 2019)

Interdependent Policy Changes:
Medi-Cal Drug Rebate Fund

Background:
State supplemental drug rebates for drugs provided through Fee-for-Service (FFS) and County Organized Health Systems are negotiated by the Department with drug manufacturers to provide additional drug rebates over and above the federal rebate levels (see the Federal Drug Rebate policy change).

SB 78 established the Medi-Cal Drug Rebate Fund (Fund 3331) effective July 1, 2019. The non-federal share of Medi-Cal federal and state supplemental drug rebates will be deposited into Fund 3331. See the Medi-Cal Drug Rebate Fund policy change for the estimated total transfers from Fund 3331 to the General Fund (GF).

Reason for Change:
The change in FY 2025-26, 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 December 2025, and
- Projections for state supplemental rebates are based on trends from actual rebate collection data to FFS drug expenditures.

The change in FY 2026-27, from the prior estimate, is an increase in rebate savings due to an increase in the estimated FFS pharmacy expenditures for the applicable expenditure period.

STATE SUPPLEMENTAL DRUG REBATES

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease in rebate savings due to two high quarters of actual rebate collections in 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 $20,437,000 FF and $17,481,000 FF in FY 2025-26 and FY 2026-27, respectively.

4. The optional expansion ACA population collections are estimated to be $464,852,000 TF for FY 2025-26, of which $418,367,000 FF is budgeted in this policy change. The amount of $46,485,000 SF is the estimated non-federal share in the Medi-Cal Drug Rebate Fund. For FY 2026-27, the ACA collections are estimated to be $442,943,000 TF, of which $398,649,000 FF is budgeted in this policy change. The amount of $44,294,000 SF is the estimated non-federal share in the Medi-Cal Drug Rebate Fund.

5. The Department estimates to transfer $255,825,000 and $231,770,000 state supplemental rebates to be collected and transferred to the Medi-Cal Drug Rebate Fund in FY 2025-26 and FY 2026-27, respectively.

FY 2025-26	TF	FF	Fund 3331 Transfer
100% Title XIX FF	($199,002,000)	($199,002,000)	($209,340,000)
100% Title XIX ACA FF	($418,367,000)	($418,367,000)	($46,485,000)
100% Title XXI FF	($20,437,000)	($20,437,000)	
Total	**($637,806,000)**	**($637,806,000)**	($255,825,000)

FY 2026-27	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	($178,661,000)	($178,661,000)	($187,476,000)
100% Title XIX ACA FF	($398,649,000)	($398,649,000)	($44,294,000)
100% Title XXI FF	($17,481,000)	($17,481,000)	
Total	**($594,791,000)**	**($594,791,000)**	($231,770,000)

*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

FISCAL REFERENCE NUMBER:55

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**-$7,210,876,000**	**-$6,982,154,000**
FEDERAL FUNDS	-$7,210,876,000	-$6,982,154,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**-$7,210,876,000**	**-$6,982,154,000**
FEDERAL FUNDS	-$7,210,876,000	-$6,982,154,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the revenues collected from the Federal Drug rebates.

Authority:
Social Security Act, section 1927 [42 U.S.C. 1396r–8]
Omnibus Budget Reconciliation Act (OBRA) of 1990, Title IV, sec. 4401(a)(3), 104 Stat.
SB 78 (Chapter 38, Statues of 2019)

Interdependent Policy Changes:
Medi-Cal Drug Rebate Fund

Background:
The Medicaid Drug Rebate Program, created by OBRA 1990, allows the Department to obtain price discounts for drugs. The 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 2025-26, from the prior estimate, is due to:

- Including two additional quarters of actual rebate collection data through the quarter ending December 2025, and
- A decrease in the estimated Fee-for-Service (FFS) pharmacy expenditures for the applicable expenditure period.

FEDERAL DRUG REBATES

The change in FY 2026-27, from the prior estimate, is due to an increase in estimated FFS pharmacy expenditures for the applicable expenditure period.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease in rebate savings due to two high quarters of actual rebate collections in FY 2025-26.

Methodology:

1. Rebates are invoiced quarterly and payments occur six months after the conclusion of each quarter.

2. 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 $179,535,000 FF and $155,309,000 FF in FY 2025-26 and FY 2026-27, respectively.

6. The optional expansion ACA population collections are estimated to be $4,297,774,000 TF for FY 2025-26, of which $3,867,997,000 FF is budgeted in this policy change. The amount of $429,777,000 SF is the estimated non-federal share in the Medi-Cal Drug Rebate Fund. For FY 2026-27, a total of $4,852,799,000 TF is estimated for the optional expansion population, of which $4,367,519,000 FF is budgeted in this policy change. The amount of $485,280,000 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 $523,599,000 TF for FY 2025-26 and $843,867,000 TF for FY 2026-27.

FEDERAL DRUG REBATES

8. The Department estimates $1,880,484,000 and $2,178,948,000 federal drug rebates to be collected and transferred to the Medi-Cal Drug Rebate Fund in FY 2025-26 and FY 2026-27, respectively.

(Dollars in Thousands)

FY 2025-26	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	($2,639,745)	($2,639,745)	($1,450,707)
100% Title XIX ACA FF	($3,867,997)	($3,867,997)	($429,777)
100% Title XXI FF	($179,535)	($179,535)	$0
ACA Offset	($523,599)	($523,599)	$0
Total	**($7,210,876)**	**($7,210,876)**	($1,880,484)

(Dollars in Thousands)

FY 2026-27	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	($1,615,459)	($1,615,459)	($1,693,668)
100% Title XIX ACA FF	($4,367,519)	($4,367,519)	($485,280)
100% Title XXI FF	($155,309)	($155,309)	$0
ACA Offset	($843,867)	($843,867)	$0
Total	**($6,982,154)**	**($6,982,154)**	($2,178,948)

*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)

RECOVERY INCENTIVES CONTINGENCY MANAGEMENT

FISCAL REFERENCE NUMBER:2278

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$13,299,000**	**$16,478,000**
FEDERAL FUNDS	$10,751,000	$13,348,000
GENERAL FUND	$0	$0
OTHER FUNDS	$2,548,000	$3,130,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$13,299,000**	**$16,478,000**
FEDERAL FUNDS	$10,751,000	$13,348,000
GENERAL FUND	$0	$0
OTHER FUNDS	$2,548,000	$3,130,000

Purpose:
This policy change, previously titled “HCBS SP – Contingency Management,” estimates the cost of adding the Recovery Incentives Program Contingency Management benefit (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.

Authority:
Budget Act of 2021 [SB 129 (Chapter 69, Statutes of 2021)]
CalAIM 1115 Demonstration Waiver

Interdependent Policy Changes:
Not Applicable

Background:
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. This benefit was originally approved in the 2021 Budget Act, funded by the Home & Community-Based American Rescue Plan (HCBS ARP) Fund.

The Department extended CM as an optional benefit for all DMC-ODS counties that choose to opt-in, in alignment with the CalAIM 1115 Demonstration waiver timeline (through December 31, 2026). Counties have the option to continue offering CM services and provide the non-federal share of the funding.

The Department will seek federal approval to extend the CM benefit in the next CalAIM 1115 Demonstration waiver renewal.

RECOVERY INCENTIVES CONTINGENCY MANAGEMENT

Reason for Change:
There is no change from the prior estimate for FY 2025-26 and FY 2026-27.

The change in the current estimate, from FY 2025-26 to FY 2026-27, is an increase due to the transition from the pilot phase to full program implementation, reflecting anticipated expansion into additional DMC-ODS counties.

Methodology:
1. CM 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 CM include the following costs:
    - Incentive costs for members averaging $300 per year (up to a maximum of $599)
    - CM services costs

4. Updated cost forecasts now reflect actual CM services and member incentive claims from the first year of implementation (April 2023 through the most recent reporting period), providing a more accurate estimate.

5. HCBS funding was available for the non-federal share of CM services and incentive costs through August 15, 2024 claim submission dates.

6. The Department implemented the CalAIM Behavioral Health Payment Reform and a new Intergovernmental Transfer (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.

7. Total estimated costs for CM, on a cash basis, are as follows:

FY 2025-26	**TF**	**IGT***	**FF**	**CF**
CM Incentive Costs	$2,559,000	$0	$1,983,000	$576,000
CM Services Costs	$11,316,000	$2,548,000	$8,768,000	$0
Total	$13,875,000	**$2,548,000**	**$10,751,000**	$576,000

FY 2026-27	**TF**	**IGT***	**FF**	**CF**
CM Incentive Costs	$3,330,000	$0	$2,580,000	$750,000
CM Services Costs	$13,898,000	$3,130,000	$10,768,000	$0
Total	$17,228,000	**$3,130,000**	**$13,348,000**	$750,000

RECOVERY INCENTIVES CONTINGENCY MANAGEMENT

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)*

DRUG MEDI-CAL PROGRAM COST SETTLEMENT

FISCAL REFERENCE NUMBER:1723

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$19,878,000**	**$15,996,000**
FEDERAL FUNDS	$10,964,000	$8,789,000
GENERAL FUND	$8,914,000	$7,207,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$19,878,000**	**$15,996,000**
FEDERAL FUNDS	$10,964,000	$8,789,000
GENERAL FUND	$8,914,000	$7,207,000
OTHER FUNDS	$0	$0

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 are 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

Cost settlements for NTP services are 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 in FY 2025-26 and FY 2026-27, from the prior estimate, is a net increase primarily due to updated cost settlement projections and revised audit settlement estimated based on actual data.

- Audit settlement projections for FY 2018-19, FY 2019-20 and FY 2020-21 have been updated to reflect net recoupments, reducing projected audit revenues compared to the prior estimate.
- Cost settlement projections for FY 2019-20 and FY 2020-21 increased due to higher volumes and increased average settlement amounts processed year over year.

The change in the current estimate, from FY 2025-26 to FY 2026-27, is a net decrease primarily due to lower projected cost settlement payments in FY 2026-27, partially offset by audit settlement recoupments.

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 2025-26 and FY 2026-27:

FY 2025-26	TF	GF	Title XIX	Title XXI	CF
FY 2018-19 Audit Settlements	($509,000)	($64,000)	($302,000)	$0	($143,000)
FY 2019-20 Audit Settlements	($203,000)	($25,000)	($121,000)	$0	($57,000)
FY 2019-20 Cost Settlements	$20,390,000	$9,003,000	$11,298,000	$89,000	$0
Total	$19,678,000	**$8,914,000**	**$10,875,000**	**$89,000**	($200,000)

DRUG MEDI-CAL PROGRAM COST SETTLEMENT

FY 2026-27	TF	GF	Title XIX	Title XXI	CF
FY 2019-20 Audit Settlements	($475,000)	($59,000)	($282,000)	$0	($134,000)
FY 2020-21 Audit Settlements	($271,000)	($34,000)	($161,000)	$0	($76,000)
FY 2019-20 Cost Settlements	$11,022,000	$4,867,000	$6,107,000	$48,000	$0
FY 2020-21 Cost Settlements	$5,510,000	$2,433,000	$3,053,000	$24,000	$0
Total	$15,786,000	**$7,207,000**	**$8,717,000**	**$72,000**	($210,000)

Funding:
100% General Fund (4260-101-0001)
100% Title XIX (4260-101-0890)
100% Title XXI (4260-101-0890)

DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT

FISCAL REFERENCE NUMBER:1724

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$657,000**	**$1,755,000**
FEDERAL FUNDS	$472,300	$1,260,600
GENERAL FUND	$42,700	$114,400
OTHER FUNDS	$142,000	$380,000
% REFLECTED IN BASE	69.3800%	36.0900%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$201,200**	**$1,121,600**
FEDERAL FUNDS	$144,620	$805,650
GENERAL FUND	$13,070	$73,110
OTHER FUNDS	$43,480	$242,860

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 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

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 2025-26 and FY 2026-27, from the prior estimate, is an increase due to the following:

- Higher estimated utilization based on updated claims data; and
- Updated rates per unit and incremental rates based on the HHA market basket index increase for the FY 2025-26 and FY 2026-27 rates.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to FY 2026-27 costs reflecting updated FY 2025-26 and FY 2026-27 rates. In addition, FY 2026-27 includes the HHA Market Basket Index increase for FY 2025-26 and FY 2026-27 rates.

Methodology:

1. The FY 2024-25, FY 2025-26, and FY 2026-27 estimated rate per unit for DMC State Plan services are:

DMC State Plan Services	FY 2024-25 Rate per Unit	FY 2025-26 Rate per Unit	FY 2026-27 Rate per Unit
NTP	$63.75	$65.72	$67.76
IOT	$23.28	$24.00	$24.74
24 Hour Services	$168.45	$173.65	$179.04
ODF	$35.55	$36.65	$37.79
MAT	$33.80	$34.85	$35.93

DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT

2. The incremental rate changes for FY 2025-26 and FY 2026-27 are shown below:

Incremental Difference	FY 2025-26	FY 2026-27
NTP	$1.97	$2.04
IOT	$0.72	$0.74
24 Hour Services	$5.21	$5.38
ODF	$1.10	$1.14
MAT	$1.04	$1.08

3. The cost estimate for FY 2025-26, based on FY 2025-26 incremental rate changes are:

FY 2025-26	Total Number of Units	FY 2025-26 Incremental Difference	FY 2025-26 Rate Adj. (A)
NTP	389,732	$1.97	$768,000
IOT	71,052	$0.72	$51,000
24 Hour Services	449	$5.21	$2,000
ODF	235,372	$1.10	$259,000
MAT	3,742	$1.04	$4,000
Total			$1,084,000

4. The cost estimate for FY 2026-27, based on the incremental rate changes for FY 2025-26 and FY 2026-27 are:

FY 2026-27	Total Number of Units	FY 2026-27 Incremental Difference	FY 2026-27 Rate Adj. (B)	Total Rate Adj. Cost (C=A+B)
NTP	389,732	$2.04	$794,000	$1,562,000
IOT	71,052	$0.74	$53,000	$104,000
24 Hour Services	449	$5.38	$2,000	$4,000
ODF	235,372	$1.14	$267,000	$526,000
MAT	3,742	$1.08	$4,000	$8,000
Total			$1,120,000	$2,204,000

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 2025-26 and FY 2026-27 rates, assume 60.7% of DMC claims are paid in the same year the services occur, 38.6% in the second year, and the remaining 0.7% in the third year.

DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT

7. Total estimated costs for the annual rate adjustments are:

Annual Rate Adj. Cost	FY 2025-26 Rates	FY 2026-27 Rates	FY 2025-26 (Lagged)	FY 2026-27 (Lagged)
NTP	$768,000	$1,562,000	$466,000	$1,245,000
IOT	$51,000	$104,000	$31,000	$82,000
24 Hour Services	$2,000	$4,000	$1,000	$3,000
ODF	$259,000	$526,000	$157,000	$419,000
MAT	$4,000	$8,000	$2,000	$6,000
Total	$1,084,000	$2,204,000	**$657,000**	**$1,755,000**

FY 2025-26	TF	GF	IGT*	FF
Regular				
Current	$297,000	$7,000	$141,000	$149,000
ACA Optional	$357,000	$36,000	$0	$321,000
Perinatal				
Current	$2,000	$0	$1,000	$1,000
ACA Optional	$1,000	$0	$0	$1,000
Total	**$657,000**	**$43,000**	**$142,000**	**$472,000**

FY 2026-27	TF	GF	IGT*	FF
Regular				
Current	$793,000	$19,000	$376,000	$398,000
ACA Optional	$952,000	$95,000	$0	$857,000
Perinatal				
Current	$8,000	$0	$4,000	$4,000
ACA Optional	$2,000	$0	$0	$2,000
Total	**$1,755,000**	**$114,000**	**$380,000**	**$1,261,000**

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

CALAIM - BH - CONNECT DEMONSTRATION

FISCAL REFERENCE NUMBER:2394

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$113,933,000**	**$422,340,000**
FEDERAL FUNDS	$71,998,000	$273,672,000
GENERAL FUND	$11,908,000	$23,815,000
OTHER FUNDS	$30,027,000	$124,853,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$113,933,000**	**$422,340,000**
FEDERAL FUNDS	$71,998,000	$273,672,000
GENERAL FUND	$11,908,000	$23,815,000
OTHER FUNDS	$30,027,000	$124,853,000

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 to and strengthen the continuum of mental health services for Medi-Cal members 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. Since the pandemic, California hospitals report significant increases in the number of adolescents seeking psychiatric treatment in emergency departments, as well as long waitlists for psychiatric inpatient beds for children and adolescents. For adults, the situation is similarly serious. More than one in 20 adult residents in California is living with significant behavioral health needs, and the evidence continues to mount that individuals who are experiencing or at risk of homelessness and those involved in the justice system experience high rates of untreated mental illness and/or substance use disorder. Even so, approximately one-third of individuals enrolled in Medi-Cal and who are living with significant behavioral health needs do not receive any Medi-Cal Specialty Mental Health Services. As a result, the Department has made strengthening California's behavioral health system a top priority and is 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.

On December 16, 2024, the Centers for Medicare & Medicaid Services (CMS) approved the BH-CONNECT demonstration that aims to expand access to and strengthen the continuum of mental health services for Medi-Cal members living with significant behavioral health needs. The

CALAIM - BH - CONNECT DEMONSTRATION

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.

California’s approved BH-CONNECT demonstration includes the following initiatives: (1) Access, Reform and Outcomes Incentive Program, (2) Workforce Initiatives, (3) Activity Funds Initiative, (4) Serious Mental Illness Program (MH IMD FFP Program), (5) Community Transition In-Reach Services, and (6) Health-Related Social Needs (i.e., Transitional Rent). The overall goals of this demonstration include:

- Expanding the continuum of community-based behavioral health services and evidence-based practices (EBPs) available through Medi-Cal.
- Strengthening family-based services and support for children and youth living with significant behavioral health needs, including children and youth involved in child welfare.
- Investing in statewide practice transformations to better enable county behavioral health delivery systems and providers to support Medicaid beneficiaries living with significant behavioral health needs.
- Strengthening the workforce needed to deliver community-based behavioral health services to Medicaid beneficiaries.
- Reducing use of institutional care by those individuals most significantly affected by significant behavioral health needs.
- Shortening lengths of stay in institutional settings and support successful transitions to community-based care settings and community reintegration.
- Promoting improved health outcomes, community integration, treatment and recovery for individuals who are homeless or at risk of homelessness and experiencing critical transitions.

Reason for Change:
The change in FY 2025-26 and FY 2026-27, from the prior estimate, is a decrease due to fewer than anticipated counties opting in to the BH-CONNECT Demonstration waiver.

The change in the current estimate, from FY 2025-26 to FY 2026-27, is an increase due to more counties projected to opt in during FY 2026-27 compared to FY 2025-26.

Methodology:
1. The BH-CONNECT Demonstration became effective in January 2025 with payments beginning in October 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 demonstration features will be phased in across 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.

CALAIM - BH - CONNECT DEMONSTRATION

5. Total estimated costs for the BH-CONNECT Demonstration, on a cash basis, are as follows:

(Dollars in Thousands)

FY 2025-26	TF	GF	FFP	IGT*
SMHS – Statewide	$23,815	$11,908	$11,907	$0
SMHS – Opt-in	$90,118	$0	$60,091	$30,027
Total	**$113,933**	**$11,908**	**$71,998**	**$30,027**

(Dollars in Thousands)

FY 2026-27	TF	GF	FFP	IGT*
SMHS – Statewide	$47,630	$23,815	$23,815	$0
SMHS – Opt-in	$374,710	$0	$249,857	$124,853
Total	**$422,340**	**$23,815**	**$273,672**	**$124,853**

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 FFPSA

FISCAL REFERENCE NUMBER:2252

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$34,932,000**	**$34,943,000**
FEDERAL FUNDS	$17,468,000	$17,471,000
GENERAL FUND	$8,732,000	$8,736,000
OTHER FUNDS	$8,732,000	$8,736,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$34,932,000**	**$34,943,000**
FEDERAL FUNDS	$17,468,000	$17,471,000
GENERAL FUND	$8,732,000	$8,736,000
OTHER FUNDS	$8,732,000	$8,736,000

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 admission to a STRTP. Beginning October 1, 2021, MHPs began providing 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 the 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 determine if home-based

MHP COSTS FOR FFPSA

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 CFTs and mental health providers, and if STRTP placement is not medically necessary, the QI 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 – Aftercare
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 - Aftercare, 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, an 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 2025-26, from the prior estimate, is due to rounding adjustments resulting in a slight increase.

The change in FY 2026-27, from the prior estimate, is a decrease, due to updated assumptions including a slight decrease in STRTP placements and lower aftercare costs.

MHP COSTS FOR FFPSA

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a net increase due to:

- Updated assumptions including a slight decrease in STRTP placements, higher average assessments per child.
- FY 2025-26 including more prior-year costs, and
- The exclusion of COVID-19 FMAP in FY 2026-27.

Methodology:
FFPSA Qualified Individual
Standardized Assessments

1. Assume 3,339 children and youth will be placed in an STRTP in FY 2024-25, 3,168 in FY 2025-26, and 3,010 in FY 2026-27. Additionally, it is assumed that there will be an average of 1.41 assessments per child in FY 2024-25, 1.23 assessments per child in FY 2025-26, and 1.45 assessments per child in FY 2026-27.

2. Assume Standardized Assessment by a QI began on October 1, 2021.

3. Assume that the total number of assessments will be a factor in 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 4,695 in FY 2024-25, a total of 3,888 in FY 2025-26, and a total of 4,377 in FY 2026-27. Each standardized assessment takes 10 total hours to complete.

4. Assume MHPs spend on average $283.20 per hour for a qualified individual to complete an assessment. The Department estimates MHPs will spend $13,296,240 for a QI to complete standardized assessments FY 2024-25, $11,011,816 in FY 2025-26, and $12,395,664 in FY 2026-27.

Fiscal Year	Total Assessments Per Year	Assessment Hours	Cost Per Hour (QI)	Assessment Cost
FY 2024-25	4,695	10	$283.20	$13,296,240
FY 2025-26	3,888	10	$283.20	$11,011,816
FY 2026-27	4,377	10	$283.20	$12,395,664

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 $5,843,838 for QI participation in CFTs in FY 2024-25, $5,562,501 in FY 2025-26, and $5,285,078 in FY 2026-27.

MHP COSTS FOR FFPSA

Fiscal Year	CFT Meetings	CFT Hours	Cost Per Hour (QI)	CFT Cost
FY 2024-25	10,318	2	$283.20	$5,843,838
FY 2025-26	9,821	2	$283.20	$5,562,501
FY 2026-27	9,331	2	$283.20	$5,285,078

FFPSA – Aftercare

6. CDSS estimates the total cost of providing services pursuant to the HFW model to be $34,203,000 in FY 2024-25, $32,955,000 in FY 2025-26, and $31,824,000 in FY 2026-27.

7. Analysis of the set of services contained in the HFW model shows 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 $18,811,650 in FY 2024-25, $18,125,250 in FY 2025-26, and $17,503,200 in FY 2026-27.

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 2025-26, the Department will pay 0.39% of FY 2023-24, 35.16% of FY 2024-25 claims and 61.69 % of FY 2025-26 claims. On a cash basis for FY 2026-27, the Department will pay 0.29% of FY 2024-25 claims, 37.84% of FY 2025-26 claims, and 61.69% of FY 2026-27 claims. The estimated costs, on a cash basis, are:

MHP COSTS FOR FFPSA

	TF	GF	FF	COVID-19 FF	IGT
FY 2023-24					
Assessments	$61,000	$15,000	$30,000	$1,000	$15,000
CFTs	$25,000	$6,000	$13,000	$0	$6,000
Aftercare	$96,000	$23,000	$48,000	$2,000	$23,000
Total	$182,000	$44,000	$91,000	$3,000	$44,000
FY 2024-25					
Assessments	$4,675,000	$1,169,000	$2,337,000	$0	$1,169,000
CFTs	$2,055,000	$514,000	$1,027,000	$0	$514,000
Aftercare	$6,615,000	$1,654,000	$3,307,000	$0	$1,654,000
Total	$13,345,000	$3,337,000	$6,671,000	$0	$3,337,000
FY 2025-26					
Assessments	$6,792,000	$1,698,000	$3,396,000	$0	$1,698,000
CFTs	$3,432,000	$858,000	$1,716,000	$0	$858,000
Aftercare	$11,181,000	$2,795,000	$5,591,000	$0	$2,795,000
Total	$21,405,000	$5,351,000	$10,703,000	$0	$5,351,000
TOTAL FY 2025-26	**$34,932,000**	**$8,732,000**	**$17,465,000**	**$3,000**	**$8,732,000**

MHP COSTS FOR FFPSA

	TF	GF	FF	IGT
FY 2024-25				
Assessments	$39,000	$10,000	$19,000	$10,000
CFTs	$16,000	$4,000	$8,000	$4,000
Aftercare	$55,000	$14,000	$27,000	$14,000
Total	$110,000	$28,000	$54,000	$28,000
FY 2025-26				
Assessments	$4,166,000	$1,041,000	$2,084,000	$1,041,000
CFTs	$2,104,000	$526,000	$1,052,000	$526,000
Aftercare	$6,859,000	$1,715,000	$3,429,000	$1,715,000
Total	$13,129,000	$3,282,000	$6,565,000	$3,282,000
FY 2026-27				
Assessments	$7,647,000	$1,912,000	$3,823,000	$1,912,000
CFTs	$3,260,000	$815,000	$1,630,000	$815,000
Aftercare	$10,797,000	$2,699,000	$5,399,000	$2,699,000
Total	$21,704,000	$5,426,000	$10,852,000	$5,426,000
TOTAL FY 2026-27	**$34,943,000**	**$8,736,000**	**$17,471,000**	**$8,736,000**

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)

MHP COSTS FOR CONTINUUM OF CARE REFORM

FISCAL REFERENCE NUMBER:1957

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$2,024,000**	**$2,026,000**
FEDERAL FUNDS	$112,700	$114,450
GENERAL FUND	$1,911,300	$1,911,550
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$2,024,000**	**$2,026,000**
FEDERAL FUNDS	$112,700	$114,450
GENERAL FUND	$1,911,300	$1,911,550
OTHER FUNDS	$0	$0

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

- 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 in FY 2025-26 and FY 2026-27, from the prior estimate, is a decrease, due to using more recent actual claims data from FY 2023-24 and FY 2024-25 and excluding any data not related to continuum of care reform costs.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a net increase, due to actual claims showing an increase in assessments and a decrease in CFTs.

Methodology:
1. The FY 2025-26 and FY 2026-27 estimated costs are forecasted based on actual claims data.

2. The CFT costs are estimated by using actual claims data from FY 2023-24 through FY 2024-25.

3. The Placement Assessments costs are estimated by using actual claims data from FY 2023-24 through FY 2024-25.

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 2025-26 and FY 2026-27, 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 2025-26: Federal Share: $3,000,000 x 0.75 x 0.53 = $1,192,000 (Rounded)
   FY 2026-27: Federal Share: $3,000,000 x 0.75 x 0.53 = $1,192,000 (Rounded)
   FY 2025-26: General Fund Match: $3,000,000 x (1-(0.75 x 0.53)) = $1,808,000 (Rounded)
   FY 2026-27: 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 paid claims data. 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 61.69% of FY 2025-26 claims. On a cash basis for FY 2026-27, the Department will pay 0.47% of FY 2024-25 claims, 37.84% of FY 2025-26 claims, and 61.69% of FY 2026-27 claims. There is no lag in payment for training costs.

MHP COSTS FOR CONTINUUM OF CARE REFORM

6. The FY 2025-26 estimate and FY 2026-27 estimate, on a cash basis, are:

FY 2025-26	TF	GF	FF
CFT	$78,000	$39,000	$39,000
Placement Assessments	$138,000	$65,000	$73,000
Training	$1,808,000	$1,808,000	$0
Total	**$2,024,000**	**$1,912,000**	**$112,000**

FY 2026-27	TF	GF	FF
CFT	$48,000	$24,000	$24,000
Placement Assessments	$170,000	$80,000	$90,000
Training	$1,808,000	$1,808,000	$0
Total	**$2,026,000**	**$1,912,000**	**$114,000**

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

OUT OF STATE YOUTH - SMHS

FISCAL REFERENCE NUMBER:2268

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$930,000**	**$857,000**
FEDERAL FUNDS	$465,000	$428,500
GENERAL FUND	$465,000	$428,500
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$930,000**	**$857,000**
FEDERAL FUNDS	$465,000	$428,500
GENERAL FUND	$465,000	$428,500
OTHER FUNDS	$0	$0

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

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 2025-26 and FY 2026-27, from the prior estimate, is an increase due to the updated number of approved claims in FY 2024-25.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to a decrease in assumed out of state youth member claims for FY 2026-27 compared to FY 2025-26.

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 2024-25 and the adjustment for payment lag, the FY 2024-25 accrual is estimated to be $979,000 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 2024-25, FY 2025-26, and FY 2026-27 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 2025-26 and FY 2026-27 are:

Fiscal Year	Accrual	FY 2025-26	FY 2026-27
FY 2024-25	$979,000	$343,000	$0
FY 2025-26	$903,000	$587,000	$316,000
FY 2026-27	$832,000	$0	$541,000
Total		$930,000	$857,000

Fiscal Year	**TF**	**GF**	**FF**
FY 2025-26	**$930,000**	**$465,000**	**$465,000**
FY 2026-27	**$857,000**	**$428,000**	**$429,000**

OUT OF STATE YOUTH - SMHS

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

IMPERIAL AND SISKIYOU COUNTY MHP OVERPAYMENT

FISCAL REFERENCE NUMBER:1660

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$200,000	-$1,200,000
OTHER FUNDS	$200,000	$1,200,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$200,000	-$1,200,000
OTHER FUNDS	$200,000	$1,200,000

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. Additionally, the Department found FF and General Fund (GF) overpayments to Imperial County during the audit and cost settlement processes. This policy change includes state GF reimbursements from Siskiyou County and Imperial County.

This policy change was previously titled “Siskiyou County Mental Health Plan Overpayment”.

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 remitted 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 in August 2012. The County has submitted fourteen payments totaling $2,800,000.

During the audit and cost settlement processes, the Department identified overpayments of FF and GF to Imperial County. Imperial County has acknowledged the overpayment but is unable to repay the full amount. Imperial County will repay the entire overpayment of FF and a portion of the GF in the current year, leaving a balance of $9,000,000 in GF. Beginning in Fiscal Year 2026-27, Imperial County will repay $1,000,000 per year until it has repaid the GF.

Reason for Change:

IMPERIAL AND SISKIYOU COUNTY MHP OVERPAYMENT

There is no change in FY 2025-26 from the prior estimate.

The change in FY 2026-27, from the prior estimate, is an increase in GF savings due to an additional annual payment of $1,000,000 GF paid to the department by Imperial County.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to an additional annual payment of $1,000,000 GF paid to the department by Imperial County.

Methodology:

1. The Department began making repayments for Siskiyou County 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.

2. Siskiyou County reimburses $200,000 GF annually. The county has submitted payments totaling $2,800,000.

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	($2,800,000)	$0	$0
Recoupments	($381,000)	$0	$0
Total	$8,808,000	$11,989,000	$0

3. Beginning in FY 2026-27, Imperial County will reimburse the department $1,000,000 GF annually.

IMPERIAL AND SISKIYOU COUNTY MHP OVERPAYMENT

4. The estimate for FY 2025-26 and FY 2026-27 is as follows:

Fiscal Year	TF	GF	FF	Reimbursement
FY 2025-26	$0	($200,000)	$0	$200,000
FY 2026-27	$0	($1,200,000)	$0	$1,200,000

Funding:
100% GF (4260-101-0001)
Reimbursement GF (4260-601-0995)

INTERIM AND FINAL COST SETTLEMENTS - SMHS

FISCAL REFERENCE NUMBER:1713

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**-$13,451,000**	**-$12,525,000**
FEDERAL FUNDS	-$15,738,000	-$14,305,000
GENERAL FUND	$2,287,000	$1,780,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**-$13,451,000**	**-$12,525,000**
FEDERAL FUNDS	-$15,738,000	-$14,305,000
GENERAL FUND	$2,287,000	$1,780,000
OTHER FUNDS	$0	$0

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

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 2025-26 and FY 2026-27, from the prior estimate, is due to the following:

- A large portion of interim and final cost settlements, which were previously estimated in FY 2020-21 and FY 2021-22 being shifted to FY 2026-27.
- Audit settlements in FY 2019-20 being reimbursed in FY 2026-27 than FY 2025-26.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to FY 2026-27 being the final year to complete cost and audit settlements.

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 GF and cost settlements after 2011 realignment may consist of GF for cost subject to Proposition 30.

5. To estimate expected expenditures for FY 2025-26 and FY 2026-27 for interim and audit settlements not yet received the following procedures are used:

   - The average recoupment of ($127,473) per interim settlement is determined by dividing the actual net settlements of ($9,687,970) from FY 2024-25 by 76, the number of interim settlements processed in FY 2024-25. The average recoupment of ($46,650) per audit settlement is determined by dividing the net recoupment, ($2,052,630), by 44, the number of audit settlements processed in FY 2024-25.

   - The average expenditure per settlement has increased by 3% for fiscal years not yet received and which were not present in calculating the averages in prior step.

   - Based on internal projections, 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.

INTERIM AND FINAL COST SETTLEMENTS - SMHS

- 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 2025-26 and FY 2026-27

7. The net GF and FF to be reimbursed and/or recouped in FY 2025-26 for interim settlements and audit settlements are as shown:

Interim Settlements	TF	GF	FF
FY 2015-16	($105,000)	$22,000	($127,000)
FY 2016-17	($217,000)	$46,000	($263,000)
FY 2017-18	($3,903,000)	$830,000	($4,733,000)
FY 2018-19	($6,088,000)	$1,295,000	($7,383,000)
FY 2019-20	($6,743,000)	$1,435,000	($8,178,000)
FY 2020-21	($1,340,000)	$285,000	$(1,625,000)
Subtotal	($18,396,000)	$3,913,000	($22,309,000)

Audit Settlements	TF	GF	FF
FY 2014-15	$34,000	($11,000)	$45,000
FY 2015-16	$351,000	($115,000)	$466,000
FY 2016-17	$1,121,000	($369,000)	$1,490,000
FY 2017-18	$1,713,000	($563,000)	$2,276,000
FY 2018-19	$1,726,000	($568,000)	$2,294,000
Subtotal	$4,945,000	($1,626,000)	$6,571,000
Total FY 2025-26	**($13,451,000)**	**$2,287,000**	**($15,738,000)**

8. The net GF and FF to be reimbursed and/or recouped in FY 2026-27 for interim settlements and audit settlements are as shown:

Interim Settlements	TF	GF	FF
FY 2020-21	($5,605,000)	$1,192,000	($6,797,000)
FY 2021-22	($7,154,000)	$1,522,000	($8,676,000)
FY 2022-23	($7,369,000)	$1,567,000	($8,936,000)
Subtotal	($20,128,000)	$4,281,000	($24,409,000)

INTERIM AND FINAL COST SETTLEMENTS - SMHS

Audit Settlements	**TF**	**GF**	**FF**
FY 2019-20	$1,817,000	($598,000)	$2,415,000
FY 2020-21	$1,872,000	($616,000)	$2,488,000
FY 2021-22	$1,928,000	($634,000)	$2,562,000
FY 2022-23	$1,986,000	($653,000)	$2,639,000
Subtotal	$7,603,000	($2,501,000)	$10,104,000
Total FY 2026-27	**($12,525,000)**	**$1,780,000**	**($14,305,000)**

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

GLOBAL PAYMENT PROGRAM

FISCAL REFERENCE NUMBER:1951

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$2,981,620,000**	**$3,013,102,000**
FEDERAL FUNDS	$1,490,811,000	$1,506,551,000
GENERAL FUND	$0	$0
OTHER FUNDS	$1,490,809,000	$1,506,551,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$2,981,620,000**	**$3,013,102,000**
FEDERAL FUNDS	$1,490,811,000	$1,506,551,000
GENERAL FUND	$0	$0
OTHER FUNDS	$1,490,809,000	$1,506,551,000

Purpose:
This policy changes estimates payments to public health care systems (PHCS) that participate in the Global Payment Program (GPP).

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:
Not Applicable

Background:
Since 2005, the Designated Public Hospital and Clinic systems (now known as Public Health Care Systems, or PHCS) 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 GPP which provides an innovative approach to financing care to California’s remaining uninsured population served by PHCSs by unifying the DSH and UC Pool funding streams into a PHCS-specific global payment system. The GPP is meant to focus on value, rather than volume, of care provided and to support PHCSs for their key role in providing services to California’s remaining uninsured and to promote the delivery of more cost-effective and higher-value care to the uninsured. The GPP was continued under the CalAIM waiver, effective through December 31, 2026.

Effective July 1, 2015, PHCSs, 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,

GLOBAL PAYMENT PROGRAM

beginning with Program Year (PY) 9 (Calendar Year [CY] 2023), the percentage of the PHCS DSH Allotment federal financial participation (FFP) allocated to DSH PHCSs is 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. Most recently, on February 3, 2026, HR 7148 was enacted, which eliminated the implementation of the Federal Fiscal Year (FFY) 2026 and 2027 reduction, leaving the reduction in effect only for FFY 2028

Reason for Change:
The change in FY 2025-26, from the prior estimate, is a net decrease due to:

- Lower FY 2025 DSH allotments due to a decrease in the released preliminary DSH allotments decreasing the GPP payment amounts compared to the previous estimate, and
- Higher FY 2026 DSH allotments due to an increase in the released preliminary DSH allotments increasing the GPP payment amounts compared to the previous estimate, and
- A final Non-Designated Public Hospitals (NDPH) DSH allocation for FFY 2025 lowering the allotment allocation for PY 10 and PY 11 and decreasing the GPP payment amounts compared to the prior estimate.
- An increase in FY 2026 NDPH allocation based on data estimates, decreasing the GPP payment amounts compared to the prior estimate.

The change in FY 2026-27 from the prior estimate, is a net decrease due to:

- Higher FY 2026 DSH allotments due to an increase in the released preliminary DSH allotments increasing the GPP payment amounts compared to the previous estimate, and
- Higher FY 2026 NDPH allocation based on data estimates decreasing the GPP payment amounts compared to the prior estimate, and
- Updated FY 2027 DSH allotment estimate, which assumes a 2% annual increase from the preliminary FY 2026 allotment, increasing the GPP payment amounts from the prior estimate.
- Updated FY 2027 NDPH allocation based on data estimates decreasing the GPP payment amounts compared to the prior estimate.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to:

- A larger available DSH allotment estimate for FY 2026-27 payments due to the FY 2027 DSH allotment being derived by trending forward the preliminary FFY 2026 allotment by 2% resulting in a larger amount of GPP available funds.

Methodology:
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

The GPP calendar year funding methodology that is derived from the DSH allotment is as follows: 50 percent of the DSH allotment federal funding is derived from the federal fiscal year prior to the start of the GPP calendar year, and 50 percent of the federal DSH allotment funding is derived from the federal fiscal year that begins during the GPP calendar year.

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.

The total federal funding for the GPP for PY 1 through PY 13 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)	$1,205,136	$263,848	$1,468,984
PY 9 (1/1/23-12/31/23)	$1,248,541	$246,620	$1,495,161
PY 10(1/1/24-12/31/24)	$1,224,664	$236,000	$1,460,664
PY 11 (1/1/25-12/31/25)	$1,239,324	$236,000	$1,475,324
PY 12 (1/1/26-12/31/26)	$1,264,315	$236,000	$1,500,315
PY 13 (1/1/27-12/31/27)	$1,289,255	$236,000	$1,525,255

GPP Payments are made on a quarterly basis. Because GPP is a CY program, the first quarter is paid in the SFY which the CY commences, and the remaining three quarters are paid in the subsequent SFY.

The FY 2026-27 DSH allotment assumes a 2% annual increase from the FY 2025-26 DSH allotment estimate.

The FY 2027-28 DSH allotment assumes a 2% annual increase from the FY 2026-27 DSH allotment estimate.

Assume GPP will continue in the new waiver period beginning January 1, 2027, for GPP PY 13.

The estimated GPP payments on a cash basis are:

GLOBAL PAYMENT PROGRAM

(Dollars in Thousands)

FY 2025-26	TF	IGT	FF
PY 10 (1/1/24-12/31/24)	$20,843	$10,421	$10,422
PY 11 (1/1/25-12/31/25)	$2,210,619	$1,105,309	$1,105,310
PY 12 (1/1/26-12/31/26)	$750,158	$375,079	$375,079
Total	**$2,981,620**	**$1,490,809**	**$1,490,811**

(Dollars in Thousands)

FY 2026-27	TF	IGT	FF
PY 12 (1/1/26-12/31/26)	$2,250,474	$1,125,237	$1,125,237
PY 13 (1/1/27-12/31/27)	$762,628	$381,314	$381,314
Total	**$3,013,102**	**$1,506,551**	**$1,506,551**

Funding:
100% Title XIX FFP (4260-101-0890)
100% Global Payment Program Special Fund (4260-601-8108)

CALAIM ECM-COMMUNITY SUPPORTS-TRANSITIONAL RENT

FISCAL REFERENCE NUMBER:2245

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$2,415,193,000**	**$2,706,233,000**
FEDERAL FUNDS	$1,401,788,700	$1,587,030,400
GENERAL FUND	$1,013,404,300	$1,119,202,600
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$2,415,193,000**	**$2,706,233,000**
FEDERAL FUNDS	$1,401,788,700	$1,587,030,400
GENERAL FUND	$1,013,404,300	$1,119,202,600
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the costs to implement a statewide Enhanced Care Management (ECM) benefit, Community Supports, and a Transitional Rent benefit to build infrastructure linked to reform within the Medi-Cal managed care delivery system.

Authority:
California Advancing and Innovating Medi-Cal (CalAIM) Initiative

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. 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.

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

CALAIM ECM-COMMUNITY SUPPORTS-TRANSITIONAL RENT

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

With federal approval secured, Community Supports were expanded effective July 1, 2025, to include Transitional Rent, which provides coverage of up to six months of rent/temporary housing as a Medi-Cal service. Coverage of Transitional Rent was optional for Medi-Cal MCPs beginning on July 1, 2025, and required effective January 1, 2026.

Reason for Change:
The change from the prior estimate, for FY 2025-26, is a net increase due to updated CY 2025 ECM actuals and the inclusion of CY 2026 prospective enrollment and rates for Community Supports and ECM, offset by a decrease in Transitional Rent costs.

The change from the prior estimate, for FY 2026-27, is a net decrease due to:

- Effective January 1, 2027, refined eligibility criteria, service definitions, utilization management levers, and payment adjustments based on implementation experience for ECM benefits.
- Effective January 1, 2027, refined referral pathways, eligibility criteria, service definitions, and utilization management levers for select Community Supports services.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to an increase in Community Supports, ECM, and Transitional Rent costs.

Methodology:

1. Starting July 1, 2025, the Department began reimbursing 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 CY 2026.

CALAIM ECM-COMMUNITY SUPPORTS-TRANSITIONAL RENT

2. Costs are estimated to be:

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
Community Supports	$1,146,988	$467,356	$679,632
Enhanced Care Management	$1,237,315	$533,696	$703,619
Transitional Rent	$30,890	$12,352	$18,538
Total for FY 2025-26	**$2,415,193**	**$1,013,404**	**$1,401,789**

(Dollars in Thousands)

FY 2026-27	TF	GF	FF
Community Supports	$1,233,553	$500,218	$733,335
Enhanced Care Management	$1,334,682	$563,967	$770,716
Transitional Rent	$137,998	$55,018	$82,980
Total for FY 2026-27	**$2,706,233**	**$1,119,203**	**$1,587,030**

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

UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

FISCAL REFERENCE NUMBER:1769

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$336,000**	**$623,000**
FEDERAL FUNDS	$336,000	$623,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$336,000**	**$623,000**
FEDERAL FUNDS	$336,000	$623,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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 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 California Bridge To Reform Demonstration 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

Reason for Change:
The change in FY 2025-26, from the prior estimate, is a decrease due to:

- Actual encounter data from April through September 2025 being lower than previously estimated.

The change in FY 2026-27 from the prior estimate, is an overall decrease due to:

- Lower actual encounter data from April through September 2025, decreasing the projected quarterly encounter average for FY 2026-27.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to:

- Projected encounters being higher than actual FY 2025-26 encounters, and
- An 8.47% estimated increase in the projected calendar year (CY) encounter rates for the FY 2026-27 projections.

Methodology:

1. Assume IHS payments will continue in the new waiver period beginning 1/1/2027.

2. The IHS global encounter rate is updated on the Federal Register for each CY. For CY 2025 the rate is $801, projected CY 2026 rate is $869, and the projected CY 2027 rate is $942.

3. IHS claims are paid for each encounter. Assume IHS payments will be made as follows on a cash basis:

FY 2025-26	TF	FF
Calendar Year 2025	$191,000	$191,000
Calendar Year 2026	$145,000	$145,000
Total	**$336,000**	**$336,000**

FY 2026-27	TF	FF
Calendar Year 2026	$465,000	$465,000
Calendar Year 2027	$158,000	$158,000
Total	**$623,000**	**$623,000**

Funding:
100% Health Care Support Fund (4260-601-7503)

2023 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.

FISCAL REFERENCE NUMBER:2408

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$15,208,141,000**	**$6,849,713,000**
FEDERAL FUNDS	$9,659,035,700	$4,046,532,100
GENERAL FUND	$5,549,105,300	$2,803,180,900
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$15,208,141,000**	**$6,849,713,000**
FEDERAL FUNDS	$9,659,035,700	$4,046,532,100
GENERAL FUND	$5,549,105,300	$2,803,180,900
OTHER FUNDS	$0	$0

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 in support of the Medi-Cal program.

Authority:
AB 119 (Chapter 13, Statutes of 2023)
AB 160 (Chapter 39, Statutes of 2024)

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, for FY 2025-26, is an increase due to the inclusion of actual capitation payments and updated CY 2026 enrollment. The change from the prior estimate, for FY 2026-27, is a decrease due to updated CY 2026 enrollment and updated one-time retroactive recoupment amounts for CY 2025 and CY 2026. The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease due to the 2023 MCO Enrollment Tax ending December 31, 2026, and one-time retroactive recoupments for CY 2025 and CY 2026 occurring in FY 2026-27.

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.

2023 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.

2. Enrollment for managed care plans is based on the number of Medi-Cal enrollees and "all-other" enrollees.

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 recoupments for CY 2025 and CY 2026 will all occur in FY 2026-27.

6. Payments associated with April through May 2025 capitation were withheld from FY 2024-25 and paid in FY 2025-26.

7. Payments associated with the August through November 2025 service months were paid in December 2025.

8. Starting CY 2024, unless noted in the bullets above, assume a one-month payment lag for all plans subject to MCO tax.

9. Beginning October 1, 2026, HR 1 reduces the federal medical assistance percentage for UIS Federal Emergency ACA costs from 90% FF to 50% FF. The impact of this change is incorporated into the dollars of this policy change. For PC specific impacts, please see the HR 1 - UIS Emergency ACA FMAP Adjustment policy change (FRN 2551).

10. 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 2025-26	**$15,208,141**	**$5,549,105**	**$9,659,036**
FY 2026-27	**$6,849,713**	**$2,803,181**	**$4,046,532**

*Totals may differ due to rounding

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

MANAGED CARE HEALTH CARE FINANCING PROGRAM

FISCAL REFERENCE NUMBER:2061

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$2,990,968,000**	**$3,185,536,000**
FEDERAL FUNDS	$1,871,447,850	$1,992,401,200
GENERAL FUND	$1,119,520,150	$1,193,134,800
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$2,990,968,000**	**$3,185,536,000**
FEDERAL FUNDS	$1,871,447,850	$1,992,401,200
GENERAL FUND	$1,119,520,150	$1,193,134,800
OTHER FUNDS	$0	$0

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
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.

Reason for Change:
The change from the prior estimate, for FY 2025-26, is an increase due to updated actuals for CY 2024. The change from the prior estimate, for FY 2026-27, is a decrease due to updated CY 2025 enrollment. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to higher projections based on the CY 2025 enrollment and rates.

Methodology:
1. Payments for the CY 2024 rating period occurred in FY 2025-26. The total payments were $2,990,968,000 TF.

2. Payments for the CY 2025 rating period are anticipated to occur in FY 2026-27. Based on growth projections and the preliminary participation levels for the twelve months of CY 2025, the total payments are estimated to be $3,185,536,000 TF.

MANAGED CARE HEALTH CARE FINANCING PROGRAM

3. Anticipated costs on a cash basis are:

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
CY 2024 Title XIX 50/50	$1,810,302	$905,151	$905,151
CY 2024 Title XXI 65/35	$149,754	$52,414	$97,340
CY 2024 ACA 90/10	$783,807	$78,381	$705,426
UIS State Only	$2,788	$2,788	$0
UIS Emergency Title XIX 50/50	$125,474	$62,737	$62,737
UIS Pregnancy Title XXI 65/35	$20,542	$7,190	$13,352
ACA UIS Emergency 90/10	$94,182	$9,418	$84,764
ACA UIS Pregnancy 65/35	$4,119	$1,442	$2,677
Total FY 2025-26	**$2,990,968**	**$1,119,521**	**$1,871,447**

*Totals may differ due to rounding.

(Dollars in Thousands)

FY 2026-27	TF	GF	FF
CY 2025 Title XIX 50/50	$1,946,926	$973,463	$973,463
CY 2025 Title XXI 65/35	$178,963	$62,637	$116,326
CY 2025 ACA 90/10	$838,437	$83,844	$754,593
UIS Emergency Title XIX 50/50	$115,152	$57,576	$57,576
UIS Pregnancy Title XXI 65/35	$17,031	$5,961	$11,070
ACA UIS Emergency 90/10	$86,021	$8,602	$77,419
ACA UIS Pregnancy 65/35	$3,006	$1,052	$1,954
Total FY 2026-27	**$3,185,536**	**$1,193,135**	**$1,992,401**

*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)
SCHIP GF (4260-101-0001/0890)
100% GF (4260-101-0001)

MANAGED CARE PUBLIC HOSPITAL EPP

FISCAL REFERENCE NUMBER:2060

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$2,362,740,000**	**$6,056,171,000**
FEDERAL FUNDS	$1,513,186,800	$3,819,208,200
GENERAL FUND	$849,553,200	$2,236,962,800
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$2,362,740,000**	**$6,056,171,000**
FEDERAL FUNDS	$1,513,186,800	$3,819,208,200
GENERAL FUND	$849,553,200	$2,236,962,800
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates Managed Care Enhanced Payment Program (EPP) Directed Payments for Designated Public Hospitals (DPHs) including University of California Health Systems.

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

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 2025-26, is a slight increase due to updated actuals for the July 1, 2023, through December 31, 2023, FFS sub-pool payments and the January 1, 2024, through June 30, 2024, capitated sub-pool payments. There is no change from the prior estimate for FY 2026-27. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to larger pooled amounts for CY 2025 and the inclusion of five months’ worth of CY 2027 capitation payments in FY 2026-27 due to accelerated payment timing.

Methodology:
1. The value of the entire public hospital EPP pool is $1,975,820,000 TF for the CY 2023 rating period on an accrual basis.

2. The value of the entire public hospital EPP pool is $2,478,380,000 TF for the CY 2024 rating period on an accrual basis.

3. The value of the entire public hospital EPP pool is $3,865,000,000 TF for the CY 2025 rating period on an accrual basis.

4. The July 1, 2023, through December 31, 2023, FFS sub-pool payments were made in September 2025. The January 1, 2024, through June 30, 2024, FFS sub-pool payments were made in March 2026. The July 1, 2024, through June 30, 2025, FFS sub-pool payments are anticipated to be made in September 2026. The July 1, 2025, through December 31, 2025, FFS sub-pool payments are anticipated to be made in March 2027. The January 1, 2027, through May 31, 2027, FFS sub-pool payments are anticipated to be made monthly beginning in February 2027.

5. The January 1, 2024, through June 30, 2024, capitated sub-pool payments were made in September 2025. The July 1, 2024, through December 31, 2024, capitated sub-pool payments were made in March 2026. The January 1, 2025, through June 30, 2025, capitated sub-pool payments are anticipated to be made in September 2026. The July 1, 2025, through December 31, 2025, capitated sub-pool payments are anticipated to be made in March 2027. The January 1, 2027, through May 31, 2027, capitated sub-pool payments are anticipated to be made monthly beginning in February 2027.

6. The January 1, 2026, through December 31, 2026, capitated sub-pool payments and FFS sub-pool payments are anticipated to be made in FY 2027-28.

7. The Title XIX and Title XXI COVID-19 increased FMAP is assumed for expenditures for the CY 2023 rating period.

MANAGED CARE PUBLIC HOSPITAL EPP

8. Beginning October 1, 2026, HR 1 reduces the federal medical assistance percentage for UIS Federal Emergency ACA costs from 90% FF to 50% FF. The impact of this change is incorporated into the dollars of this policy change. For PC specific impacts, please see the HR 1 - UIS Emergency ACA FMAP Adjustment policy change (FRN 2551).

9. On a cash basis, the estimated payments are:

(Dollars in Thousands)

FY 2025-26	TF	GF	FF	ACA FF
Title XIX	$841,784	$420,892	$420,892	$0
Title XXI 65/35	$85,422	$29,897	$55,525	$0
UIS State Only	$287,249	$287,249	$0	$0
ACA 2020 90/10	$1,148,285	$114,829	$0	$1,033,456
COVID-19 Title XIX Increased FMAP	$0	($3,159)	$3,159	$0
COVID-19 Title XXI Increased FMAP	$0	($155)	$155	$0
Total FY 2025-26	**$2,362,740**	**$849,553**	**$479,731**	**$1,033,456**

*Totals may differ due to rounding.

(Dollars in Thousands)

FY 2026-27	TF	GF	FF	ACA FF
Title XIX	$2,269,112	$1,134,556	$1,134,556	$0
Title XXI 65/35	$237,350	$83,072	$154,278	$0
UIS State Only	$705,338	$705,338	$0	$0
ACA 50/50 ER UIS	$73,898	$36,949	$0	$36,949
ACA 2020 90/10	$2,770,473	$277,047	$0	$2,493,426
Total FY 2026-27	**$6,056,171**	**$2,236,962**	**$1,288,834**	**$2,530,375**

*Totals may differ due to rounding.

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

MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL

FISCAL REFERENCE NUMBER:2062

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$2,204,499,000**	**$5,159,793,000**
FEDERAL FUNDS	$1,541,776,900	$3,591,978,400
GENERAL FUND	$662,722,100	$1,567,814,600
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$2,204,499,000**	**$5,159,793,000**
FEDERAL FUNDS	$1,541,776,900	$3,591,978,400
GENERAL FUND	$662,722,100	$1,567,814,600
OTHER FUNDS	$0	$0

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, 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)

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 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.

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

MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL

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.

Reason for Change:
The change from the prior estimate, for FY 2025-26, is a slight decrease in total funds and an increase in General Funds (GF) due to updated CY 2024 actuals and funding splits. There is no total fund change from the prior estimate for FY 2026-27. However, due to updated funding splits, there was an increase in GF. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to larger pooled amounts for CY 2025 and the inclusion of five months' worth of CY 2027 capitation payments in FY 2026-27 due to accelerated payment timing.

Methodology:

1. Based on actual performance measured, the CY 2024 QIP payments were $2.2 billion TF and were paid in FY 2025-26.

2. The CY 2025 QIP estimated payments are $3.6 billion TF and are anticipated to pay in FY 2026-27.

3. The CY 2027 QIP estimated payments are $3.6 billion TF, and 5 months' worth of this amount is anticipated to pay in FY 2026-27 due to an accelerated payment schedule effective for the January 1, 2027, service period.

4. The CY 2026 QIP estimated payments are not impacted by an accelerated payment schedule and are anticipated to pay in FY 2027-28.

5. On a cash basis, the estimated QIP payments are:

(Dollars in Thousands)

FY 2025-26	TF	GF	FF	ACA FF
CY 2024 Title XIX 50/50	$1,069,652	$534,826	$534,826	$0
CY 2024 ACA 90/10	$1,081,429	$108,143	$0	$973,286
CY 2024 Title XXI 65/35	$51,792	$18,127	$33,665	$0
CY 2024 UIS State Only	$1,626	$1,626	$0	$0
Total FY 2025-26	**$2,204,499**	**$662,722**	**$568,491**	**$973,286**

*Totals may differ due to rounding.

(Dollars in Thousands)

FY 2026-27	TF	GF	FF	ACA FF
CY 2025 / Jan-May CY 2027 Title XIX 50/50	$2,545,373	$1,272,687	$1,272,687	$0
CY 2025 / Jan-May CY 2027 ACA 90/10	$2,489,709	$248,971	$0	$2,240,738
CY 2025 / Jan-May CY 2027 Title XXI 65/35	$120,852	$42,298	$78,554	$0
CY 2025 / Jan-May CY 2027 UIS State Only	$3,859	$3,859	$0	$0
Total FY 2026-27	**$5,159,793**	**$1,567,815**	**$1,351,241**	**$2,240,738**

*Totals may differ due to rounding.

MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL

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)

WORKFORCE & QUALITY INCENTIVE PROGRAM

FISCAL REFERENCE NUMBER:2388

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$310,868,000**	**-$15,679,000**
FEDERAL FUNDS	$145,021,950	-$7,738,950
GENERAL FUND	$165,846,050	-$7,940,050
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$310,868,000**	**-$15,679,000**
FEDERAL FUNDS	$145,021,950	-$7,738,950
GENERAL FUND	$165,846,050	-$7,940,050
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the cost of 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)
AB 116 (Chapter 21, Statutes of 2025)

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.

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.

DHCS calculates payments to managed care plans (MCPs) based on qualifying bed days that are reported by MCPs to the Post-Adjudicated Claims and Encounters System (PACES). DHCS also calculates each Skilled Nursing Facility (SNF) WQIP-eligible Network Provider's performance metrics, WQIP score, and resulting interim and final per diem payment amounts. An aggregate curve factor is applied to all facilities' WQIP scores based on projected qualifying bed days to calculate the interim and final per diem payment amounts.

Per the Budget Act of 2025, the WQIP program will sunset as of January 1, 2026.

WORKFORCE & QUALITY INCENTIVE PROGRAM

Reason for Change:
The change in FY 2025-26 from the prior estimate, is an increase due to updated calculations based on actual capitation data.

The change in FY 2026-27 from the prior estimate, is a net decrease due to recalculations of CY 2025 using actual enrollment figures. In addition, there is no change in the total fund CY 2026 WQIP savings, but the funding split assumptions have been updated.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease due to the conclusion of the WQIP program as well as recalculations using actual enrollment for CY 2025.

Methodology:
1. CY 2024 directed payments of $319.2 million total fund, on a cash basis, were paid in FY 2024-25. Recalculations associated with CY 2024 are anticipated to pay in FY 2025-26.

2. Assume CY 2025 directed payments will be $320.5 million total fund, on a cash basis, paying in FY 2025-26. Recalculations associated with CY 2025 are anticipated to pay in FY 2026-27.

3. Assume CY 2026 directed payments would be $315.6 million total fund and would have paid in FY 2026-27 on a cash basis.

4. With the WQIP program sunsetting as of January 1, 2026, the CY 2026 savings would be $315.6 million total fund, resulting in a net of $0 total fund being paid in FY 2026-27 for CY 2026 directed payments.

(Dollars in Thousands)

FY 2025-26	TF	GF	FFP
CY 2024 WQIP Payment Adjustment	($9,636)	$3,539	($13,175)
CY 2025 WQIP Directed Payments	$320,504	$162,307	$158,197
Total	**$310,868**	**$165,846**	**$145,022**

(Dollars in Thousands)

FY 2026-27	TF	GF	FFP
CY 2025 WQIP Payment Adjustment	($15,679)	($7,940)	($7,739)
CY 2026 WQIP Directed Payments	$315,635	$159,842	$155,793
WQIP Elimination Savings	($315,635)	($159,842)	($155,793)
Total	**($15,679)**	**($7,940)**	**($7,739)**

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)

MEDI-CAL MANAGED CARE QUALITY WITHHOLD RELEASE

FISCAL REFERENCE NUMBER:2504

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$252,096,000**	**$593,866,000**
FEDERAL FUNDS	$148,457,400	$339,891,600
GENERAL FUND	$103,638,600	$253,974,400
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$252,096,000**	**$593,866,000**
FEDERAL FUNDS	$148,457,400	$339,891,600
GENERAL FUND	$103,638,600	$253,974,400
OTHER FUNDS	$0	$0

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:
The change from the prior estimate, for FY 2025-26, is a slight increase due to updated actuals for CY 2024. There is no change from the prior estimate for FY 2026-27. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to the withhold percentage increasing from 0.5% in CY 2024 to 1% in CY 2025.

Methodology:
1. The CY 2024 performance results were calculated and earned withhold dollars were distributed back to the MCPs in FY 2025-26.

2. Assume the CY 2025 performance results will be calculated and earned withhold dollars will be distributed back to the MCPs in FY 2026-27.

MEDI-CAL MANAGED CARE QUALITY WITHHOLD RELEASE

3. Unearned withhold dollars will roll over into a separate incentive program to pay MCPs for meeting specified performance metrics on the quality measures.

4. CY 2024 Quality Withhold Release and Incentive amounts were paid out in FY 2025-26.

5. CY 2025 Quality Withhold Release and Incentive amounts are anticipated to pay out in FY 2026-27.

6. Quality Withhold Release and Incentive amounts are estimated to be:

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
Title XIX 50/50	$132,169	$66,085	$66,085
Title XXI 65/35	$7,160	$2,506	$4,654
ACA 90/10	$71,196	$7,120	$64,077
UIS State Only	$21,944	$21,944	$0
UIS Emergency Title XIX 50/50	$8,926	$4,463	$4,463
UIS Pregnancy Title XXI 65/35	$1,409	$493	$916
ACA UIS Emergency 90/10	$8,896	$890	$8,006
ACA UIS Pregnancy 65/35	$395	$138	$257
Total FY 2025-26	**$252,096**	**$103,639**	**$148,457**

*Totals may differ due to rounding.

(Dollars in Thousands)

FY 2026-27	TF	GF	FF
Title XIX 50/50	$298,012	$149,006	$149,006
Title XXI 65/35	$22,256	$7,790	$14,466
ACA 90/10	$168,120	$16,812	$151,308
UIS State Only	$69,413	$69,413	$0
UIS Emergency Title XIX 50/50	$16,498	$8,249	$8,249
UIS Pregnancy Title XXI 65/35	$2,389	$836	$1,553
ACA UIS Emergency 90/10	$16,574	$1,657	$14,916
ACA UIS Pregnancy 65/35	$605	$212	$393
Total FY 2026-27	**$593,866**	**$253,974**	**$339,891**

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

MANAGED CARE DISTRICT HOSPITAL DIRECTED PAYMENTS

FISCAL REFERENCE NUMBER:2437

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$204,032,000**	**$1,297,033,000**
FEDERAL FUNDS	$133,580,000	$828,388,000
GENERAL FUND	$0	$0
OTHER FUNDS	$70,452,000	$468,645,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$204,032,000**	**$1,297,033,000**
FEDERAL FUNDS	$133,580,000	$828,388,000
GENERAL FUND	$0	$0
OTHER FUNDS	$70,452,000	$468,645,000

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 transitioned to the DHDP and are reflected in this 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

MANAGED CARE DISTRICT HOSPITAL DIRECTED PAYMENTS

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.

Reason for Change:
There is no change in total fund from the prior estimate, for FY 2025-26 and FY 2026-27. Funding assumptions have been updated to incorporate actual capitation data for the July through December 2023 service period. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to higher pooled amounts for the CY 2025 service period onwards, and more service periods are expected to pay out in FY 2026-27.

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. For CY 2025 the pooled amount is $842.4 million, and this is held constant to estimate the CY 2027 pooled amount.

2. Within each managed care rating period, payments are calculated and issued separately for each 6-month service period until the CY 2027 service period which has accelerated payment timing.

3. The following program payments have been or are expected to be made:
    - Payment for the January through June 2023 service period was paid in March 2025.
    - Payment for the July through December 2023 service period occurred in September 2025.
    - Payment for the January through June 2024 service period occurred in March 2026.
    - Payments for the July through December 2024 and January through June 2025 service periods are expected to occur in September 2026.
    - Payments for July to December 2025 are expected in March 2027 and monthly payments will start in February 2027 for the CY 2027 service period.
    - The CY 2026 service period is not impacted by payment acceleration and so payments are not anticipated to occur until FY 2027-28.

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 2025-26	TF	IGT*	FF	ACA FF
Title XIX 50/50	$111,570	$55,785	$55,785	$0
Title XXI 65/35	$12,748	$4,462	$8,286	$0
ACA Optional Expansion	$76,493	$7,843	$0	$68,650
100% State	$3,221	$3,221	$0	$0
COVID-19 Tile XIX Increased FMAP	$0	($817)	$817	$0
COVID-19 Tile XXI Increased FMAP	$0	($42)	$42	$0
Total FY 2025-26	**$204,032**	**$70,452**	**$64,930**	**$68,650**

MANAGED CARE DISTRICT HOSPITAL DIRECTED PAYMENTS

(Dollars in Thousands)

FY 2026-27	TF	IGT*	FF	ACA FF
Title XIX 50/50	$778,676	$389,338	$389,338	$0
Title XXI 65/35	$85,925	$30,074	$55,851	$0
ACA Optional Expansion	$432,432	$49,233	$0	$383,199
100% State	$0	$0	$0	$0
Total FY 2026-27	**$1,297,033**	**$468,645**	**$445,189**	**$383,199**

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% State (4260-101-0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)
COVID-19 Title XXI Increased FFP (4260-101-0890)
*Reimbursement GF (4260-601-0995)

COMMUNITY CLINIC DIRECTED PAYMENT PROGRAM

FISCAL REFERENCE NUMBER:2499

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$205,000,000**
FEDERAL FUNDS	$0	$134,518,600
GENERAL FUND	$0	$70,481,400
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$205,000,000**
FEDERAL FUNDS	$0	$134,518,600
GENERAL FUND	$0	$70,481,400
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the cost of managed care directed payments for the Community Clinic Directed Payment Program.

Authority:
SB 159 (Chapter 40, Statutes of 2024)
Welfare and Institutions (W&I) Code 14105.468

Interdependent Policy Change:
Not Applicable

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.

The Community Clinic Directed Payment (CCDP) preprint was submitted to CMS in December 2024. The CCDP is a performance-adjusted uniform per visit dollar add-on payment for services provided by eligible community clinics when a visit occurs with at least one procedure code contained on the eligible procedure code list. The actual uniform dollar increase will be calculated after the end of the rate period based on actual eligible visits that occurred adjusted for performance measures.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is due to payments are now expected to begin in FY 2026-27.

The change in FY 2026-27, from the prior estimate, is an increase due to:

- Assume payments will occur in September 2026 for January 2025- December 2025 service months, and

COMMUNITY CLINIC DIRECTED PAYMENT PROGRAM

- Payment amounts for calendar year 2025 have been updated.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to payments are now assumed to begin in FY 2026-27.

Methodology:

1. The estimated Community Clinic Directed Payment Program annual cost is $205,000,000 TF.

2. Assume the managed care payments will begin September 2026 and include payments for service months January 2025 to December 2025.

3. The estimated payments on a cash basis for Community Clinic Directed Payments are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2026-27	$205,000	$70,482	$134,518

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)

MANAGED CARE PUBLIC DP-NF PASS-THROUGH PYMT PROG

FISCAL REFERENCE NUMBER:2448

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$76,397,000**	**$0**
FEDERAL FUNDS	$36,623,100	$0
GENERAL FUND	$39,773,900	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$76,397,000**	**$0**
FEDERAL FUNDS	$36,623,100	$0
GENERAL FUND	$39,773,900	$0
OTHER FUNDS	$0	$0

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)
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.

Reason for Change:
The change from the prior estimate, for FY 2025-26, is an increase due to use of actual capitation data. There is no change for FY 2026-27 from the prior estimate. The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease due to the program ending.

MANAGED CARE PUBLIC DP-NF PASS-THROUGH PYMT PROG

Methodology:

1. The final seven-months' worth of CY 2025 service period payments were paid in FY 2025-26 and this three-year program has ended.

2. Retroactive rate adjustments related to the CY 2023 through CY 2025 service periods for the DP-NF Pass-Through Payment Program will be captured in the Retro Managed Care Rate Adjustment policy change.

3. On a cash basis, the estimated payments are:

FY 2025-26	TF	GF	FF	ACA FF
Title XIX 50/50	$58,538,000	$29,269,000	$29,269,000	$0
Title XXI 65/35	$10,000	$4,000	$6,000	$0
ACA 2020 90/10	$8,164,000	$816,000	$0	$7,348,000
100% State GF	$9,685,000	$9,685,000	$0	$0
Total FY 2025-26	**$76,397,000**	**$39,774,000**	**$29,275,000**	**$7,348,000**

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

CCI-QUALITY WITHHOLD REPAYMENTS

FISCAL REFERENCE NUMBER:2031

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$15,837,000**	**$0**
FEDERAL FUNDS	$7,918,500	$0
GENERAL FUND	$7,918,500	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$15,837,000**	**$0**
FEDERAL FUNDS	$7,918,500	$0
GENERAL FUND	$7,918,500	$0
OTHER FUNDS	$0	$0

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

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 both FY 2025-26 and FY 2026-27. The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease due to the final quality withhold repayments being made in FY 2025-26.

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. The CCI program sunset December 31, 2022. Quality withholds for CY 2022 will be the final payments and are anticipated to be repaid in FY 2025-26.

FY 2025-26	**TF**	**GF**	**FF**
Quality Withhold Repayment (CY 2022)	**$15,837,000**	$7,918,500	$7,918,500

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

CHILDREN'S HOSPITAL SUPPLEMENTAL PAYMENT PROGRAM

FISCAL REFERENCE NUMBER:2474

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$440,833,000**
FEDERAL FUNDS	$0	$220,417,000
GENERAL FUND	$0	$220,416,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$440,833,000**
FEDERAL FUNDS	$0	$220,417,000
GENERAL FUND	$0	$220,416,000
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates costs related to the Children's Hospital Supplemental Payment (CHSP) Program.

Authority:
Budget Act of 2024
Title 42, Code of Federal Regulations (CFR) 438.6(c)

Interdependent Policy Changes:
Not Applicable

Background:
Title 42, CFR, section 438.6 (c) provides authority to implement delivery system and provider payment initiatives under managed care plan (MCP) contracts based on allowable supplemental payment mechanisms. The Department implemented new supplemental 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 supplemental 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 SUPPLEMENTAL PAYMENT PROGRAM

Reason for Change:
There is no change from the prior estimate for FY 2025-26 and FY 2026-27. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to supplemental payments starting in FY 2026-27.

Methodology:

1. The Department received CMS approval for the July 2024 through December 2024 program period on July 28, 2025, and for Calendar Year (CY) 2025 program period on September 9, 2025. Payments for the July 2024 through June 2025 service periods are anticipated to be made in September 2026. Payments for the July through December 2025 service period are anticipated to be made in March 2027. Payments for the CY 2027 program period are anticipated to begin paying monthly in February 2027, consistent with other utilization-based hospital supplemental payments. CY 2026 program period is anticipated to pay in FY 2027-28.

2. Costs are expected to be $230,000,000 TF ($115,000,000 General Fund for Children’s Hospital Supplemental Payment and $115,000,000 FF) each rating period.

3. The estimated costs for FY 2026-27 are $440,833,000 TF ($220,416,000 GF).

Funding:
50% Title XIX FFP (4260-101-0890)
General Fund for Children’s Hospital Supplemental Payment (4260-603-0001)

2023 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ

FISCAL REFERENCE NUMBER:2406

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$4,712,883,000	-$3,639,403,000
OTHER FUNDS	$4,712,883,000	$3,639,403,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$4,712,883,000	-$3,639,403,000
OTHER FUNDS	$4,712,883,000	$3,639,403,000

Purpose:
This policy change estimates the adjustment of funds collected from the tax on managed care organizations (MCOs) to the General Fund (GF) to be used by the Department for the non-federal share of MCO tax capitation rate increases.

Authority:
AB 119 (Chapter 13, Statutes of 2023)
AB 160 (Chapter 39, Statutes of 2024)
Welfare & Institutions Code 14199.108.3

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 tax period as it existed on July 1, 2023, are to be allocated, beginning with taxes collected in CY 2025. Proposition 35 allocates specified revenues to support the portion of the non-federal share of Medi-Cal managed care rates for health care services furnished to children, adults, seniors, persons with disabilities, and persons dually eligible for the Medi-Cal and Medicare programs. Proposition 35 creates additional funds into which MCO tax revenues are deposited, appropriated, and spent.

2023 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ

Reason for Change:
The change from the prior estimate, for FY 2025-26, is a decrease in the GF reimbursements due to the inclusion of actual capitation payments and updated CY 2026 enrollment. The change from the prior estimate, for FY 2026-27, is a decrease in the GF reimbursements due to updated CY 2026 enrollment and updated one-time retroactive recoupment amounts for CY 2025 and CY 2026. The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease in GF reimbursements due to the 2023 MCO Enrollment Tax ending December 31, 2026, and one-time retroactive recoupments for CY 2025 and CY 2026 occurring in FY 2026-27.

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 covered the non-federal share of all MCO-tax related capitated rate increases through December 31, 2024. Beginning January 1, 2025, the MCE 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 Proposition 35. Proposition 35 provides for the non-federal share of Medi-Cal managed care rates related to the MCO tax as approved in AB 119 (Chapter 13, Statutes of 2023) and amended by AB 160 (Chapter 39, Statute of 2024), covered from the Health Care Oversight & Accountability (HCO&A) Subfund beginning January 1, 2025.

5. The 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 2025-26	$0	($4,712,883)	$1,464,937	$3,247,946
FY 2026-27	$0	($3,639,403)	$1,080,095	$2,559,308

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

FISCAL REFERENCE NUMBER:2407

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$4,478,050,000	-$2,477,639,000
OTHER FUNDS	$4,478,050,000	$2,477,639,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$4,478,050,000	-$2,477,639,000
OTHER FUNDS	$4,478,050,000	$2,477,639,000

Purpose:
This policy change estimates the use of funds from the enrollment tax on managed care organizations (MCOs) to support the nonfederal share of Medi-Cal managed care rates for health care services furnished to children, adults, seniors, and persons with disabilities, and persons dually eligible for the Medi-Cal and Medicare programs.

Authority:
AB 119 (Chapter 13, Statutes of 2023)
AB 160 (Chapter 39, Statutes of 2024)
Welfare & Institutions Code 14199.108.3

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. In November 2024, voters approved the Protect Access to Health Care Act of 2024 (Proposition 35), which specifies how revenues from the current tax period as it existed on July 1, 2023, are to be allocated, beginning with taxes collected in CY 2025.

This policy change estimates the use of MCO Tax funds to support the nonfederal share of Medi-Cal managed care rates for health care services furnished to children, adults, seniors, and persons with disabilities, and persons dually eligible for the Medi-Cal and Medicare programs.

Reason for Change:
The change from the prior estimate, for FY 2025-26, is an increase in MCO tax revenue used due to the inclusion of actual capitation payments and updated enrollment and cash projections for CY 2026. The change from the prior estimate, for FY 2026-27, is a decrease in MCO tax revenue used due to updated enrollment and cash projections for CY 2026 and the removal of

2023 MCO ENROLLMENT TAX MANAGED CARE PLANS

General Fund (GF) support associated with CY 2027 from the Health Care Oversight & Accountability (HCO&A) Subfund. The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease in MCO tax revenue used due to the 2023 MCO Enrollment Tax ending December 31, 2026.

Methodology:

1. The 2023 MCO Enrollment Tax is based on the cumulative enrollment of health plans during the 12-month CY 2022 period.

2. 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.

3. The non-federal share of capitation payments is first reflected in the Two Plan Model, County Organized Health Systems and Single Plan Model, Geographic Managed Care, and Regional Model. Because of technical limitations in the Department's fiscal systems, the non-federal share of Medi-Cal expenditures must be first charged to the GF in a "clearing account" capacity before being adjusted to the correct special funding sources. This PC adjusts the applicable costs to the Managed Care Enrollment (MCE) Fund and HCO&A Subfund.

4. The values below are reflective of Proposition 35. Proposition 35 provides for $2 billion from the HCO&A Subfund for both CY 2025 and CY 2026 to cover Medi-Cal costs. On a cash basis, the estimated amounts from the HCO&A Subfund are $2 billion in FY 2025-26 and $731 million in FY 2026-27.

5. The adjustments to the GF, MCE Fund, and HCO&A Subfund expenditures are expected to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	MCE Fund	HCO&A Subfund
FY 2025-26	$0	($4,478,050)	$2,478,050	$2,000,000
FY 2026-27	$0	($2,477,639)	$1,747,061	$730,578

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

FISCAL REFERENCE NUMBER:2063

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$3,054,480,000	-$6,010,266,000
OTHER FUNDS	$3,054,480,000	$6,010,266,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$3,054,480,000	-$6,010,266,000
OTHER FUNDS	$3,054,480,000	$6,010,266,000

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 2025-26, is an increase due to updated program calculations for CY 2021 through CY 2025. The change from the prior estimate, for FY 2026-27, is an increase due to updated program calculations for CY 2024 through CY 2026 and six months of CY 2027. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to larger pooled amounts for CY 2025 and the inclusion of six months' worth of CY 2027 GF reimbursements in FY 2026-27 due to accelerated payment timing.

MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND

Methodology:

1. Data from CY 2021 through CY 2026, and six months' worth of CY 2027 (January – June) 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 2021 through 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 2021	$44,919
CY 2022	($5,192)
CY 2023	$217,758
CY 2024	$2,785,062
CY 2025	$12,184
Total	$3,054,731
CY 2024 Support Cost to GF	($251)
GF	($3,054,480)
FY 2025-26 Net Impact	**$0**

(Dollars in Thousands)

Reimbursement	GF
CY 2024	$269,595
CY 2025	$4,304,278
CY 2026	$11,282
CY 2027	$1,425,362
Total	$6,010,517
CY 2025 Support Cost to GF	($251)
GF	($6,010,266)
FY 2026-27 Net Impact	**$0**

Funding:
Reimbursement (4260-601-0995)
100% State GF (4260-101-0001)

RETRO MC RATE ADJUSTMENTS

FISCAL REFERENCE NUMBER:1788

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$154,235,000**	**-$607,888,000**
FEDERAL FUNDS	$156,864,200	-$287,397,500
GENERAL FUND	-$2,629,200	-$474,996,500
OTHER FUNDS	$0	$154,506,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$154,235,000**	**-$607,888,000**
FEDERAL FUNDS	$156,864,200	-$287,397,500
GENERAL FUND	-$2,629,200	-$474,996,500
OTHER FUNDS	$0	$154,506,000

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 2025-26, is an increase due to:

- An increase in payments from applying actual capitation data, and
- A decrease in recoupments as all risk corridor impacts are now captured in the Managed Care Risk Corridors policy change.

The change from the prior estimate, for FY 2026-27, is an increase in recoupments due to updated data for pass-through payments and the inclusion of updated recoupment amounts.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease from net costs in the current year to net recoupments in the budget year, due to more recoupments occurring in FY 2026-27.

RETRO MC RATE ADJUSTMENTS

Methodology:

1. The Department estimates the following retroactive managed care capitation rate adjustments and retroactive pass-through payments in FY 2025-26 and FY 2026-27:

(Dollars in Thousands)

FY 2025-26	TF	GF	State Only	FF
Retro MC Rate Adjustments Payments	$48,110	($167,251)	$122,305	$93,056
Retro Pass-Through Payments	$106,125	$32,878	$0	$73,247
Funding Adjustments	$0	$9,439	$0	($9,439)
Total FY 2025-26	**$154,235**	**($124,934)**	**$122,305**	**$156,864**

(Dollars in Thousands)

FY 2026-27	TF	GF	Fund 3156	FF
MC Rate Adjustment Payments	($701,288)	($350,814)	$0	($350,474)
Retro Pass-Through Payments	$93,400	$30,324	$0	$63,076
SB 78 MCO Tax Reconciliation	$0	($154,506)	$154,506	$0
Total FY 2026-27	**($607,888)**	**($474,996)**	**$154,506**	**($287,398)**

Funding:
50% Title XIX FF / 50% GF (4260-101-0001/0890)
65% Title XXI FF / 35% GF (4260-101-0001/0890)
ACA 90/10 (2020 and later) (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)
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

FISCAL REFERENCE NUMBER:88

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$1,028,121,000**	**$1,697,432,000**
FEDERAL FUNDS	$456,347,550	$753,431,900
GENERAL FUND	$571,773,450	$944,000,100
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	58.1700%	35.2400%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$430,063,000**	**$1,099,257,000**
FEDERAL FUNDS	$190,890,180	$487,922,500
GENERAL FUND	$239,172,830	$611,334,460
OTHER FUNDS	$0	$0

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 both FY 2025-26 and FY 2026-27, is an increase due to higher estimated CBRC rates based on updated actuals. The change from FY 2025-26 to FY 2026-27, 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

2. The rate increase will be used as a trend factor to calculate the estimated cost per visit rate. The rate increase percent was 10.74% for calendar year (CY) 2024 and 8.01% for CY 2025 and CY 2026.

Rate Year	Projected Visits	Current Rate	Rate with Increase
2024	27,572,974	$214.59	$214.59 x (1+10.74%) = $237.63
2025	29,972,322	$237.63	$237.63 x (1+8.01%) = $256.66
2026	32,580,457	$256.66	$256.66 x (1+8.01%) = $277.21

*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
2024	$5,916,884	$6,552,166	$635,281
2025	$7,122,323	$7,692,696	$570,373
2026	$8,362,100	$9,031,628	$669,528

4. The FY 2025-26 CBRC rate increase of $28,850,000 is based on the FY 2024-25 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 2022-23, FY 2023-24, and FY 2024-25.

5. The FY 2026-27 CBRC rate increase of $35,481,000 is based on the FY 2024-25 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 2022-23, FY 2023-24, and FY 2024-25.

6. The estimated expenditures in FY 2025-26 and FY 2026-25 are:

(Dollars in Thousands)

FY 2025-26	TF
CY 2025 Increase	$514,061
CY 2026 Increase	$514,061
FY 2025-26 Total	**$1,028,121**

(Dollars in Thousands)

FY 2026-27	TF
CY 2026 Increase	$848,716
CY 2027 Increase	$848,716
FY 2026-27 Total	**$1,697,432**

RATE INCREASE FOR FQHCS/RHCS/CBRCS

Funding:

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF	$614,640,000	$307,320,000	$307,320,000
90% Title XIX ACA / 10% GF	$125,960,000	$12,596,000	$113,364,000
65% Title XXI / 35% GF	$54,867,000	$19,203,000	$35,664,000
100% GF	$232,654,000	$232,654,000	$0
FY 2025-26 Total	**$1,028,121,000**	**$571,773,000**	**$456,348,000**

FY 2026-27	TF	GF	FF
50% Title XIX / 50% GF	$1,014,774,000	$507,387,000	$507,387,000
90% Title XIX ACA / 10% GF	$207,960,000	$20,796,000	$187,164,000
65% Title XXI / 35% GF	$90,586,000	$31,705,000	$58,881,000
100% GF	$384,112,000	$384,112,000	$0
FY 2026-27 Total	**$1,697,432,000**	**$944,000,000**	**$753,432,000**

*Totals may differ due to rounding.

PP-GEMT IGT PROGRAM

FISCAL REFERENCE NUMBER:2267

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$450,469,000**	**$736,177,000**
FEDERAL FUNDS	$298,170,000	$479,644,000
GENERAL FUND	$9,824,000	$72,583,000
OTHER FUNDS	$142,475,000	$183,950,000
% REFLECTED IN BASE	8.8200%	5.4300%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$410,737,600**	**$696,202,600**
FEDERAL FUNDS	$271,871,410	$453,599,330
GENERAL FUND	$8,957,520	$68,641,740
OTHER FUNDS	$129,908,700	$173,961,520

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
SPA 24-0002
SPA 25-0002

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

PP-GEMT IGT PROGRAM

specific standards, including eligible providers' average costs directly associated with providing Medi-Cal emergency medical transports under the Medi-Cal program.

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 CMS approved SPA 22-0002 on January 13, 2025, authorizing the add-on increase of $1,049.98 to the Medi-Cal FFS fee schedule rates for eligible GEMT services when provided by qualified public providers in CY 2024. SPA 25-0002 was submitted to CMS on March 25, 2025 for an add-on increase of $1,478.68 to the Medi-Cal FFS fee schedule rates for eligible GEMT services when provided by qualified public providers in CY 2025. SPA 25-0030 was submitted to CMS on September 30, 2025, for an add-on increase of $1,518.61 to the Medi-Cal FFS fee schedule rates for eligible GEMT services when provided by qualified public providers in CY 2026.

Reason for Change:
The change in FY 2025-26 from the prior estimate, is a net increase due to:
- Delayed implementation of CY 2025 and 2026 FFS rates.
- Updated projections for managed care payments based on actuals.

The change in FY 2026-27 from the prior estimate, is an increase due to:
- Implementation of CY 2025, 2026, and 2027 FFS rates expected to occur in FY 2026-27.
- Updated projections for managed care payments.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to:
- Implementation of CY 2025, 2026, and 2027 FFS rates expected to occur in FY 2026-27.
- Anticipated CY 2025 managed care retro payments to account for the CY 2025 add-on.

Methodology:
1. The PP-GEMT IGT program was implemented on January 1, 2023.

2. The total payments in FY 2025-26 on a cash basis are expected to be $450,469,000 Total Fund (TF), of which $45,738,000 TF is FFS and $404,731,000 is for managed care.

3. The total payments in FY 2026-27 on a cash basis are expected to be $736,177,000 TF, of which $95,480,000 is FFS and $640,697,000 is for managed care.

   The $640,697,000 in managed care payments includes $114,470,000 in retro payments for CY 2025.

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 2025-26 or FY 2026-27.

5. FY 2025-26 and FY 2026-27 are summarized as follows:

PP-GEMT IGT PROGRAM

FY 2025-26	TF	GF	IGT*	FF
FFS Payments	$45,738,000	$897,000	$13,010,000	$31,831,000
MC Payments	$404,731,000	$8,927,000	$129,465,000	$266,339,000
Total	**$450,469,000**	**$9,824,000**	**$142,475,000**	**$298,170,000**

FY 2026-27	TF	GF	IGT*	FF
FFS Payments	$95,480,000	$8,398,000	$20,632,000	$66,450,000
MC Payments	$640,697,000	$64,185,000	$163,318,000	$413,194,000
Total	**$736,177,000**	**$72,583,000**	**$183,950,000**	**$479,644,000**

Funding:

FY 2025-26	TF	GF	IGT*	FF
100% General Fund (4260-101-0001)	$9,824,000	$9,824,000	$0	$0
Reimbursement GF (4260-601-0995)	$142,475,000	$0	$142,475,000	$0
Title XIX FF (4260-101-0890)	$131,035,000	$0	$0	$131,035,000
ACA Title XIX FF (4260-101-0001 / 0890)	$160,943,000	$0	$0	$160,943,000
Title XXI FF (4260-101-0890)	$6,192,000	$0	$0	$6,192,000
Total	**$450,469,000**	**$9,824,000**	**$142,475,000**	**$298,170,000**

FY 2026-27	TF	GF	IGT*	FF
100% General Fund (4260-101-0001)	$72,583,000	$72,583,000	$0	$0
Reimbursement GF (4260-601-0995)	$178,321,000	$0	$178,321,000	$0
ACA 50/50 ER UIS-Reimb. (4260-601-0890 / 0995)	$11,258,000	$0	$5,629,000	$5,629,000
Title XIX FF (4260-101-0890)	$218,248,000	$0	$0	$218,248,000
ACA Title XIX FF (4260-101-0001 / 0890)	$245,969,000	$0	$0	$245,969,000
Title XXI FF (4260-101-0890)	$9,798,000	$0	$0	$9,798,000
Total	**$736,177,000**	**$72,583,000**	**$183,950,000**	**$479,644,000**

*Reimbursement GF (4260-601-0995)

GROUND EMERGENCY MEDICAL TRANSPORTATION QAF

FISCAL REFERENCE NUMBER:2081

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$157,594,000**	**$140,986,000**
FEDERAL FUNDS	$110,237,000	$95,952,500
GENERAL FUND	-$6,061,000	-$5,462,000
OTHER FUNDS	$53,418,000	$50,495,500
% REFLECTED IN BASE	10.7800%	13.3100%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$140,605,400**	**$122,220,800**
FEDERAL FUNDS	$98,353,450	$83,181,220
GENERAL FUND	-$5,407,620	-$4,735,010
OTHER FUNDS	$47,659,540	$43,774,550

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
SPA 24-0025

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

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. SPA 24-0025 for the FY 2024-25 add-on was approved on January 15, 2025. SPA 25-0003-A, which continues the FY 2025-26 add-on, is currently pending federal approval. The Department will submit SPA 26-0021 by September 30, 2026 in Quarter 2 to continue the FY 2026-27 add-on.

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.

Recent changes to federal law under House Resolution 1 (HR 1, Public Law No. 119-21) established new limits on the maximum allowable rate for provider taxes. Under HR 1, the federal maximum tax threshold will be reduced in phases from the current 6 percent to 3.5 percent by 2032. To ensure compliance with these federal requirements, the Department will adjust the rate add-on accordingly in future years to ensure it does not exceed the maximum threshold permitted under HR 1.

Reason for Change:
The change in FY 2025-26 from the prior estimate, is a net decrease due to:

- Projected decreases in utilization.
- An increase in projected FFS payments.
- A decrease in projected managed care payments.

The change in FY 2026-27 from the prior estimate, is a decrease due to:

- Projected decreases in utilization.
- A decrease in projected FFS payments.
- A decrease in projected managed care payments.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a net decrease due to:

- Projected decreases in utilization.
- An increase in projected FFS payments.
- A decrease in projected managed care payments.

Methodology:

1. The effective date for the GEMT QAF is July 1, 2018 with the approved add-on amount of $220.80.

GROUND EMERGENCY MEDICAL TRANSPORTATION QAF

2. Assume the GEMT QAF revenue will be $53,417,000 in FY 2025-26 and $50,495,000 in FY 2026-27.

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 annual administration cost and 10% set aside for health care coverage is estimated to be $12,247,000 for FY 2025-26, including amounts from prior years, and $18,818,000 for FY 2026-27.

5. From the remaining GEMT QAF revenue available, total annual GEMT add-on payments for FY 2025-26 are estimated to be $157,594,000 TF, of which $16,991,000 TF is for FFS and $140,603,000 TF is for Managed Care GEMT transport services.

6. From the remaining GEMT QAF revenue available, total annual GEMT add-on payments for FY 2026-27 are estimated to be $140,986,000 TF, of which $18,771,000 TF is for FFS and $122,215,000 TF is for Managed Care GEMT transport services.

7. Managed Care Payments:
   a. FY 2025-26 is expected to include 7 months of the CY 2025 rates and 5 months of the CY 2026 rates.
   b. FY 2026-27 is expected to include 7 months of the CY 2026 rates and 5 months of the CY 2027 rates.

8. The cash basis estimate is summarized as follows:

FY 2025-26	TF	GF	MEMTF	FF
FFS Payments	$16,991,000	$0	$5,518,000	$11,473,000
Managed Care Payments	$140,603,000	$0	$41,839,000	$98,764,000
General Fund Offset	$0	($6,061,000)	$6,061,000	$0
Total	**$157,594,000**	**($6,061,000)**	**$53,418,000**	**$110,237,000**

FY 2026-27	TF	GF	MEMTF	FF
FFS Payments	$18,771,000	$0	$6,097,000	$12,674,000
Managed Care Payments	$122,215,000	$0	$38,936,000	$83,279,000
General Fund Offset	$0	($5,462,000)	$5,462,000	$0
Total	**$140,986,000**	**($5,462,000)**	**$50,495,000**	**$95,953,000**

GROUND EMERGENCY MEDICAL TRANSPORTATION QAF

Funding:

FY 2025-26	TF	GF	MEMTF	FF
100% General Fund (4260-101-0001)	($6,061,000)	($6,061,000)	$0	$0
MEMTF (4260-601-3323)	$53,418,000	$0	$53,418,000	$0
ACA Title XIX FF (4260-101-0890)	$69,019,000	$0	$0	$69,019,000
Title XIX FF (4260-101-0890)	$37,846,000	$0	$0	$37,846,000
Title XXI FF (4260-101-0890)	$3,372,000	$0	$0	$3,372,000
Total	**$157,594,000**	**($6,061,000)**	**$53,418,000**	**$110,237,000**

FY 2026-27	TF	GF	MEMTF	FF
100% General Fund (4260-101-0001)	($5,462,000)	($5,462,000)	$0	$0
MEMTF (4260-601-3323)	$48,815,000	$0	$48,815,000	$0
ACA 50/50 ER UIS-MEMTF (4260-601-0890 / 3323)	$3,361,000	$0	$1,680,000	$1,681,000
ACA Title XIX FF (4260-101-0890)	$55,751,000	$0	$0	$55,751,000
Title XIX FF (4260-101-0890)	$35,569,000	$0	$0	$35,569,000
Title XXI FF (4260-101-0890)	$2,952,000	$0	$0	$2,952,000
Total	**$140,986,000**	**($5,462,000)**	**$50,495,000**	**$95,953,000**

DPH INTERIM & FINAL RECONS

FISCAL REFERENCE NUMBER:1152

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$130,113,000**	**$530,548,000**
FEDERAL FUNDS	$130,113,000	$530,548,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$130,113,000**	**$530,548,000**
FEDERAL FUNDS	$130,113,000	$530,548,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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

Reason for Change:
The change in FY 2025-26, from the prior estimate, is due to shifting FY 2020-21 final reconciliations from FY 2025-26 to FY 2026-27.

The change in FY 2026-27, from the prior estimate, is due to shifting FY 2020-21 final reconciliations from FY 2025-26 to FY 2026-27.

The change from FY 2025-26 to FY 2026-27, 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 2025-26	TF	FF	ACA FF
2016-17 Final Reconciliation (LA County)	($1,849)	($276)	($1,573)
2017-18 Final Reconciliation (LA County)	$1,704	$8,714	($7,010)
2018-19 Final Reconciliation	($8,835)	$6,520	($15,355)
2019-20 Final Reconciliation	$139,093	$103,328	$35,765
Total	**$130,113**	**$118,286**	**$11,827**

(Dollars in Thousands)

FY 2026-27	TF	FF	ACA FF
2020-21 Final Reconciliation	$17,839	$56,415	($38,576)
2021-22 Final Reconciliation	$147,034	$130,788	$16,246
2022-23 Final Reconciliation	$365,675	$99,946	$265,729
Total	**$530,548**	**$287,149**	**$243,399**

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

NURSING FACILITY RATE ADJUSTMENTS

FISCAL REFERENCE NUMBER:2181

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$725,253,000**	**$698,236,000**
FEDERAL FUNDS	$385,544,500	$371,182,400
GENERAL FUND	$339,708,500	$327,053,600
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	88.1900%	95.1600%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$85,652,400**	**$33,794,600**
FEDERAL FUNDS	$45,532,800	$17,965,230
GENERAL FUND	$40,119,570	$15,829,390
OTHER FUNDS	$0	$0

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)
Budget Act of 2026

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) 2024 through 2026, annual rate increase for labor costs will be limited to 5% and annual rate increases for non-labor costs will be limited to 1%.

The Department is proposing a one-year extension of the FS/NF-B and FSSA/NF-B rate methodology to continue the 5% rate increase for labor costs and 1% increase for non-labor costs for CY 2027.

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 (LTC QAF) Expenditures policy change. The Department proposes to extend the LTC QAF through CY 2027, effective January 1, 2027, through December 31, 2027.

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

NURSING FACILITY RATE ADJUSTMENTS

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. The Department proposes to extend the WSP through CY 2027.

Reason for Change:
The change in FY 2025-26 from the prior estimate, is a net decrease due to:
- Updated total Medi-Cal days and rates.

The change in FY 2026-27 from the prior estimate, is a net decrease due to:
- Updated total Medi-Cal days and rates.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a net decrease due to:
- Updated total Medi-Cal days and rates,
- Including the estimated costs for the CY 2027 rate adjustments.

Methodology:
1. The 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. The FFS CY 2024 rates were implemented in June 2025. The retroactive correction for the period from January 2024 to May 2025 was implemented in September 2025.

3. The FFS CY 2025 rates were implemented in July 2025. The retroactive correction for the period from January 2025 to June 2025 was implemented in October 2025.

4. The FFS CY 2026 rates were implemented in February 2026. The retroactive correction for January 2026 is expected to be implemented in April 2026.

5. Assume the managed care rate impacts are budgeted in the managed care base capitation rates.

6. **Calendar Year 2027 Extension:** The one-year Calendar Year 2027 extension is estimated to cost $256.3 million TF ($120.1 million GF).

(Dollars in Thousands)

Calendar Year 2027 Annual	TF	GF	FF
FFS	$28,030	$13,129	$14,901
Managed Care (In MC Base, display only)	$228,304	$106,938	$121,366
Total	**$256,334**	**$120,067**	**$136,267**

NURSING FACILITY RATE ADJUSTMENTS

On a cash basis, six months of FFS costs with payments lags are estimated at $8.1 million TF ($3.8 million GF) and five months of managed care costs are estimated at $95.1 million TF ($44.6 million GF) in FY 2026-27.

- o Assume the FFS CY 2027 rates will be implemented January 2027.
- o The managed care costs are display only in this policy change as these costs are assumed to be included in the managed care base capitation rates.

(Dollars in Thousands)

Calendar Year 2027 FY 2026-27	TF	GF	FF
FFS (Lagged)	$8,129	$3,808	$4,321
Managed Care (In MC Base, display only)	$95,126	$44,557	$50,569
Total	**$103,255**	**$48,365**	**$54,890**

7. 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.

8. The total cash basis FFS and managed care rate adjustment impact for FY 2025-26 and FY 2026-27 are estimated to be:

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
FFS (Lagged)	$235,158	$110,148	$125,010
Managed Care (In MC Base)	$490,095	$229,560	$260,535
Total	**$725,253**	**$339,708**	**$385,545**

(Dollars in Thousands)

FY 2026-27	TF	GF	FF
FFS (Lagged)	$179,502	$84,079	$95,423
Managed Care (In MC Base)	$518,734	$242,975	$275,759
Total	**$698,236**	**$327,054**	**$371,182**

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX / 10% GF (4260-101-0001/0890)

FQHC/RHC/CBRC RECONCILIATION PROCESS

FISCAL REFERENCE NUMBER:1329

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$108,847,000**	**$108,847,000**
FEDERAL FUNDS	$48,313,350	$48,313,350
GENERAL FUND	$60,533,650	$60,533,650
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$108,847,000**	**$108,847,000**
FEDERAL FUNDS	$48,313,350	$48,313,350
GENERAL FUND	$60,533,650	$60,533,650
OTHER FUNDS	$0	$0

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 both FY 2025-26 and FY 2026-27, is a net increase due to updated Erroneous Payment Corrections (EPCs) and actual settlement recoveries. There is no change from FY 2025-26 to FY 2026-27 in the current estimate.

FQHC/RHC/CBRC RECONCILIATION PROCESS

Methodology:

1. FY 2025-26 and FY 2026-27 FQHC and RHC reconciliations are based on a three-year average of projected and actual settlements from July 2022 through June 2025. The FQHC reconciliation amount includes settlements for IHS.

2. The estimated FQHC retroactive rate adjustment of $57,322,000 for FY 2025-26 and FY 2026-27 is based on paid EPCs from July 2024 through June 2025. Currently, the fiscal intermediary processes EPCs quarterly.

3. The LA CBRC reconciliation for FY 2025-26 and FY 2026-27 is based on a three-year average of actual settlements from July 2022 through June 2025.

Reconciliations and Adjustments	FY 2025-26	FY 2026-27
FQHCs Reconciliation	$15,571,000	$15,571,000
RHCs Reconciliation	($6,280,000)	($6,280,000)
FQHC Retroactive Rate Adjustment	$57,322,000	$57,322,000
LA CBRCs Reconciliation	$42,234,000	$42,234,000
Total	**$108,847,000**	**$108,847,000**

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF	$65,072,000	$32,536,000	$32,536,000
90% Title XIX ACA / 10% GF	$13,335,000	$1,334,000	$12,001,000
65% Title XXI / 35% GF	$5,809,000	$2,033,000	$3,776,000
100% GF	$24,631,000	$24,631,000	$0
Total	**$108,847,000**	**$60,534,000**	**$48,313,000**

*Totals may differ due to rounding.

FY 2026-27	TF	GF	FF
50% Title XIX / 50% GF	$65,072,000	$32,536,000	$32,536,000
90% Title XIX ACA / 10% GF	$13,335,000	$1,334,000	$12,001,000
65% Title XXI / 35% GF	$5,809,000	$2,033,000	$3,776,000
100% GF	$24,631,000	$24,631,000	$0
Total	**$108,847,000**	**$60,534,000**	**$48,313,000**

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

GDSP NBS & PNS FEE ADJUSTMENTS

FISCAL REFERENCE NUMBER:2184

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$44,550,000**	**$18,457,000**
FEDERAL FUNDS	$27,185,050	$11,262,700
GENERAL FUND	$17,364,950	$7,194,300
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$44,550,000**	**$18,457,000**
FEDERAL FUNDS	$27,185,050	$11,262,700
GENERAL FUND	$17,364,950	$7,194,300
OTHER FUNDS	$0	$0

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, fees for the GDSP, including both the NBS and PNS Programs, shall be periodically adjusted to fully support GDSP. Section 124977(d)(1) authorizes GDSP to adopt emergency regulations for newborn and prenatal screening.

CDPH administers California's GDSP, which includes the PNS Program and the NBS Program. These programs screen for genetic disorders that are, for the most part, preventable or remediable by early intervention and provide clinical oversight for the follow-up services, which include genetic counseling and confirmatory testing, including ultrasound and diagnostic procedures.

The Department submitted SPA 23-0040 in December 2023 to implement a rate adjustment for Current Procedural Terminology (CPT) code 0327U, effective November 1, 2023. Additionally, the SPA proposes to establish a reimbursement methodology to align its reimbursement rate for

GDSP NBS & PNS FEE ADJUSTMENTS

NBS and PNS with the participation fee that CDPH charges. SPA 23-0040 is currently pending Centers of Medicare and Medicaid Services' (CMS) approval.

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 submitted 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. In August 2024, CDPH incorporated the screening for MPS II and GAMT deficiency into the Newborn Screening panel. On July 1, 2024, CDPH implemented a fee increase in the NBS program to cover the cost to include the two new conditions. The Department included the $15 increase in SPA 24-0034 that was submitted in September 2024.

Prenatal Screening Program
CDPH replaced GDSP's conventional biochemical screening for chromosome abnormalities with a Cell-free DNA (cfDNA) screening that screens 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 effective September 19, 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 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 submitted SPA 24-0034 in September 2024, which proposes to increase rate reimbursement from $232 to $344 for codes 0327U and 81420 effective July 1, 2024.

Effective July 1, 2024, CDPH implemented 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:
There is minimal change in FY 2025-26 and FY 2026-27, from the prior estimate, due to:
- Projected caseloads reported by CDPH from December 2025, and
- Updated implementation dates resulting in revised prospective and retroactive estimates.

GDSP NBS & PNS FEE ADJUSTMENTS

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease due to:

- No retroactive Erroneous Payment Corrections (EPCs) estimated in FY 2026-27.
- A full year's implementation of the NBS and PNS prospective rate changes are estimated in FY 2026-27 compared to a partial year 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 Fee-for-Service (FFS) GDSP NBS rate increases based on the CDPH fee increases.

2. The Department expects to implement the $15 fee increase in March 2026. The EPC for the July 1, 2024 through February 28, 2026 period is expected to implement in June 2026.

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.

Prenatal Screening Program

1. 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 EPC for the October 1, 2022 through May 21, 2023 period was implemented on August 2, 2023, occurring over 12 months.

2. The Department proposes to increase the PNS rates for PLA code 0327U from $0.00 to $232.00, effective November 1, 2023. The implementation date is estimated to be March 2026. The EPC for the November 1, 2023 to February 28, 2026 period is expected to implement in June 2026.

3. CDPH has proposed a fee increase for CPT code 81420 and PLA code 0327U, increasing the rate by $112 from $232.00 to $344.00, effective July 1, 2024. The Department will implement a corresponding Medi-Cal FFS GDSP PNS rate adjustment based on the CDPH fee increase and new fee structure. This adjustment is expected to be implemented in March 2026. The EPC for the July 1, 2024 through February 28, 2026 period is expected to implement in June 2026.

4. The estimated Medi-Cal FFS costs for the NBS and PNS rate changes in FY 2025-26 and FY 2026-27 are:

GDSP NBS & PNS FEE ADJUSTMENTS

FY 2025-26	TF	GF	FF
NBS FFS Prospective Rate Change	$482,000	$188,000	$294,000
PNS FFS Prospective Rate Change	$5,670,000	$2,210,000	$3,460,000
NBS FFS Retroactive Rate Change	$2,413,000	$941,000	$1,472,000
PNS FFS Retroactive Rate Change	$35,985,000	$14,026,000	$21,959,000
Total	**$44,550,000**	**$17,365,000**	**$27,185,000**

FY 2026-27	TF	GF	FF
NBS FFS Prospective Rate Change	$1,448,000	$564,000	$884,000
PNS FFS Prospective Rate Change	$17,009,000	$6,630,000	$10,379,000
Total	**$18,457,000**	**$7,194,000**	**$11,263,000**

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)

LTC RATE ADJUSTMENT

FISCAL REFERENCE NUMBER:1046

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$205,820,000**	**$294,555,000**
FEDERAL FUNDS	$107,768,950	$154,231,000
GENERAL FUND	$98,051,050	$140,324,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	95.5100%	96.4100%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$9,241,300**	**$10,574,500**
FEDERAL FUNDS	$4,838,830	$5,536,890
GENERAL FUND	$4,402,490	$5,037,630
OTHER FUNDS	$0	$0

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 (RY) 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

LTC RATE ADJUSTMENT

in reimbursement at the 2008-09 rate levels for DP/NF-Bs, Rural Swing Beds, DP Adult Subacute, and DP/PSA.

Effective June 1, 2011, AB 97 required the Department to freeze rates and reduce payments by up to 10% for the facilities enjoined from the original rate freeze. In addition, AB 97 extended this requirement to the other LTC facility types. The Department received approval from the Centers for Medicare & Medicaid Services (CMS) to implement a rate freeze on NF-As and DP/NF-Bs and to reduce the payments by 10%.

ABX1 19 extended the Quality Assurance (QA) Fee to freestanding Pediatric Subacute Care Facilities beginning August 1, 2011. Distinct Part Pediatric Subacute Care Facilities were not included in this QA Fee extension. Also effective June 1, 2011, it minimized the 10 percent payment reduction by lessening the reduction to 5.75 percent and clarified that reimbursement rates will include the projected cost of complying with new state or federal laws.

SB 239 enacted the Medi-Cal Hospital Reimbursement Improvement Act of 2013 which imposed a hospital QA fee on certain general acute care hospitals from January 1, 2014, through December 30, 2016. It required Medi-Cal reimbursement for nursing facilities that are a distinct part of a general acute care hospital to be used as part of the calculation without the Medi-Cal rate reduction and rate roll-back required under existing law for dates of services on and after October 1, 2013.

AB 81 exempted freestanding pediatric subacute skilled nursing facilities from paying the state skilled nursing facility (SNF) Quality Assurance Fee (QAF).

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 extended 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 required 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 removed 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 received an unfrozen reimbursement rate inclusive of any Proposition 56 supplemental payments, no 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.

LTC RATE ADJUSTMENT

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 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, 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, 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 2025-26 from the prior estimate, is a net decrease due to:

- Updated Medi-Cal days.
- Updated per diem rates.
- Delayed implementation of some fee-for-service (FFS) rates.

The change in FY 2026-27 from the prior estimate, is a net decrease due to:

- Updated Medi-Cal days.
- Updated per diem rates.
- Delayed implementation of some FFS rates.

LTC RATE ADJUSTMENT

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a net increase due to:

- Updated Medi-Cal days.
- Updated per diem rates.
- New rates for calendar year (CY) 2027.

Methodology:

1. Beginning in CY 2024, the effective date for rate adjustments is January 1st of each calendar year. The assumed actual and forecasted dates that rates are implemented into the payment system are as follows:

Facility	CY 2024	CY 2025	CY 2026	CY 2027
DP/NF-B	6/25/2024	12/22/2025	2/1/2026	2/1/2027
Rural Swing Beds (non-exempt)	6/25/2024	12/22/2025	2/1/2026	2/1/2027
Rural Swing Beds (exempt)	6/25/2024	12/22/2025	2/1/2026	2/1/2027
DP Adult Subacute	8/26/2024	12/22/2025	2/1/2026	2/1/2027
NF-A	10/28/2024	7/28/2025	2/1/2026	2/1/2027
ICF/DDs	7/22/2024	4/21/2025	2/1/2026	2/1/2027
DP Pediatric Subacute	6/14/2024	5/27/2025	2/1/2026	2/1/2027
FS Pediatric Subacute	8/16/2024	5/27/2025	2/1/2026	2/1/2027

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:

LTC RATE ADJUSTMENT

Unlagged Fee-for-Service	FY 2025-26	FY 2026-27
Rate Adjustment (CY 2024)		
DP/NF-B	$3,853,000	$3,853,000
Rural Swing Beds (non-exempt)	$0	$0
Rural Swing Beds (exempt)	$2,000	$2,000
DP Adult Subacute	$2,574,000	$2,574,000
NF-A	$1,000	$1,000
ICF/DDs	$113,000	$113,000
DP Pediatric Subacute	$453,000	$453,000
FS Pediatric Subacute	$0	$0
Rate Adjustment (CY 2025)		
DP/NF-B	$2,424,000	$4,848,000
Rural Swing Beds (non-exempt)	$0	$0
Rural Swing Beds (exempt)	$2,000	$4,000
DP Adult Subacute	$141,000	$281,000
NF-A	$0	$0
ICF/DDs	$726,000	$726,000
DP Pediatric Subacute	$554,000	$554,000
FS Pediatric Subacute	$190,000	$190,000
Rate Adjustment (CY 2026)		
DP/NF-B	$463,000	$1,111,000
Rural Swing Beds (non-exempt)	$0	$0
Rural Swing Beds (exempt)	$0	$1,000
DP Adult Subacute	$400,000	$959,000
NF-A	$0	$0
ICF/DDs	$229,000	$550,000
DP Pediatric Subacute	$245,000	$588,000
FS Pediatric Subacute	$182,000	$437,000
Rate Adjustment (CY 2027)		
DP/NF-B	$0	$1,374,000
Rural Swing Beds (non-exempt)	$0	$0
Rural Swing Beds (exempt)	$0	$1,000
DP Adult Subacute	$0	$474,000
NF-A	$0	$0
ICF/DDs	$0	$332,000
DP Pediatric Subacute	$0	$140,000
FS Pediatric Subacute	$0	$146,000
Retro FFS Rate Adjustments		
DP/NF-B	$4,941,000	$275,000
Rural Swing Beds (non-exempt)	$0	$0
Rural Swing Beds (exempt)	$4,000	$0
DP Adult Subacute	$361,000	$95,000
NF-A	$0	$0
ICF/DDs	$288,000	$66,000
DP Pediatric Subacute	$280,000	$28,000
FS Pediatric Subacute	$115,000	$29,000
Total FFS	**$18,541,000**	**$20,205,000**

LTC RATE ADJUSTMENT

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 2025-26	FY 2026-27
Rate Adjustment (CY 2024)	$48,537,000	$48,537,000
Rate Adjustment (CY 2025)	$109,981,000	$109,981,000
Rate Adjustment (CY 2026)	$35,893,000	$71,785,000
Rate Adjustment (CY 2027)	$0	$54,587,000
Total Managed Care	**$194,411,000**	**$284,890,000**

4. The estimated impact of SB 525 on LTC facility payments is roughly estimated to be $7.9 million total funds ($3.7 million General Fund) in FY 2025-26 and $8.8 million total funds ($4.2 million General Fund) in FY 2026-27. These amounts are included in the FFS and managed care totals shown above.

5. Payment lag factors of 0.967 for FY 2025-26 and 0.965 for FY 2026-27 are applied to the FFS and managed care costs to account for payment timing. Lagged amounts are displayed below.

Lagged Amounts	FY 2025-26	FY 2026-27
Fee-for-Service	$17,391,000	$18,762,000
Managed Care	$188,429,000	$275,793,000
Total Lagged Costs	**$205,820,000**	**$294,555,000**

Funding:

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	$190,332,000	$95,166,000	$95,166,000
90% Title XIX / 10% GF (4260-101-0001 / 0890)	$10,143,000	$1,014,000	$9,129,000
65% Title XXI / 35% GF (4260-101-0001 / 0890)	$5,345,000	$1,871,000	$3,474,000
Total	**$205,820,000**	**$98,051,000**	**$107,769,000**

FY 2026-27	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	$272,390,000	$136,195,000	$136,195,000
90% Title XIX / 10% GF (4260-101-0001 / 0890)	$14,515,000	$1,451,000	$13,064,000
65% Title XXI / 35% GF (4260-101-0001 / 0890)	$7,650,000	$2,678,000	$4,972,000
Total	**$294,555,000**	**$140,324,000**	**$154,231,000**

HOSPICE RATE INCREASES

FISCAL REFERENCE NUMBER:96

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$14,341,000**	**$17,345,000**
FEDERAL FUNDS	$9,367,550	$11,329,700
GENERAL FUND	$4,973,450	$6,015,300
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	29.1800%	21.6700%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$10,156,300**	**$13,586,300**
FEDERAL FUNDS	$6,634,100	$8,874,550
GENERAL FUND	$3,522,200	$4,711,780
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the annual rate increase for hospice services and hospice room and board rates in the Fee-for-Service (FFS) delivery system.

Authority:
Sections 1902(a)(13) and 1814(i)(1)(C)(ii) of the Social Security Act
Title 42, Code of Federal Regulations (CFR) Part 418

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 1 of each year.

   Effective January 1, 2016, the CMS hospice final 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 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.

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

HOSPICE RATE INCREASES

Disabled – Nursing (ICF/DD-N), and Intermediate Care Facility for the Developmentally Disabled – Habilitative (ICF/DD-H).

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 Standards Program 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 2025-26, from the prior estimate, is a net increase due to updated projections for FY 2025-26 using actual hospice service rates for Rate Year (RY) 2025-26 and updated implementation dates.

The change in FY 2026-27, from the prior estimate, is a net increase due to updated projections for FY 2026-27 using actual hospice service rates for RY 2025-26.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a net increase due to:

- Expected increases in hospice, RHC, and room and board service rates in FY 2026-27 when compared with FY 2025-26.
- The addition of RY 2026-27 hospice and RHC rate increase are expected to occur in February 2027 with the corresponding retroactive EPC expected to occur in May 2027.
- Calendar Year (CY) 2027 hospice and room and board rates are expected to increase and implement in January 2027.

Methodology:

1. Hospice Services:
   a. The weighted increase for hospice service rates, excluding RHC and SIA, is estimated to be 2.86% for RY 2025-26 and RY 2026-27.

   b. The RY 2024-25 hospice rates, including RHC rates, was implemented in August 2025. The retroactive payment for the period from October 2024 through July 2025 was implemented in December 2025.

   c. The RY 2025-26 hospice rates, including RHC rates, are expected to implement in April 2026. The retroactive payment for the period from October 2025 through March 2026 is expected to be implemented in June 2026.

   d. The RY 2026-27 hospice rates, including RHC rates, are expected to implement in February 2027. The retroactive payment for the period from October 2026 through January 2027 is expected to be implemented in May 2027.

HOSPICE RATE INCREASES

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 3.64% for RY 2025-26 and RY 2026-27.

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 FFS payments on a cash basis are:

Cash Basis – Lagged	**FY 2025-26**	**FY 2026-27**
Hospice Services (24-25)	$27,000	$29,000
RHC & SIA Payments (24-25)	$4,831,000	$5,281,000
Room & Board (CY 2025)	$1,329,000	$1,341,000
Hospice Services (24-25) Retro	$24,000	$0
RHC & SIA Payments (24-25) Retro	$4,392,000	$0
Hospice Services (25-26)	$7,000	$33,000
RHC & SIA Payments (25-26)	$1,077,000	$5,438,000
Room & Board (CY 2026)	$486,000	$1,376,000
Hospice Services (25-26) Retro	$13,000	$0
RHC & SIA Payments (25-26) Retro	$2,155,000	$0
Hospice Services (26-27)	$0	$11,000
RHC & SIA Payments (26-27)	$0	$1,846,000
Room & Board (CY 2027)	$0	$504,000
Hospice Services (26-27) Retro	$0	$9,000
RHC & SIA Payments (26-27) Retro	$0	$1,477,000
TOTAL	**$14,341,000**	**$17,345,000**

HOSPICE RATE INCREASES

Funding:

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	$8,844,000	$4,422,000	$4,422,000
90% Title XIX / 10% GF (4260-101-0001 / 0890)	$5,490,000	$549,000	$4,941,000
65% Title XXI / 35% GF (4260-101-0001 / 0890)	$7,000	$3,000	$4,000
Total	**$14,341,000**	**$4,974,000**	**$9,367,000**

FY 2026-27	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	$10,697,000	$5,348,000	$5,349,000
90% Title XIX / 10% GF (4260-101-0001 / 0890)	$6,640,000	$664,000	$5,976,000
65% Title XXI / 35% GF (4260-101-0001 / 0890)	$8,000	$3,000	$5,000
Total	**$17,345,000**	**$6,015,000**	**$11,330,000**

DPH INTERIM RATE GROWTH

FISCAL REFERENCE NUMBER:1162

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$19,724,000**
FEDERAL FUNDS	$0	$19,724,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$19,724,000**
FEDERAL FUNDS	$0	$19,724,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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:
Not Applicable

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 2025-26, from the prior estimate, is due to DPH county and DPH community growth rates for FY 2025-26 are included in the Fee-for-Service (FFS) base and no longer reflected in this policy change.

The change in FY 2026-27, from the prior estimate, is due to a decrease in estimated DPH expenditures.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to DPH county and DPH community growth rates for FY 2025-26 are included in the FFS base.

Methodology:
1. The FY 2025-26 interim rates were implemented July 2025.

DPH INTERIM RATE GROWTH

2. For FY 2025-26:
   - The county-based and community based DPH interim rate growths are in the FFS base and are not included in this policy change.

3. For FY 2026-27:
   - Assume a 4.11% interim rate increase for county-based DPHs and 0.94% for community-based DPHs.
   - An additional cost of $19,724,000 TF is estimated for the FY 2026-27 interim rates.

4. The interim payments are 100% federal funds.

5. Assume the FY 2026-27 increase in payments to DPHs due to interim rate growth is:

FY 2026-27	TF	FFP
DPH Interim Rate Payment Increase	$19,724,000	$19,724,000
Total FY 2026-27	**$19,724,000**	**$19,724,000**

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

LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES

FISCAL REFERENCE NUMBER:1784

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$688,731,000	-$753,912,000
OTHER FUNDS	$688,731,000	$753,912,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$688,731,000	-$753,912,000
OTHER FUNDS	$688,731,000	$753,912,000

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 1629 (Chapter 875, Statutes of 2004)
AB 186 (Chapter 46, Statutes of 2022)
Budget Act of 2026

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)

AB 1467 established the LTCQAF. Effective August 1, 2013, the QA fees collected by LTC and ICF-DD facilities are deposited into the fund and transferred to the state GF to offset LTC provider reimbursement rate expenditures.

SB 833 established a continuous appropriation for the LTCQAF to allow moneys from the fund to be appropriated without further legislative action.

LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES

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 186 (Chapter 46, Statutes of 2022) extends the QAF and AB 1629 methodology through December 31, 2026.

The Department is proposing a one-year extension of the FS/NF-B and FSSA/NF-B rate methodology and QAF program through December 31, 2027.

Reason for Change:
The change in FY 2025-26 from the prior estimate, is a net increase due to:

- Actual collections for the June 2025 to January 2026 months coming in higher than estimated.
- An increase in the estimated monthly QAF collections.
- Fewer number of months to be transferred in FY 2025-26 than previously estimated.

The change in FY 2026-27 from the prior estimate, is an increase due to:

- An increase in the estimated monthly QAF collections.
- An increase in the number of months estimated to be transferred in FY 2026-27.
- An increase in the withhold estimate for FY 2026-27.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to:

- An increase in the FY 2026-27 collection estimates based on FY 2025-26 actuals.
- More months are estimated to be transferred in FY 2026-27 than FY 2025-26.
- An increase in the withhold transfer expected for FY 2026-27.

Methodology:

1. Based on collections and transfer data through January 2026; assume $688.7 million will be transferred to the GF in FY 2025-26 and $753.9 million in FY 2026-27.

2. The estimated withhold transfers for the AB 1629 QAF and QAF assessed on ICF-DDs expected to occur are $21.2 million in FY 2025-26 and $31.1 million in FY 2026-27.

3. The estimated fund adjustment from the LTCQAF to the GF is:

(Dollars in Thousands)

FY 2025-26	TF	GF	LTCQAF
FY 2024-25	$0	($187,227)	$187,227
FY 2025-26	$0	($480,300)	$480,300
Subtotal	$0	($667,527)	$667,527
Withhold Transfers	$0	($21,204)	$21,204
Total	**$0**	**($688,731)**	**$688,731**

LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES

(Dollars in Thousands)

FY 2026-27	TF	GF	LTCQAF
FY 2025-26	$0	($222,403)	$222,403
FY 2026-27	$0	($500,408)	$500,408
Subtotal	$0	($722,811)	$722,811
Withhold Transfers	$0	($31,101)	$31,101
Total	**$0**	**($753,912)**	**$753,912**

Funding:
Long Term Care Quality Assurance Fund (4260-601-3213)
100% GF (4260-101-0001)

PROP 35 - PROVIDER PAYMENT INCREASE FUNDING

FISCAL REFERENCE NUMBER:2509

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$1,585,433,000	-$2,439,400,000
OTHER FUNDS	$1,585,433,000	$2,439,400,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$1,585,433,000	-$2,439,400,000
OTHER FUNDS	$1,585,433,000	$2,439,400,000

Purpose:
This policy change estimates the funding to be spent from the Health Care Oversight & Accountability Subfund (Fund 3443) for provider payment increases and increased base payment rates.

Authority:
Protect Access to Health Care Act of 2024 (Proposition 35)

Interdependent Policy Changes:
Prop 35 – Provider Payment Increases
CalAIM ECM-Community Supports – Transitional Rent
Qualified Community-Based Mobile Crisis Services
Specialty Mental Health Services (SMHS) for Adults
SMHS for Children
Drug Medi-Cal State Plan Services
Drug Medi-Cal Organized Delivery System Waiver
CYBHI – Fee Schedule Third Party Administrator
Community Clinic Directed Payment Program
Managed Care District Hospital Directed Payments
Managed Care Public Hospital Enhanced Payment Program (EPP)
Retro Payments to Counties for State-Only BH Svcs.

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.

PROP 35 - PROVIDER PAYMENT INCREASE FUNDING

The Health Care Oversight & Accountability (HCO&A) Subfund receives revenues from the MCO Tax to be used to support provider payments. The cost of provider payment increases and increased base payment rates is budgeted in the Prop 35 – Provider Payment Increases policy change, Two Plan Model, County Organized Health Systems & Single Plan, Geographic Managed Care, Regional Model, and various fee-for-service (FFS) base policy changes using General Fund as the non-federal share. This policy change replaces General Fund budgeted for provider payment increases and increased base payment rates 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).

The Department proposes to use the HCO&A Subfund to support a portion of the non-federal share of costs for transitional rent, Medi-Cal community-based mobile crisis services, behavioral health (BH) rate growth, Community Clinic Directed Payments, Managed Care District Hospital Directed Payments, Managed Care Private Hospital Directed Payments, Managed Care Public Hospital Enhanced Payment Program Directed Payments, and Retro Payments to Counties for State-Only BH Services in FY 2025-26 and FY 2026-27 to expand the health care services and payment rates above and beyond those already in effect or in existence as of January 1, 2024.

For the Managed Care Private Hospital Directed Payments Program, the HCO&A Subfund dollars are budgeted in that policy change.

See the Proposition 35 Funding – CYBHI & BH-CONNECT policy change for transfers from the HCO&A Subfund to the GF for various administration costs.

Reason for Change:
The change in FY 2025-26 from the prior estimate, is due to decreased estimates for the 2024 Targeted Rate Increases and Managed Care Base Rate Increases.

The change in FY 2026-27 from the prior estimate, is due to updated General Fund (GF) reimbursement amounts to reflect the latest Prop 35 spending plan.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to increased Prop 35 expenditures occurring in FY 2026-27.

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 fee-for-service and managed care bases. 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 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 Prop 35 – Provider Payment Increases

PROP 35 - PROVIDER PAYMENT INCREASE FUNDING

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, as well as increases to managed care plan base capitation payments for primary care, specialty care, hospital outpatient, and ground emergency medical transportation services. Higher managed care capitation rates reflect increased costs of purchasing health care services due to projected increases in per-service payment rates, per-member utilization and acuity, expansion of covered services and health care benefits, services, and workforce above and beyond those in effect or in existence in the prior rating period.

(Dollars in Thousands)

Proposition 35	FY 2025-26	FY 2026-27
Prop 35 – Provider Payment Increases	$0	$1,505,600

3. The HCO&A Subfund is assumed to provide a portion of support for the non-federal share for a portion of transitional rent, Medi-Cal community-based mobile crisis services, BH rate growth costs, and CYBHI – Fee Schedule Third Party Administrator funding in FY 2025-26 and FY 2026-27 as follows:

(Dollars in Thousands)

Proposition 35	FY 2025-26	FY 2026-27
Transitional Rent	$22,600	$53,200
Community-Based Mobile Crisis Services	$25,400	$25,300
BH Rate Growth	$17,000	$17,000
CYBHI - Fee Schedule Third Party Administrator	$39,500	$0
Total	**$104,500**	**$95,500**

These costs are budgeted in various policy changes using General Fund as the non-federal share. The policy changes include the CalAIM ECM-Community Supports – Transitional Rent, Qualified Community-Based Mobile Crisis Services, SMHS for Adults, SMHS for Children, Drug Medi-Cal State Plan Services, Drug Medi-Cal Organized Delivery System Waiver, and the CYBHI – Fee Schedule Third Party Administrator policy changes.

4. The HCO&A Subfund is assumed to provide a portion of support for the non-federal share for a portion of the Community Clinic Directed Payment Program, Managed Care District Hospital Directed Payment Program, Managed Care Public Hospital Enhanced Payment Directed Payments Program, and Retro Payments to Counties for State-Only BH Services in FY 2026-27. These costs are budgeted in the aforementioned policy changes using General Fund as the non-federal share.

PROP 35 - PROVIDER PAYMENT INCREASE FUNDING

(Dollars in Thousands)

Proposition 35	FY 2025-26	FY 2026-27
Community Clinic Directed Payment Program	$0	$50,000
Managed Care District Hospital Directed Payment Program	$0	$22,500
Managed Care Public Hospital Enhanced Payment Program Directed Payments	$0	$22,500
Retro Payments to Counties for State-Only BH Svcs.	$0	$56,000
Total	**$0**	**$151,000**

5. Total spending on the items listed above are:

(Dollars in Thousands)

Proposition 35	FY 2025-26	FY 2026-27
Targeted Rate Increases (In Base)	$283,483	$234,750
Managed Care Base Rate Increases (In Base)	$1,197,450	$452,550
Prop 35 - Provider Payment Increases and other expenditures	$104,500	$1,752,100
Total	**$1,585,433**	**$2,439,400**

6. The amount of General Fund that is replaced by HCO&A is summarized below:

(Dollars in Thousands)

Fiscal Year	TF	GF	SF (3443 Fund)
FY 2025-26	$0	($1,585,433)	$1,585,433
FY 2026-27	$0	($2,439,400)	$2,439,400

Funding:
Health Care Oversight & Accountability Subfund (4260-601-3443)
100% General Fund (4260-101-0001)

LABORATORY RATE METHODOLOGY CHANGE

FISCAL REFERENCE NUMBER:1703

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**-$2,046,000**
FEDERAL FUNDS	$0	-$1,205,700
GENERAL FUND	$0	-$840,300
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**-$2,046,000**
FEDERAL FUNDS	$0	-$1,205,700
GENERAL FUND	$0	-$840,300
OTHER FUNDS	$0	$0

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

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. The Department will submit SPA 26-0011 to adjust clinical laboratory or laboratory services reimbursement rates based on the Triennial reimbursement methodology, effective July 1, 2026.

Reason for Change:
There is no change in FY 2025-26 from the prior estimate. The 2023 triennial rate adjustment remains fully incorporated into the fee-for-service base, but this policy change no longer displays these amounts in FY 2025-26.

The change in FY 2026-27 from the prior estimate, is due to:
- Updated projections for the 2026 triennial rate adjustment savings, effective July 1, 2026.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to:
- Including the 2026 triennial rate adjustment savings, effective July 1, 2026.

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 2025 annual rate adjustment is effective July 1, 2025. No fiscal impact is assumed due to updated Medicare rates.
   b. The 2026 annual rate adjustment is effective July 1, 2026. No fiscal impact is assumed.

LABORATORY RATE METHODOLOGY CHANGE

4. **Triennial rate adjustment:** The CMS approved the new laboratory rate methodology in July 2015.
    a. The savings resulting from the July 2026 rate adjustment are estimated to be $2.3 million TF.

5. The expected adjustments are as follows:

FY 2026-27	TF	GF	FF
Prospective Savings	($2,046,000)	($840,000)	($1,206,000)
Total	**($2,046,000)**	**($840,000)**	**($1,206,000)**

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)

ELIMINATE PPS FOR STATE-ONLY SERVICES

FISCAL REFERENCE NUMBER:2536

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**-$1,010,655,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$0	-$1,010,655,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**-$1,010,655,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$0	-$1,010,655,000
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the impact of eliminating payment at the Prospective Payment System (PPS) per-visit rate for state-only services, primarily non-emergency and non-pregnancy-related services, for Medi-Cal members with Unsatisfactory Immigration Status (UIS) by Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC).

Authority:
Budget Act of 2025

Interdependent Policy Changes:
Not Applicable

Background:
The Department proposes to eliminate payment at the PPS rate for state-only services, primarily non-emergency and non-pregnancy-related services, delivered to Medi-Cal UIS members by FQHCs and RHCs. These services are not eligible for matching federal funds and are not subject to federal requirements to reimburse FQHC and RHC services at the PPS rate. Emergency and pregnancy related services delivered to Medi-Cal UIS members are federally covered services under Section 1903(v) of the Social Security Act and remain eligible for PPS reimbursement.

Following the elimination, these state-only services will be reimbursed at the applicable Medi-Cal Fee Schedule rate in the fee-for-service delivery system and at the applicable negotiated rate between a Medi-Cal managed care plan and FQHC/RHC in the managed care delivery system.

Reason for Change:
There is no change from the prior estimate for both FY 2025-26 and FY 2026-27. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase in savings due to implementation occurring in FY 2026-27 and not FY 2025-26.

ELIMINATE PPS FOR STATE-ONLY SERVICES

Methodology:

1. Assume implementation will be no sooner than July 1, 2026.

2. Annual PPS payments for state-only services in excess of the Medi-Cal Fee Schedule rate in the fee-for-service delivery system and the negotiated rate between a Medi-Cal managed care plan and FQHC/RHC in the managed care delivery system, as applicable, are estimated to be approximately $1,130,487,000.

3. The impact of eliminating PPS payments for state-only services, assuming a lag in payment timing, is shown below:

(Dollars in Thousands)

Fiscal Year	TF	GF
FY 2026-27	($1,010,655)	($1,010,655)

Funding:

100% GF (4260-101-0001)

REDUCTION TO RADIOLOGY RATES

FISCAL REFERENCE NUMBER:1505

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**-$65,471,000**
FEDERAL FUNDS	$0	-$38,742,450
GENERAL FUND	$0	-$26,728,550
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**-$65,471,000**
FEDERAL FUNDS	$0	-$38,742,450
GENERAL FUND	$0	-$26,728,550
OTHER FUNDS	$0	$0

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 do 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 2025-26 from the prior estimate, is due to:

- Delayed implementation of the January 2023, 2024, 2025, and 2026 rate adjustments from April 2026 to July 2026, leaving no fiscal impact in FY 2025-26.

The change in FY 2026-27 from the prior estimate, is due to:

- Delayed retroactive recoupment savings for the January 2023, 2024, 2025, and 2026 rate adjustments from July 2026 to October 2026, reducing the overall savings in FY 2026-27.

REDUCTION TO RADIOLOGY RATES

- Updated savings estimates for CY 2026 and 2027 rate adjustments.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to:
- Delayed implementation of the January 2023, 2024, 2025, and 2026 rate adjustments from April 2026 to July 2026.
- Including retroactive recoupments for the January 2023, 2024, 2025, and 2026 rate adjustments starting October 2026.
- Updated savings estimates for CY 2026 and 2027 rate adjustments.

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 on July 1, 2026.

   The total recoupment of retroactive savings from January 1, 2023, through June 30, 2026, is expected to be implemented October 1, 2026, 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 on July 1, 2026.

   The total recoupment of retroactive savings from January 1, 2024, through June 30, 2026, is expected to be implemented on October 1, 2026, with recoupments occurring over 12 months.

5. The annual FFS savings for the rate adjustments effective January 1, 2025, is expected to be $13,810,000 TF. These adjustments are expected to be implemented on July 1, 2026.

   The total recoupment of retroactive savings from January 1, 2025, through June 30, 2026, is expected to be implemented October 1, 2026, with recoupments occurring over 12 months.

6. The annual FFS savings for the rate adjustments effective January 1, 2026, is expected to be $14,108,000 TF. These adjustments are expected to be implemented on July 1, 2026.

   The total recoupment of retroactive savings from January 1, 2026, through June 30, 2026, is expected to be implemented October 1, 2026, with recoupments occurring over 12 months.

7. The annual FFS savings for the rate adjustments effective January 1, 2027, is expected to be $14,108,000 TF. These adjustments are expected to be implemented on April 1, 2027.

   The total recoupment of retroactive savings from January 1, 2027, through March 31, 2027, is expected to be implemented July 1, 2027, with recoupments occurring over 12 months.

REDUCTION TO RADIOLOGY RATES

8. The estimated savings for the reduction to radiology reimbursement rates are:

FY 2026-27	TF	GF	TITLE XIX FF	TITLE XXI FF	ACA FF
Prospective Savings	($34,835,000)	($14,221,000)	($12,856,000)	($1,179,000)	($6,579,000)
Recoupment of Retro Savings	($30,636,000)	($12,507,000)	($11,306,000)	($1,037,000)	($5,786,000)
Total	**($65,471,000)**	**($26,728,000)**	**($24,162,000)**	**($2,216,000)**	**($12,365,000)**

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)

MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS

FISCAL REFERENCE NUMBER:2055

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$6,291,696,000**	**$15,828,192,000**
FEDERAL FUNDS	$3,996,900,400	$9,879,161,000
GENERAL FUND	$0	$0
OTHER FUNDS	$2,294,795,600	$5,949,031,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$6,291,696,000**	**$15,828,192,000**
FEDERAL FUNDS	$3,996,900,400	$9,879,161,000
GENERAL FUND	$0	$0
OTHER FUNDS	$2,294,795,600	$5,949,031,000

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)
Families First Coronavirus Response Act (FFCRA)

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

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.

CMS issued a final rule (CMS-2439-F) in May 2024 that significantly alters the financing of State Directed Payments (SDPs) in Medi-Cal managed care. Effective for rating periods beginning on or after July 9, 2027, the rule prohibits the use of separate payment terms for SDPs, requiring all such payments to be incorporated into actuarially sound capitation rates. This change aims to reinforce the risk-based nature of managed care and improve fiscal transparency. States, including California, must transition away from current SDP funding mechanisms—such as separate payment pools—and ensure compliance through revised rate-setting practices and monthly base capitation payments.

H.R. 1, enacted on July 4, 2025, contains provisions affecting the permissible size and structure of health care-related taxes. The Department has considered potential impacts of H.R. 1 on the Hospital QAF and is awaiting further federal regulatory action and/or guidance.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is an increase due to:

- Updated capitation data for CY 2023 P2.

The change in FY 2026-27 from the prior estimate is a decrease due to:

- Lower updated CY 2025 and forward payment projections.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to:

- An additional six months' worth of CY 2025 capitation payments and five months' worth of CY 2027 capitation payments in FY 2026-27 due to accelerated payment timing.

Methodology:

1. The total value of the funding for the private hospital directed payment pool on an accrual basis is $5.39 billion total fund for the CY 2023 rating period, $7.19 billion total fund for the CY 2024 rating period, and an estimated $8.755 billion total fund for the CY 2025 rating period and beyond.

2. The non-federal share will be supported by the Hospital Quality Assurance Revenue Fund (HQARF) and MCO Tax for the CY 2025 service period.

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 through CY 2026.

5. The final six months of the CY 2023 rating period (July 1, 2023, though December 31, 2023) payments occurred in September 2025. The first six months of the CY 2024 rating

MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS

period (January 1, 2024, through June 30, 2024) payments are expected to occur in March 2026.

6. The final six months of the CY 2024 rating period (July 1, 2024, through December 31, 2024) and the first six months of the CY 2025 rating period (January 1, 2025, through June 30, 2025) payments are expected to occur in September 2026.
7. The final six months of the CY 2025 rating period (July 1, 2025, through December 2025) payments are expected to occur in March 2027.
8. Starting in February 2027, five monthly payments for the January through May 2027 service periods are expected to be made in FY 2026-27.
9. The first six months of the CY 2026 rating period (January 1, 2026, through June 30, 2026) and the final six months of the CY 2026 rating period (July 1, 2026, through December 31, 2026) payments are expected to occur in FY 2027-28.
10. On a cash basis, the estimated payments are:

(Dollars in Thousands)

FY 2025-26	TF	SF (HQARF)	FF (Title 19)	FF (Title 21)	ACA FF	COVID-19 FF
CY 2023 P2 (Jul-Dec 23) CY 2024 P1 (Jan-Jun 24)	$6,291,696	$2,294,796	$1,707,071	$215,794	$2,052,497	$21,538
Total FY 2025-26	**$6,291,696**	**$2,294,796**	**$1,707,071**	**$215,794**	**$2,052,497**	**$21,538**

(Dollars in Thousands)

FY 2026-27	TF	SF (HQARF)	SF (HCO&A)	FF (Title 19)	FF (Title 21)	ACA FF
CY 2024 P2 (Jul-Dec 24) CY 2025 P1 (Jan-Jun 25) CY 2025 P2 (Jul-Dec 25) CY 2027 (Jan-May 27)	$15,828,192	$5,759,031	$190,000	$4,350,522	$440,039	$5,088,900
Total FY 2026-27	**$15,828,192**	**$5,759,031**	**$190,000**	**$4,350,522**	**$440,039**	**$5,088,900**

MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS

Funding:
Hospital Quality Assurance Revenue Fund (4260-611-3158)
ACA 50/50 ER UIS – HQARF (4260-101-0890 / 3158)
Title XIX FFP (4260-101-0890)
ACA Title XIX FFP (4260-101-0890)
Title XXI FFP (4260-101-0890)
SCHIP HQARF (4260-101-0890 / 3158)
COVID-19 Title XIX Increased FFP (4260-101-0890)
COVID-19 SCHIP Increased FFP (4260-101-0890)
Health Care Oversight & Accountability Subfund (4260-601-3443)

HOSPITAL QAF - FFS PAYMENTS

FISCAL REFERENCE NUMBER:1475

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**-$199,543,000**	**$3,961,466,000**
FEDERAL FUNDS	$149,013,000	$2,173,312,000
GENERAL FUND	$0	$0
OTHER FUNDS	-$348,556,000	$1,788,154,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**-$199,543,000**	**$3,961,466,000**
FEDERAL FUNDS	$149,013,000	$2,173,312,000
GENERAL FUND	$0	$0
OTHER FUNDS	-$348,556,000	$1,788,154,000

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 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.

The Department is awaiting federal approval of the subsequent HQAF program period (HQAF IX) which includes payments for dates of service January 1, 2025, through December 31, 2025,

HOSPITAL QAF - FFS PAYMENTS

submitted to the Centers for Medicare and Medicaid Services (CMS) in March 2025 via State Plan Amendments (SPAs) 25-0012 and 25-0013.

The Department began developing the subsequent program period (HQAF X) in FY 2025-26 Q1 which will include payments for the period beginning January 1, 2026 through December 31, 2026.

H.R. 1, enacted on July 4, 2025, contains provisions affecting the permissible size and structure of health care-related taxes. H.R. 1 also authorizes the federal Health and Human Services Secretary to approve a transition period of up to three years for impacted taxes. The Department has considered potential impacts of H.R. 1 on the HQAF and is awaiting further federal regulatory action and/or guidance.

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 2025-26, from the prior estimate, is a decrease due to:

- HQAF VI FY 2020-21 additional Outpatient (OP) payments for Cycles 5-8 shifted and are expected to be paid in FY 2026-27.
- HQAF VI FY 2020-21 additional OP ACA FFCRA Adjustments for Cycles 5-6 shifted and are expected to be processed in FY 2026-27.
- HQAF VI FY 2021-22 additional OP payments for Cycles 9-10 shifted and are expected to be paid in FY 2026-27.
- HQAF VI FY 2021-22 additional OP ACA FFCRA Adjustments for Cycles 9-10 shifted and are expected to be processed in FY 2026-27.
- Updated HQAF VIII Cycles 7-8 ACA adjustment based on actuals.
- HQAF IX Cycles 1-4 FFS payments shifted and are expected to be paid in FY 2026-27.
- HQAF IX Cycles 1-2 ACA adjustments shifted and are expected to be processed in FY 2026-27.

The change in FY 2026-27 from the prior estimate, is an overall increase due to:

- HQAF VI FY 2020-21 additional OP payments for Cycles 5-8 are budgeted in FY 2026-27.
- HQAF VI FY 2021-22 additional OP payments for Cycles 9-10 are budgeted in FY 2026-27.
- HQAF VI FY 2020-21 additional ACA FFCRA adjustments for Cycles 5-6 are budgeted in FY 2026-27 and the amounts are updated based on updated data.
- HQAF VI FY 2021-22 additional OP ACA Adjustments for Cycles 9-10 are budgeted in FY 2026-27 and the amounts are updated based on updated data.
- HQAF IX Cycles 1-4 FFS payments are budgeted in FY 2026-27.
- HQAF IX Cycles 1-2 ACA adjustments are budgeted in FY 2026-27.
- The HQAF X Cycles 1-2 FFS payment amount was updated based on updated data.
- Assuming only two cycles of HQAF X FFS payment will be processed in FY 2026-27.
- Assuming only one cycle of HQAF X ACA Adjustment will be processed in FY 2026-27.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to:

- FY 2026-27 includes the HQAF VI FY 2020-21 additional OP payments for Cycles 5-8.

HOSPITAL QAF - FFS PAYMENTS

- FY 2026-27 includes the HQAF VI FY 2021-22 additional OP payments for Cycles 9-10.
- FY 2026-27 includes the HQAF VI FY 2020-21 additional ACA FFCRA Adjustments for Cycles 5-8.
- FY 2026-27 includes the HQAF VI FY 2021-22 additional OP ACA Adjustments for Cycles 9-10.
- FY 2026-27 includes HQAF IX Cycles 1-4 FFS payments and Cycles 1-4 ACA adjustments.
- Two cycles of HQAF X FFS payment are assumed to be processed in FY 2026-27.
- The HQAF X FFS payment amounts were updated based on revised data.
- One cycle of the HQAF X ACA Adjustment is assumed to be processed in FY 2026-27.

Methodology:

HQAF VI - HQAF X

1. The ACA allows for enhanced FMAP for newly eligible Medi-Cal members. The ACA claiming methodology for the FFS supplemental payments was approved by CMS in FY 2017-18. The Hospital Quality Assurance Revenue Fund (HQARF) will be reimbursed for the Special Fund (SF) portion (non-federal share) and an adjustment will be made for the federal share processed at the applicable FMAP.

2. The HQAF VI outpatient (OP) UPLs were recalculated allowing for additional payments to be made for FY 2020-21 and FY 2021-22 which is anticipated to take place in FY 2026-27 and 2027-28.

3. HQAF VIII payments are based on the HQAF VIII model that was approved by CMS.

4. Reductions to DSH replacement payments were initially anticipated to take effect during the Federal Fiscal Year (FFY) 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 CY 2023. CMS conditionally approved the CY 2023 UPL calculations on the condition that if the DSH reductions were further delayed, the Department would repay any federal financial participation (FFP) that was overpaid for CY 2023. On March 15, 2025, HR 1968 was enacted, which eliminated FFY 2025 reduction and shifted the effective reduction period to FFY 2026 through 2028, so providers were overpaid HQAF payments for CY 2023. As a result, HQAF overpaid providers by approximately $199 million in total funds. Program repaid CMS for the federal financial participation (FFP) attributable to the overpayment in May 2025 from fund 3158. The program is expected to collect the $199 million overpayment from providers, and the reclaimed funds will be deposited into Fund 3158 which will be anticipated to occur in FY 2025-26. The non-federal share of these funds will be used as a future offset for the program.

5. HQAF IX estimated payments are based on the current version of the HQAF IX Fee and Payment model which is awaiting CMS approval. Payment timing and amounts will change.

6. HQAF X estimated payments are based on the resubmitted version of the HQAF IX Fee and Payment model which is pending CMS approval. Payment timing and amounts will change.

7. 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

8. On a cash basis, the estimated HQAF VI - HQAF X payments are:

(Dollars in Thousands)

FY 2025-26	TF	SF (HQARF)	FF	ACA FF	*Return to Fund 3158
HQAF VIII					
CY 2023 DSH Overpayment Recoupment	($199,543)	($199,543)	$0	$0	$199,543
CY 2024 ACA Adjustment	$0	($149,013)	($186,266)	$335,279	$149,013
Total FY 2025-26	**($199,543)**	**($348,556)**	**($186,266)**	**$335,279**	$348,556

(Dollars in Thousands)

FY 2026-27	TF	SF (HQARF)	FF	ACA FF	*Return to Fund 3158
HQAF VI					
FY 2020-21 Additional OP Payments	$113,078	$56,539	$56,539	$0	$0
FY 2021-22 Additional OP Payments	$105,850	$52,925	$52,925	$0	$0
HQAF IX					
CY 2025	$2,495,025	$1,323,963	$1,171,062	$0	$0
CY 2025 ACA Adjustment	$0	($245,803)	($307,253)	$553,056	$245,803
HQAF X					
CY 2026	$1,247,513	$661,981	$585,532	$0	$0
CY 2026 ACA Adjustment Cycle 1	$0	($61,451)	($76,813)	$138,264	$61,451
Total FY 2026-27	**$3,961,466**	**$1,788,154**	**$1,481,992**	**$691,320**	$307,254

*The Return to Fund 3158 column is for display purposes only (see HQAF VI - HQAF X Methodology #1 and #6).

HOSPITAL QAF - FFS PAYMENTS

Funding:
Hospital Quality Assurance Revenue Fund (4260-611-3158)
ACA Title XIX FFP (4260-101-0890)
Title XIX FFP (4260-101-0890)

HOSPITAL QAF - MANAGED CARE PAYMENTS

FISCAL REFERENCE NUMBER:1761

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$1,793,000,000**
FEDERAL FUNDS	$0	$1,231,935,250
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$561,064,750
% REFLECTED IN BASE	0%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$1,793,000,000**
FEDERAL FUNDS	$0	$1,231,935,250
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$561,064,750

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, 2024) in December 2023. This HQAF program is referred to as HQAF VIII.

HOSPITAL QAF - MANAGED CARE PAYMENTS

The Department submitted the HQAF IX fee model for federal approval for the HQAF IX program period (January 1, 2025, through December 31, 2025) in March 2025. This HQAF program period is referred to as HQAF IX.

On July 4, 2025 Section 1903(w) of the Social Security Act (42 U.S.C. 1396b(w)) was amended to redefine the requirements regarding the waiver of uniform tax requirement for Medicaid provider taxes such as HQAF.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is a decrease due to:

- Shift in the payment timing for the CY 2025 HQAF pass-through from FY 2025-26 to FY 2026-27.

The change in FY 2026-27 from the prior estimate, is an increase due to:

- Shift in the payment timing for the CY 2025 HQAF pass-through from FY 2025-26 to FY 2026-27.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to:

- Shift in the payment timing for the CY 2025 HQAF pass-through from FY 2025-26 to FY 2026-27.

Methodology:

1. CY 2025 HQAF payments are anticipated to occur in FY 2026-27 along with the CY 2026 HQAF payments.

2. Effective January 1, 2025, expenses related to the DMPH program are captured in the Managed Care District Hospital Directed Payments policy change.

3. The CY 2025 total amounts are within the HQAF IX model, which was submitted on March 28, 2025 to CMS for approval.

4. The HQAF managed care pass-through program will sunset on 12/31/2026.

5. On a cash basis, the estimated QAF payments are:

(Dollars in Thousands)

FY 2026-27	TF	SF (HQARF)	FF (TITLE 19)	FF (TITLE 21)	ACA FF
Managed Care					
Calendar Year 2025	$900,000	$278,939	$225,675	$21,330	$374,056
Calendar Year 2026	$893,000	$282,126	$220,601	$28,962	$361,311
Total MC	$1,793,000	$561,065	$446,276	$50,292	$735,367
Total FY 2026-27	**$1,793,000**	**$561,065**	**$446,276**	**$50,292**	**$735,367**

Funding:
Hospital Quality Assurance Revenue Fund (4260-611-3158)
SCHIP HQARF 65/35 (4260-101-0890/4260-611-3158)

HOSPITAL QAF - MANAGED CARE PAYMENTS

Title XIX FFP (4260-101-0890)
Title XXI FFP (4260-101-0890)

GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS

FISCAL REFERENCE NUMBER:2024

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$1,110,346,000**	**$1,346,207,000**
FEDERAL FUNDS	$613,787,000	$744,900,000
GENERAL FUND	$0	$0
OTHER FUNDS	$496,559,000	$601,307,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$1,110,346,000**	**$1,346,207,000**
FEDERAL FUNDS	$613,787,000	$744,900,000
GENERAL FUND	$0	$0
OTHER FUNDS	$496,559,000	$601,307,000

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 (CMS) 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

- 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 2025-26, from the prior estimate, is a decrease due to:

- Decreases in FY 2023-24 Q3-Q4 Affordable Care Act (ACA) Adjustments based on actuals.

The change in FY 2026-27 from the prior estimate, is a decrease due to:

- Decreases in FY 2024-25 Q1 through Q4 ACA Adjustments based on more recent data.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to:

- Increases in FY 2026-27 interim payments and final settlement expenditures compared to FY 2025-26 due to expected increases in direct and indirect graduate medical costs.
- Increases in FY 2026-27 ACA Adjustments compared to FY 2025-26 due to expected increases in direct and indirect medical graduate 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 2025-26 payments were calculated based on FY 2023-24 cost report data and are estimated at $724 million Total Funds (TF).
    - FY 2026-27 payments were calculated based on the percentage change from FY 2024-25 and FY 2025-26 and are estimated at $876 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.

GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS

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 enhanced FMAP for newly eligible Medi-Cal members. The ACA reimbursement methodology was approved by CMS in the fourth quarter of FY 2022-23. 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 are 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, and an adjustment will be made for the federal share processed at the applicable FMAP.

7. Assume FY 2024-25 final settlements will be paid in FY 2025-26.

8. Assume all four quarters of FY 2025-26 interim payments will be paid in FY 2025-26.

9. Assume ACA adjustments for FY 2023-24 will occur in FY 2025-26.

10. Assume FY 2025-26 final settlements will occur in FY 2026-27.

11. Assume all four quarters of FY 2026-27 interim payments will be paid in FY 2026-27.

12. Assume ACA adjustments for FY 2024-25 will be paid in FY 2026-27.

(Dollars in Thousands)

FY 2025-26	TF	IGT	FF	ACA FF	COVID-19 FF	Return to DPHs*
FY 2023-24 Q1-Q2 ACA Adjustment	$57,889	$0	($76,164)	$137,095	($3,042)	$57,889
FY 2023-24 Q3-Q4 ACA Adjustment	$59,339	$0	($74,174)	$133,513	$0	$59,339
FY 2024-25 Final Settlement	$269,078	$134,539	$134,539	$0	$0	$0
FY 2025-26 Interim Payment Q1-Q4	$724,040	$362,020	$362,020	$0	$0	$0
Total	**$1,110,346**	**$496,559**	**$346,221**	**$270,608**	**($3,042)**	**$117,228**

GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS

FY 2026-27	TF	IGT	FF	ACA FF	Return to DPHs*
FY 2024-25 Q1-Q2 ACA Adjustment	$71,797	$0	($89,747)	$161,544	$71,797
FY 2024-25 Q3-Q4 ACA Adjustment	$71,797	$0	($89,747)	$161,544	$71,797
FY 2025-26 Final Settlement	$326,032	$163,016	$163,016	$0	$0
FY 2026-27 Interim Payment Q1-Q4	$876,581	$438,291	$438,290	$0	$0
Total	**$1,346,207**	**$601,307**	**$421,812**	**$323,088**	**$143,594**

*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

FISCAL REFERENCE NUMBER:1071

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$769,852,000**	**$787,980,000**
FEDERAL FUNDS	$384,926,000	$393,990,000
GENERAL FUND	$384,926,000	$393,990,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$769,852,000**	**$787,980,000**
FEDERAL FUNDS	$384,926,000	$393,990,000
GENERAL FUND	$384,926,000	$393,990,000
OTHER FUNDS	$0	$0

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
SB 90 (Chapter 19, Statutes of 2011)
SB 335 (Chapter 286, Statutes of 2011)
State Plan Amendment (SPA) 05-022
SPA 16-010
American Rescue Plan (ARP) Act (2021)
HR 7148 (2026)

Interdependent Policy Changes:
Not Applicable

Background:
Beginning July 1, 2005, based on SB 1100, private hospitals receive Medi-Cal DSH replacement payments under the DSH Replacement Program. These payments are determined using the same formulas and methodology that were previously in effect under the prior DSH methodology for the 2004-05 fiscal year. These payments are distributed to private hospitals along with $160, 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 Section 1115(a) Medicaid Demonstration 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.

PRIVATE HOSPITAL DSH REPLACEMENT

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. Most recently, on February 3, 2026, HR 7148 was enacted, which eliminated the implementation of the Federal Fiscal Year (FFY) 2026 and 2027 reduction, leaving the reduction in effect only for FFY 2028.

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, the American Rescue Plan Act, enacted on March 11, 2021, authorized increased federal medical assistance percentage (FMAP) 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.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is a net increase due to:

- Lower FY 2024-25 June Phase II payments due to a decrease in the released preliminary FFY 2025 DSH allotments compared to the previous estimate, and
- Higher FY 2025-26 payment amounts due to an increase in the released preliminary FFY 2026 DSH allotments compared to the previous estimate.

The change in FY 2026-27 from the prior estimate, is an increase due to:

- Updated FFY 2027 DSH allotment estimate, assuming a 2% annual increase from the preliminary FFY 2026 allotment.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to:

- A larger DSH allotment estimate due to the FFY 2027 DSH allotment being derived by trending forward the preliminary FFY 2026 allotment by 2% resulting in a larger amount of funds.

Methodology:

1. CMS released a revised FFY 2025 DSH allotment on August 5, 2025, and a preliminary FFY 2026 DSH allotment on October 2, 2025.

2. The FFY 2027 DSH allotment assumes a 2% annual increase from the preliminary FFY 2026 DSH allotment.

3. The remaining 1/12 of the FY 2024-25 DSH Replacement payment was completed in FY 2025-26.

4. Assume 11/12 of the FY 2025-26 DSH Replacement payment will occur in FY 2025-26 and the remaining 1/12 will occur in FY 2026-27.

5. Assume 11/12 of the FY 2026-27 DSH Replacement payment will occur in FY 2026-27.

6. DSH replacement payments will be made as follows on a cash basis:

PRIVATE HOSPITAL DSH REPLACEMENT

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
FY 2024-25	$61,812	$30,906	$30,906
FY 2025-26	$708,040	$354,020	$354,020
Total FY 2025-26	**$769,852**	**$384,926**	**$384,926**

(Dollars in Thousands)

FY 2026-27	TF	GF	FF
FY 2025-26	$64,368	$32,184	$32,184
FY 2026-27	$723,612	$361,806	$361,806
Total FY 2026-27	**$787,980**	**$393,990**	**$393,990**

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

DSH PAYMENT

FISCAL REFERENCE NUMBER:1073

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$604,637,000**	**$606,362,000**
FEDERAL FUNDS	$358,834,000	$366,725,500
GENERAL FUND	$43,553,000	$41,769,000
OTHER FUNDS	$202,250,000	$197,867,500
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$604,637,000**	**$606,362,000**
FEDERAL FUNDS	$358,834,000	$366,725,500
GENERAL FUND	$43,553,000	$41,769,000
OTHER FUNDS	$202,250,000	$197,867,500

Purpose:
This policy change estimates the Disproportionate Share Hospital (DSH) payments to public hospitals eligible for the DSH program.

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions (W&I) Code 14166.6 and 14166.16
State Plan Amendment (SPA) 05-022
American Rescue Plan (ARP) Act (2021)
HR 7148 (2026)

Interdependent Policy Changes:
Not Applicable

Background:
The federal DSH allotment is available to provide federal 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 (now known as Public Health Care Systems, or PHCS) 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. PHCSs may also receive allocations of federal and non-federal DSH funds through intergovernmental transfer-funded payments for expenditures above 100% of costs, up to 175% of the hospitals' uncompensated Medi-Cal and uninsured costs.

  Effective July 1, 2015, PHCSs, 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 PAYMENT

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.

- 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 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. Most recently, on February 3, 2026, HR 7148 was enacted, which eliminated the Federal Fiscal Year (FFY) 2026 and 2027 reduction, leaving the reduction in effect only for FFY 2028.

As a result of the COVID-19 national public health emergency, the American Rescue Plan Act, enacted on March 11, 2021, authorized increased federal medical assistance percentage (FMAP) 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.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is an overall decrease due to:

- The release of a revised FFY 2025 preliminary DSH allotment by CMS resulting in a decrease from the previously estimated preliminary allotment.
- The release of a preliminary FFY 2026 DSH allotment by CMS resulting in increased payment amounts for FY 2025-26 than previously estimated.
- The finalization of the DSH eligibility list for FY 2025-26 and the use of proxy OBRA and CAPDAY for FY 2025-26, increasing the estimated NDPH amount of funds.
- The removal of FY 2010-11 (DY6) Final Reconciliation payments and recoupments. These transactions are pending CMS approval.
- No longer budgeting recoupments for FY 2020-21 in FY 2025-26.

The change in FY 2026-27 from the prior estimate, is an overall increase due to:

- The updated FFY 2027 DSH allotment estimate, which assumes a 2% annual increase from the preliminary FFY 2026 allotment and is higher than previously estimated.
- The finalization of the DSH eligibility list for FY 2025-26 and the use of proxy OBRA and CAPDAY for FY 2025-26, increasing the estimated NDPH amount of funds.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a net increase due to:

- A larger DSH allotment estimate due to the FFY 2027 DSH allotment being derived by trending forward the preliminary FFY 2026 allotment by 2%, resulting in a larger amount of funds.
- Lower NDPH payments estimated in FY 2026-27 compared to FY 2025-26.

DSH PAYMENT

Methodology:

1. CMS released a revised FFY 2025 DSH allotment on August 5, 2025, and a preliminary FFY 2026 DSH allotment on October 2, 2025.

2. The FFY 2027 DSH allotment assumes a 2% annual increase from the preliminary FFY 2026 DSH Allotment.

3. Assume 11/12 of the FY 2025-26 NDPH DSH payment will occur in FY 2025-26 and the remaining 1/12 will occur in FY 2026-27.

4. Assume 11/12 of the FY 2026-27 NDPH DSH payment will occur in FY 2026-27.

5. Assume 3/4 of the FY 2025-26 UC DSH payment will occur in FY 2025-26 and the remaining 1/4 will occur in FY 2026-27.

6. Assume 3/4 of the FY 2026-27 UC DSH payment will occur in FY 2026-27.

7. FY 2021-22 NDPH DSH Audit recoupments and redistributions will be subject to a 56.2% FMAP as outlined in the FFCRA. The FY 2021-22 NDPH DSH Audit recoupments and redistributions are equal and offsetting and will result in an aggregate net zero cash impact in FY 2025-26. The FY 2021-22 aggregate net zero amounts will be included in the FY 2025-26 cash basis table to reflect this Audit recoupment and redistribution activity.

8. 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.

9. DSH payments will be made as follows on a cash basis:

FY 2025-26	TF	GF**	IGT*	FF
DSH 2024-25	$146,090,000	$7,597,000	$55,925,000	$82,568,000
DSH 2025-26	$458,547,000	$35,956,000	$146,325,000	$276,266,000
Total FY 2025-26	**$604,637,000**	**$43,553,000**	**$202,250,000**	**$358,834,000**

DSH PAYMENT

FY 2026-27	TF	GF**	IGT*	FF
DSH 2025-26	$135,416,000	$3,269,000	$48,775,000	$83,372,000
DSH 2026-27	$470,946,000	$38,500,000	$149,092,000	$283,354,000
Total FY 2026-27	**$606,362,000**	**$41,769,000**	**$197,867,000**	**$366,726,000**

Funding:
100% Demonstration DSH Fund (4260-601-7502)
50% Title XIX / 50% GF (4260-101-0001/0890)**
100% GF (4260-101-0001)

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

FISCAL REFERENCE NUMBER:1085

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$505,332,000**	**$439,952,000**
FEDERAL FUNDS	$267,739,000	$240,631,000
GENERAL FUND	$118,400,000	$118,400,000
OTHER FUNDS	$119,193,000	$80,921,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$505,332,000**	**$439,952,000**
FEDERAL FUNDS	$267,739,000	$240,631,000
GENERAL FUND	$118,400,000	$118,400,000
OTHER FUNDS	$119,193,000	$80,921,000

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) 25-0010

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

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 2024-25. The most recent submitted SPA, 25-0010, is pending approval by CMS, which authorizes the extension of the Private Hospital Supplemental Fund Program through June 30, 2026. SPA 25-0010 also updates the program's total computable amount for FY 2025-26 for carryover funds to be matched with federal financial participation (FFP) and distributed to private hospitals. In the fourth quarter of FY 2025-26, a one-year SPA will be submitted to CMS to extend the Private Hospital Supplemental Fund program through FY 2026-27 and add payment amounts for FY 2026-27.

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 2025-26, from the prior estimate, is an overall increase due to:

- Updated FY 2024-25 Affordable Care Act (ACA) adjustment amounts based on more recent data, and
- Decrease in FY 2025-26 Cash Expenditures to Providers due to lower IGT supported payments.

The change in FY 2026-27 from the prior estimate, is an overall increase due to:

- Increased FY 2026-27 Cash Expenditures to Providers due to increase in anticipated FY 2026-27 PHSF distributions, and
- Updated FY 2025-26 ACA adjustment amounts based on more recent data.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a net decrease due to:

- Delayed Cash Expenditures to Providers in FY 2025-26 from a prior FY, and
- Lower Cash Expenditures to Providers in FY 2026-27 compared to FY 2025-26 due to a decrease in PHSF distributions, and
- Increase in ACA FF Adjustment to Special Fund in FY 2026-27 compared to FY 2025-26 due to higher PHSF distributions from FY 2024-25 to FY 2025-26, and
- Increase in ACA FF Adjustments to Counties in FY 2026-27 compared to FY 2025-26 due to higher IGT supported payments from FY 2025-26 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 2025-26 and FY 2026-27 $118,400,000 GF appropriation will be adjusted by the enhanced federal funds provided by the ACA, resulting in carryover funds. The Department

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

will match carryover funds with FFP and distribute to private hospitals in the subsequent SFY.

3. IGT supported payments will be $91.9 million TF in FY 2025-26, and $99.7 million TF in FY 2026-27.

4. The ACA allows for enhanced FMAP for newly eligible Medi-Cal members. CMS approved the ACA claiming methodology in August 2017. 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 2024-25 ACA supplemental payments will be claimed in FY 2025-26, and FY 2025-26 ACA supplemental payments will be claimed in FY 2026-27.

   - The counties will be reimbursed for the IGTs (non-federal share), and an adjustment will be made for the federal share processed at the applicable FMAP.

   - 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 applicable FMAP.

5. The ending balance shown is on a cash basis and does not necessarily mean that the remaining funds are available. Funds in the ending balance may be committed and scheduled to be expended in the following year.

6. The estimated 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	$196,448
Appropriation (GF)	$118,400
Carryover Funds	$26,259
FY 2025-26 IGT	$45,946
Est. FY 2024-25 Interest Earned	$8,150
Funds Available	$395,203
Less: FY 2025-26 Cash Expenditures to Hospitals	($237,593)
Est. FY 2025-26 Remaining Balance	$157,610

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

(Dollars in Thousands)

FY 2025-26	TF	SF	FF	ACA FF	Covid-10 FF	Return to SF*	Return to Counties*
FY 2023-24 Cash Expenditure to Provider	$4,781	$2,343	$2,390	$0	$48	$0	$0
FY 2025-26 Cash Expenditures to Providers**	$470,497	$235,250	$235,247	$0	$0	$0	$0
FY 2024-25 ACA FF Adjustment to Special Fund***	$26,259	$0	($32,824)	$59,083	$0	$26,259	$0
FY 2024-25 ACA FF Adjustment to Counties***	$3,795	$0	(4,743)	$8,538	$0	$0	$3,795
Total	**$505,332**	**$237,593**	**$200,070**	**$67,621**	**$48**	**$26,259**	**$3,795**

7. The estimated Private Hospital Supplemental payments and ending balance for FY 2026-27 are shown below:

FY 2026-27 Private Hospital Supplemental Fund Summary	SF
FY 2025-26 Ending Balance	$157,610
Appropriation (GF)	$118,400
Carryover Funds	$35,583
FY 2026-27 IGT	$49,863
Est. FY 2025-26 Interest Earned	$8,150
Funds Available	$369,606
Less: FY 2026-27 Cash Expenditures to Hospitals	($199,321)
Est. FY 2026-27 Remaining Balance	$170,285

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

(Dollars in Thousands)

FY 2026-27	TF	SF	FF	ACA FF	Return to SF*	Return to Counties*
FY 2026-27 Cash Expenditures to Providers**	$398,641	$199,321	$199,320	$0	$0	$0
FY 2025-26 ACA FF Adjustment to Special Fund***	$35,583	$0	($44,479)	$80,062	$35,583	$0
FY 2025-26 ACA FF Adjustment to Counties***	$5,728	$0	($7,160)	$12,888	$0	$5,728
Total	**$439,952**	**$199,321**	**$147,681**	**$92,950**	**$35,583**	**$5,728**

*The Return to SF and Return to Counties columns are for display purposes only (see Methodology #4).

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)
COVID-19 Title XIX Increased FMAP (4260-101-0890)

PROP 56 - MEDI-CAL FAMILY PLANNING

FISCAL REFERENCE NUMBER:2130

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$442,849,000**	**$433,165,000**
FEDERAL FUNDS	$296,694,900	$302,044,500
GENERAL FUND	$146,154,100	$131,120,500
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$442,849,000**	**$433,165,000**
FEDERAL FUNDS	$296,694,900	$302,044,500
GENERAL FUND	$146,154,100	$131,120,500
OTHER FUNDS	$0	$0

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

annual basis. On January 17, 2025, the Department received pre-print approval from CMS for January 1, 2025, through December 31, 2025, 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.

On July 3, 2025, the United States Congress passed House Resolution 1 (H.R. 1), Section 71113 (2025) Federal Payments to Prohibited Entities, which eliminated the use of Federal Funds to make payments to a prohibited entity for items and services furnished during the 1-year period beginning on July 4, 2025, (Public Law No: 119-21). The term ‘‘prohibited entity” includes essential community providers described in section 156.235 of title 45, Code of Federal Regulations, primarily engaged in family planning services, reproductive health, and related medical care. The Federal District Court Judge in Massachusetts issued a temporary restraining order (TRO) blocking immediate implementation of Section 71113. On July 21, 2025, and July 28, 2025, the Federal District Court issued two separate Preliminary Injunctions that modified the TRO.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is a decrease primarily due to updated Calendar Year (CY) 2025 actual payments, and lower CY 2026 enrollment projections. The change in FY 2026-27, from the prior estimate, is a decrease due to updated enrollment projections for CY 2026 and CY 2027. The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease primarily due to updated enrollment projections for CY 2026 and CY 2027.

Methodology:
1. This policy became effective on July 1, 2019.

2. Assume the continuation of the Proposition 56 payments through FY 2026-27, 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. Assume the combined costs for FY 2025-26 and FY 2026-26 are:

(Dollars in Thousands)

Fiscal Years	TF	GF	FF
FY 2025-26	$452,606	$149,724	$302,882
FY 2026-27	$442,282	$134,457	$307,825

4. FFS expenditures are display only and are captured in the FFS base. FFS expenditures for FY 2025-26 and FY 2026-27 are estimated to be:

PROP 56 - MEDI-CAL FAMILY PLANNING

(Dollars in Thousands)

Fiscal Years	TF	GF	FF
FY 2025-26	$9,757	$3,570	$6,187
FY 2026-27	$9,117	$3,336	$5,781

5. MC expenditures for FY 2025-26 and FY 2026-27 are estimated to be:

(Dollars in Thousands)

Fiscal Years	TF	GF	FF
FY 2025-26	$442,849	$146,154	$296,695
FY 2026-27	$433,165	$131,121	$302,044

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

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS

FISCAL REFERENCE NUMBER:78

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$231,553,000**	**$209,844,000**
FEDERAL FUNDS	$231,553,000	$209,844,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$231,553,000**	**$209,844,000**
FEDERAL FUNDS	$231,553,000	$209,844,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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, an 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

Reason for Change:
The change in FY 2025-26, from the prior estimate, is due to:
- FY 2019-20 and FY 2020-21 Non-LAC Final Reconciliations shifted to FY 2026-27 based on updated timeline.

The change in FY 2026-27, from the prior estimate, is due to:
- FY 2018-19 Non-LAC Final Reconciliation removed from the estimate based on updated timeline.
- FY 2018-19 and 2019-20 LAC Final Reconciliations removed from the estimate based on updated timeline.
- FY 2019-20 and FY 2020-21 Non-LAC Final Reconciliations shifted from FY 2025-26 to FY 2026-27 based on updated timeline.
- Revised FY 2025-26 Interim Payments based on updated data.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to:
- Final reconciliations are expected to occur in FY 2026-27 compared to FY 2025-26.
- Higher interim payment expenditures occurring in FY 2026-27 compared to FY 2025-26 due to more UC acquisitions occurring.

Methodology:
1. Payments of $231,553,000 and $209,844,000 are expected to be made in FY 2025-26 and FY 2026-27 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 2026-27.
   - Final reconciliations for LAC hospitals will be on a separate timeline from non-LAC hospitals.

3. The Affordable Care Act (ACA) allows for enhanced FMAP for newly eligible Medi-Cal members. The ACA reimbursement methodology was approved by CMS in August 2017.

4. Traditional and ACA claims are processed separately. Payments are based on CPE claims which are adjusted based on the applicable FMAP. FY 2024-25 and FY 2025-26 Traditional and ACA claims are estimated based on FY 2023-24 actuals that further adjusted the estimated percentage change in the Consumer Price Index for all Urban Consumers (CPI-U) for outpatient hospital services.

FY 2025-26	TF	FF	ACA
FY 2023-24 (Calendar Year) Interim Payments	$605,000	$351,000	$254,000
FY 2024-25 Interim Payments	$230,948,000	$124,731,000	$106,217,000
Total	**$231,553,000**	**$125,082,000**	**$106,471,000**

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS

FY 2026-27	TF	FF	ACA	COVID-19 FF
FY 2019-20 (Non-LAC Final Rec)	($16,902,000)	($8,778,000)	($7,843,000)	($281,000)
FY 2020-21 (Non-LAC Final Rec)	($13,189,000)	($6,978,000)	($5,750,000)	($461,000)
FY 2020-21 (LAC Final Rec)	($834,000)	($322,000)	($491,000)	($21,000)
FY 2024-25 (Calendar Year) Interim Payments	$624,000	$362,000	$262,000	$0
FY 2025-26 Interim Payments	$240,145,000	$130,012,000	$110,133,000	$0
Total	**$209,844,000**	**$114,296,000**	**$96,311,000**	**($763,000)**

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)

DPH PHYSICIAN & NON-PHYS. COST

FISCAL REFERENCE NUMBER:1078

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$181,065,000**	**$85,031,000**
FEDERAL FUNDS	$181,065,000	$85,031,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$181,065,000**	**$85,031,000**
FEDERAL FUNDS	$181,065,000	$85,031,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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
SPA 24-0026

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

DPH PHYSICIAN & NON-PHYS. COST

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 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, was approved by CMS on December 16, 2024, which updated 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 2025-26, from the prior estimate, is due to:

- The FY 2017-18 and FY 2018-19 final reconciliations for Los Angeles (LA) County DPHs have been shifted from FY 2025-26 to FY 2026-27,
- The FY 2005-06 through FY 2017-18 final reconciliations for Non-LA County DPHs have been shifted from FY 2025-26 to FY 2026-27,
- The FY 2021-22 final reconciliations for have been updated based on actual payments,
- The FY 2023-24 interim reconciliations for all DPHs have been updated based on actual payments, and
- The FY 2025-26 interim payments for all DPHs have been updated based on revised data.

The change in FY 2026-27, from the prior estimate, is due to:

- The FY 2017-18 and FY 2018-19 final reconciliations for LA County DPHs have been shifted from FY 2025-26 to FY 2026-27 and updated based on revised data,
- The FY 2005-06 through FY 2017-18 final reconciliations for Non-LA County DPHs have been shifted from FY 2025-26 to FY 2026-27 and updated based on revised data,
- The FY 2019-20 through FY 2021-22 final reconciliations for LA County DPHs have been added,
- The FY 2022-23 final reconciliations for Non-LA County DPHs have been updated based on revised data, and
- The FY 2024-25 interim reconciliations and FY 2026-27 interim payments for all DPHs have been updated based on revised data

The change from FY 2025-26 to FY 2026-27, 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 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.

DPH PHYSICIAN & NON-PHYS. COST

3. The Affordable Care Act (ACA) optional population supplemental payment methodology was approved by CMS on August 17, 2021, and first time ACA payments were issued in FY 2021-22 Quarter 2. ACA payments will be retroactive to January 1, 2014. The ACA allows for enhanced FMAP 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.

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 2025-26	TF	FF	ACA FF	COVID-19 FF
FY 2018-19 Final Reconciliation	($314,000)	($314,000)	$0	$0
FY 2019-20 Final Reconciliation	$3,295,000	$3,093,000	$10,000	$192,000
FY 2020-21 Final Reconciliation	$3,080,000	$1,486,000	$1,410,000	$184,000
FY 2021-22 Final Reconciliation	$334,000	$472,000	($111,000)	($27,000)
FY 2023-24 Interim Reconciliation	$88,330,000	$20,876,000	$67,036,000	$418,000
FY 2025-26 Interim Payment	$86,340,000	$86,340,000	$0	$0
Total	**$181,065,000**	**$111,953,000**	**$68,345,000**	**$767,000**

DPH PHYSICIAN & NON-PHYS. COST

FY 2026-27	TF	FF	ACA FF	COVID-19 FF
FY 2005-06 Final Reconciliation	($2,449,000)	($2,449,000)	$0	$0
FY 2006-07 Final Reconciliation	($2,454,000)	($2,454,000)	$0	$0
FY 2007-08 Final Reconciliation	($13,222,000)	($13,222,000)	$0	$0
FY 2008-09 Final Reconciliation	$6,891,000	$6,891,000	$0	$0
FY 2009-10 Final Reconciliation	($1,933,000)	($1,933,000)	$0	$0
FY 2010-11 Final Reconciliation	($7,277,000)	($7,277,000)	$0	$0
FY 2011-12 Final Reconciliation	($2,815,000)	($2,815,000)	$0	$0
FY 2012-13 Final Reconciliation	$6,588,000	$6,588,000	$0	$0
FY 2013-14 Final Reconciliation	($9,135,000)	($8,789,000)	($346,000)	$0
FY 2014-15 Final Reconciliation	($18,052,000)	($10,710,000)	($7,342,000)	$0
FY 2015-16 Final Reconciliation	($10,936,000)	($8,854,000)	($2,082,000)	$0
FY 2016-17 Final Reconciliation	($6,243,000)	($4,901,000)	($1,342,000)	$0
FY 2017-18 Final Reconciliation	($4,474,000)	($3,706,000)	($768,000)	$0
FY 2018-19 Final Reconciliation	($4,553,000)	($2,438,000)	($2,115,000)	$0
FY 2019-20 Final Reconciliation	($9,615,000)	($7,822,000)	($1,616,000)	($177,000)
FY 2020-21 Final Reconciliation	($5,899,000)	($447,000)	($5,397,000)	($55,000)
FY 2021-22 Final Reconciliation	($6,682,000)	$162,000	($6,864,000)	$20,000
FY 2022-23 Final Reconciliation	$5,735,000	$4,450,000	$1,014,000	$271,000
FY 2024-25 Interim Reconciliation	$83,410,000	$12,713,000	$70,697,000	$0
FY 2026-27 Interim Payment	$88,146,000	$88,146,000	$0	$0
Total	**$85,031,000**	**$41,133,000**	**$43,839,000**	**$59,000**

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

FISCAL REFERENCE NUMBER:1899

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$134,080,000**	**$132,843,000**
FEDERAL FUNDS	$78,347,000	$77,353,000
GENERAL FUND	-$1,388,000	-$1,169,000
OTHER FUNDS	$57,121,000	$56,659,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$134,080,000**	**$132,843,000**
FEDERAL FUNDS	$78,347,000	$77,353,000
GENERAL FUND	-$1,388,000	-$1,169,000
OTHER FUNDS	$57,121,000	$56,659,000

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 inpatient 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,

MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS

the GF will be required to fund the non-federal share of the additional payments up to 72% of the costs.

In order to enable reimbursement for the MLK-LA to reach 100% of the FFS inpatient projected costs, the remaining non-federal share amounts may be transferred by the County of Los Angeles via voluntary intergovernmental transfers (IGTs). Any public funds transferred shall be expended solely for the non-federal share of the supplemental payment. Additionally, the Department shall seek further federal approval to enable MLK-LA to receive Medi-Cal supplemental payments to the extent necessary to meet minimum funding requirements. Further reimbursement exceeding the 100% minimum funding requirement may be sought through additional supplemental programs upon federal approval.

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. Effective July 1, 2025, the $116.8 million total payment represents $108.1 million in supplemental payments and $8.7 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 2025-26, from the prior estimate, is a net decrease due to:

- Updated FY 2024-25 Affordable Care Act (ACA) adjustment to L.A. County based on actual ACA ratio.
- Updated FY 2024-25 interim reconciliation based on actual data.
- Updated FY 2022-23 final reconciliation based on actuals.

The change in FY 2026-27 from the prior estimate, is a slight decrease due to:

- Updated FY 2025-26 ACA adjustment to L.A. County based on updated data.
- Updated FY 2025-26 interim reconciliation based on updated data.
- Updated FY 2023-24 final reconciliation based on updated data.

MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a net decrease 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.

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 2025-26 and FY 2026-27.

5. Expenditures for FY 2025-26 and FY 2026-27 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 2025-26 and FY 2026-27, the supplemental payments and DRG add-on payments are limited by the payment cap of $116.8 million. FY 2025-26 and FY 2026-27 supplemental payments are estimated to be $108.1 million.

8. The ACA allows for enhanced FMAP for newly eligible Medi-Cal members. The ACA claiming methodology for the FFS supplemental payments was approved by CMS in FY 2017-18. 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 2024-25 ACA supplemental payments will be claimed in FY 2025-26. For FY 2025-26, the ACA payment will be claimed in FY 2026-27. 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

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 2025-26 and FY 2026-27 are expected to be:

MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS

(Dollars in Thousands)

FY 2025-26	TF	GF	IGT*	FF	ACA FF	COVID-19 FF	Return to County**
Supplemental FY 2025-26	$108,100	$0	$54,050	$54,050	$0	$0	$0
Supplemental ACA FY 2024-25	$18,824	$0	$0	($23,530)	$42,354	$0	$18,824
Interim Reconciliation FY 2024-25	($3,193)	($1,322)	$0	($1,253)	($618)	$0	$0
Final Reconciliation FY 2022-23	$10,349	($66)	$3,071	$2,891	$4,110	$343	$0
Total	**$134,080**	**($1,388)**	**$57,121**	**$32,158**	**$45,846**	**$343**	**$18,824**

(Dollars in Thousands)

FY 2026-27	TF	GF	IGT*	FF	ACA FF	COVID-19 FF	Return to County**
Supplemental FY 2026-27	$108,100	$0	$54,050	$54,050	$0	$0	$0
Supplemental ACA FY 2025-26	$19,288	$0	$0	($24,110)	$43,398	$0	$19,288
Interim Reconciliation FY 2025-26	($2,844)	($1,168)	$0	($1,104)	($572)	$0	$0
Final Reconciliation FY 2023-24	$8,299	($1)	$2,609	$2,280	$3,365	$46	$0
Total	**$132,843**	**($1,169)**	**$56,659**	**$31,116**	**$46,191**	**$46**	**$19,288**

**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)

FFP FOR LOCAL TRAUMA CENTERS

FISCAL REFERENCE NUMBER:104

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$131,325,000**	**$181,489,000**
FEDERAL FUNDS	$70,997,000	$98,453,000
GENERAL FUND	$0	$0
OTHER FUNDS	$60,328,000	$83,036,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$131,325,000**	**$181,489,000**
FEDERAL FUNDS	$70,997,000	$98,453,000
GENERAL FUND	$0	$0
OTHER FUNDS	$60,328,000	$83,036,000

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.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is due to the:

- FY 2024-25 Affordable Care Act (ACA) adjustment estimate increased based on updated ACA data.

The change in FY 2026-27 from the prior estimate, is due to the:

- FY 2025-26 ACA adjustment estimate increased based on updated ACA data.
- Estimated FY 2025-26 payments are lower due to decreased County IGTs.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to:

- Higher estimated payments and ACA adjustments, from increased County IGTs, are expected to occur in FY 2026-27 as compared to FY 2025-26.

FFP FOR LOCAL TRAUMA CENTERS

Methodology:

1. IGTs are deposited in the Special Deposit Fund (Local Trauma Centers).

2. ACA allows for enhanced Federal Medical Assistance Percentage (FMAP) for newly eligible Medi-Cal members. The ACA methodology was approved by the Centers for Medicare & Medicaid Services in August 2017.

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 2024-25 will be claimed in FY 2025-26 and ACA payments for FY 2025-26 will be claimed in FY 2026-27. The County will be reimbursed for the non-federal share, and an adjustment will be made for the federal share processed at the applicable FMAP.

(Dollars in Thousands)

FY 2025-26	TF	Special Deposit Fund	FF	ACA FF	*Return to Counties
FY 2024-25 ACA Adjustment to Counties	$10,669	$0	($13,337)	$24,006	$10,669
FY 2024-25	$120,656	$60,328	$60,328	$0	$0
Total FY 2025-26	**$131,325**	**$60,328**	**$46,991**	**$24,006**	$10,669

(Dollars in Thousands)

FY 2026-27	TF	Special Deposit Fund	FF	ACA FF	*Return to Counties
FY 2025-26 ACA Adjustment to Counties	$15,417	$0	($19,271)	$34,688	$15,417
FY 2025-26	$166,072	$83,036	$83,036	$0	$0
Total FY 2026-27	**$181,489**	**$83,036**	**$63,765**	**$34,688**	$15,417

*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)

CAPITAL PROJECT DEBT REIMBURSEMENT

FISCAL REFERENCE NUMBER:82

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$81,745,000**	**$79,036,000**
FEDERAL FUNDS	$58,430,000	$55,149,000
GENERAL FUND	$23,315,000	$23,887,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$81,745,000**	**$79,036,000**
FEDERAL FUNDS	$58,430,000	$55,149,000
GENERAL FUND	$23,315,000	$23,887,000
OTHER FUNDS	$0	$0

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, an increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased

CAPITAL PROJECT DEBT REIMBURSEMENT

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 2025-26, from the prior estimate, is due to:
For hospitals (SB 1732):

- Updated interim payment amounts for FY 2024 25 and FY 2025-26 based on more recent data.
- Updated interim reconciliation amounts for FY 2022 23 based on more recent data.
- Updated final reconciliation amounts for FY 1997-98 to FY 2022-23 and FY 1989-90 to FY 2022-23 based on more recent data.

For DP-NFs (SB 1128):

- Updated FY 2024-25 payment amounts based on actuals.

The change in FY 2026-27, from the prior estimate, is due to:
For hospitals (SB 1732):

- Updated interim payment amounts for FY 2025-26 and FY 2026-27 based on more recent data.
- Updated Affordable Care Act Adjustment amounts for FY 2024-25 based on more recent data.
- Updated interim reconciliation amounts for FY 2023-24 based on more recent data.

For DP-NFs (SB 1128):

- Updated FY 2024-25 and FY 2025-26 payment amounts based on more recent data.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to:

- Decreased hospital interim payment expenditures expected to occur in FY 2026-27 due to fewer providers with eligible projects.
- Increased interim reconciliation expenditures expected to occur 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 2023-24.
- Fewer final reconciliations are expected to occur in FY 2026-27 than in FY 2025-26.
- Increased DP-NF interim payments in FY 2026-27.

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 enhanced FMAP for newly eligible Medi-Cal members. The ACA reimbursement methodology was approved by CMS in August 2017.

   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 2023-24 and FY 2024-25 ACA supplemental payments will be claimed in FY 2025-26 and FY 2026-27, respectively. The General Fund (GF) will be reimbursed for the

CAPITAL PROJECT DEBT REIMBURSEMENT

non-federal share, and an adjustment will be made for the federal share processed at the applicable FMAP.

3. For SB 1732, capital projects funded by new debt for which final plans were submitted to the Office of the Statewide Architect and the Office of Statewide Health Planning and Development after September 1, 1988, and prior to June 30, 1994, are eligible for this program.

   Once the debt service for a project is paid in full, the hospital's interim supplemental payments and interim reconciliation will be reconciled using the final MUR data. If during the final reconciliation, it is determined that the eligible hospital has been overpaid, the hospital will repay the Medi-Cal program the overpayment amount. If it is determined that the eligible hospital has been underpaid, the hospital will receive an adjusted supplemental payment amount.

4. The estimated payments on a cash basis are:

FY 2025-26	TF	GF	FF	COVID-19 FF	ARRA	ACA
Hospitals (SB 1732)						
Interim Payment						
FY 2024-25	$37,606,000	$18,803,000	$18,803,000	$0	$0	$0
FY 2025-26	$33,558,000	$16,779,000	$16,779,000	$0	$0	$0
ACA Adjustment						
FY 2023-24	$0	($12,630,000)	($16,150,000)	($289,000)	$0	$29,069,000
Interim Reconciliation						
FY 2022-23	$645,000	($139,000)	($249,000)	$5,000	$0	$1,028,000
Final Reconciliation						
FY 1997-98 to FY 2022-23	$1,260,000	$514,000	$660,000	$88,000	($2,000)	$0
FY 1989-90 to FY 2022-23	($100,000)	($12,000)	($57,000)	$0	($31,000)	$0
DP-NF (SB 1128)						
Interim Payment						
FY 2023-24	$126,000	$0	$126,000	$0	$0	$0
FY 2024-25	$8,650,000	$0	$8,650,000	$0	$0	$0
Total FY 2025-26	**$81,745,000**	**$23,315,000**	**$28,562,000**	**($196,000)**	**($33,000)**	**$30,097,000**

CAPITAL PROJECT DEBT REIMBURSEMENT

FY 2026-27	TF	GF	FF	COVID-19 FF	ACA
Hospitals (SB 1732)					
Interim Payment					
FY 2025-26	$40,220,000	$20,110,000	$20,110,000	$0	$0
FY 2026-27	$27,200,000	$13,600,000	$13,600,000	$0	$0
ACA Adjustment					
FY 2024-25	$0	($10,869,000)	($13,586,000)	$0	$24,455,000
Interim Reconciliation					
FY 2023-24	($1,300,000)	$1,053,000	$1,514,000	$29,000	($3,896,000)
Final Reconciliation					
FY 2023-24	($14,000)	($7,000)	($7,000)	$0	$0
DP-NF (SB 1128)					
Interim Payment					
FY 2024-25	$200,000	$0	$200,000	$0	$0
FY 2025-26	$12,730,000	$0	$12,730,000	$0	$0
Total FY 2026-27	**$79,036,000**	**$23,887,000**	**$34,561,000**	**$29,000**	**$20,559,000**

Funding:
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 (4260-102-0890)
COVID-19 Title XIX Increased FFP (4260-102-0890)

NDPH IGT SUPPLEMENTAL PAYMENTS

FISCAL REFERENCE NUMBER:1600

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$43,685,000**	**$56,001,000**
FEDERAL FUNDS	$24,980,500	$30,321,000
GENERAL FUND	-$1,397,000	-$972,000
OTHER FUNDS	$20,101,500	$26,652,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$43,685,000**	**$56,001,000**
FEDERAL FUNDS	$24,980,500	$30,321,000
GENERAL FUND	-$1,397,000	-$972,000
OTHER FUNDS	$20,101,500	$26,652,000

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). For each fiscal year up to and including FY 2025-26, 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 through FY 2025-26. Amendments were made to Welfare and Institutions (W&I) Code 14165.57(j) to remove the State's authority to retain 9% of each IGT and replace it with a methodology that retains only an amount of each IGT equal to the projected administrative cost of operating the program to reimburse the Department, beginning in FY 2026-27.

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 1 of each State fiscal year.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is due to:
- FY 2024-25 payment finalization decreased based on more recent data.
- FY 2024-25 GF savings transfer for the benefit of Children's Services decreased based on more recent data.

NDPH IGT SUPPLEMENTAL PAYMENTS

- FY 2025-26 interim payments updated based on more recent data.

The change in FY 2026-27 from the prior estimate, is due to:

- FY 2025-26 GF savings transfer for the benefit of Children's Services decreased slightly based on more recent data.
- FY 2025-26 ACA adjustments updated based on more recent data.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to:

- ACA adjustments expected to occur in FY 2026-27 whereas a payment finalization will occur in FY 2025-26. The payment finalization is anticipated to have a higher expenditure due to interim payments being reconciled to the approved UPL, which is anticipated to result in additional payments.
- Higher interim payments in FY 2026-27 compared to FY 2025-26 due to higher anticipated UPL room.
- Lower FY 2025-26 Children's Services GF transfer occurring in FY 2026-27.

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. Amendments to W&I Code 14165.57(j) replaced the State's authority to retain 9% of each IGT with a methodology that retains only an amount of each IGT equal to the projected administrative cost of operating the program to reimburse the Department beginning in FY 2026-27.

2. The FY 2024-25 UPL will be submitted to CMS in FY 2025-26 Q3 and the FY 2025-26 UPL will be subsequently submitted.

3. FY 2024-25 interim supplemental payments were processed using 80% of the approved UPL room from FY 2023-24, which was the last approved UPL at the date of payment. Payment finalizations for FY 2024-25 will occur in FY 2025-26. FY 2025-26 and FY 2026-27 interim payment estimates assume the respective fiscal year's UPL will be approved prior to interim supplemental payments being processed. For this estimate, FY 2024-25 payment finalizations utilized the tentative FY 2024-25 UPL room and FY 2025-26 ACA adjustments, FY 2025-26 interim payments, and FY 2026-27 interim payments utilized the approved FY 2023-24 UPL room.

4. The ACA allows for enhanced FMAP for newly eligible Medi-Cal members. The ACA methodology was approved by CMS in August 2017.

   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 2024-25 ACA supplemental payments will be claimed in FY 2025-26, and FY 2025-26 ACA supplemental payments will be claimed in FY 2026-27. An adjustment will be made for the federal share processed at the applicable FMAP and the nonfederal share of the adjusted amount will be reimbursed to the NDPHs.

5. FY 2024-25 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 room and processed in FY 2025-26. FY 2025-26 Children's Services payments will be processed based on the approved FY 2025-26 UPL in FY 2026-27.

NDPH IGT SUPPLEMENTAL PAYMENTS

6. The estimated NDPH IGT supplemental payments are:

(Dollars in Thousands)

FY 2025-26	TF	GF	IGT	FF	ACA
FY 2024-25 Payment Finalization	$9,824	$0	$1,596	($5,073)	$13,301
FY 2024-25 Children's Services (Est.)	$356	($1,397)	$1,753	$0	$0
FY 2025-26 Interim Payments*	$33,505	$0	$16,753	$16,752	$0
Total FY 2025-26	**$43,685**	**($1,397)**	**$20,102**	**$11,679**	**$13,301**

(Dollars in Thousands)

FY 2026-27	TF	GF	IGT	FF	ACA	Return to NDPHs
FY 2025-26 ACA Adjustments	$4,641	$0	$0	($5,801)	$10,442	$4,641
FY 2025-26 Children's Services (Est.)	$0	($972)	$972	$0	$0	$0
FY 2026-27 Interim Payments	$51,360	$0	$25,680	$25,680	$0	$0
Total FY 2026-27	**$56,001**	**($972)**	**$26,652**	**$19,879**	**$10,442**	$4,641

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

FISCAL REFERENCE NUMBER:2049

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$765,052,000**	**$82,091,000**
FEDERAL FUNDS	$477,320,000	$51,303,950
GENERAL FUND	$287,732,000	$30,787,050
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	94.2700%	95.4500%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$43,837,500**	**$3,735,100**
FEDERAL FUNDS	$27,350,440	$2,334,330
GENERAL FUND	$16,487,040	$1,400,810
OTHER FUNDS	$0	$0

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

Reason for Change:
The change from the prior estimate, for FY 2025-26 and FY 2026-27, is a decrease due to updated check write projections. The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease due to the Proposition 56 supplemental payments concluding at the end of FY 2025-26.

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. Dental Managed Care withholds resumed in February 2026 and are projected to be released in July of the following fiscal year.

5. Proposition 56 payments for this program will end June 30, 2026. Costs budgeted in FY 2026-27 are payments for services rendered in FY 2025-26. The final withhold payment for Dental Managed Care is scheduled for July 2027.

6. Funds allocated for the supplemental payments are as follows:

FY 2025-26	TF	SF	FF
Fee-for-Service			
50% Title XIX / 50% GF	$440,316,000	$220,158,000	$220,158,000
ACA 90% FFP/10% GF	$206,829,000	$20,683,000	$186,146,000
Title 21 65% FFP/35% GF	$73,748,000	$25,812,000	$47,936,000
UIS 100% State GF	$304,000	$304,000	$0
Total Fee-for-Service	**$721,197,000**	**$266,957,000**	**$454,240,000**
FY 2025-26	**TF**	**SF**	**FF**
Dental Managed Care			
50% Title XIX / 50% GF	$22,669,000	$11,335,000	$11,335,000
ACA 90% FFP/10% GF	$11,351,000	$1,135,000	$10,216,000
Title 21 65% FFP/35% GF	$2,354,000	$823,000	$1,530,000
UIS 100% State GF	$7,481,000	$7,481,000	$0
Total Dental Managed Care	**$43,855,000**	**$20,774,000**	**$23,081,000**

PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS

Combined FY 2025-26			
50% Title XIX / 50% GF	$462,986,000	$231,493,000	$231,493,000
ACA 90% FFP/10% GF	$218,180,000	$21,818,000	$196,362,000
Title 21 65% FFP/35% GF	$76,100,000	$26,635,000	$49,465,000
UIS 100% State GF	$7,786,000	$7,786,000	$0
Grand Total	**$765,052,000**	**$287,732,000**	**$477,320,000**

FY 2026-27	**TF**	**SF**	**FF**
Fee-for-Service			
50% Title XIX / 50% GF	$47,839,000	$23,920,000	$23,920,000
ACA 90% FFP/10% GF	$22,471,000	$2,247,000	$20,224,000
Title 21 65% FFP/35% GF	$8,013,000	$2,804,000	$5,208,000
UIS 100% State GF	$33,000	$33,000	$0
Total Fee-for-Service	**$78,356,000**	**$29,004,000**	**$49,352,000**
Dental Managed Care			
50% Title XIX / 50% GF	$1,917,000	$959,000	$959,000
ACA 90% FFP/10% GF	$960,000	$96,000	$864,000
Title 21 65% FFP/35% GF	$199,000	$70,000	$129,000
UIS 100% State GF	$658,000	$658,000	$0
Total Dental Managed Care	**$3,735,000**	**$1,783,000**	**$1,952,000**
Combined FY 2026-27			
50% Title XIX / 50% GF	$49,756,000	$24,878,000	$24,878,000
ACA 90% FFP/10% GF	$23,432,000	$2,343,000	$21,089,000
Title 21 65% FFP/35% GF	$8,211,000	$2,874,000	$5,337,000
UIS 100% State GF	$692,000	$692,000	$0
Grand Total	**$82,091,000**	**$30,787,000**	**$51,304,000**

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)

NDPH SUPPLEMENTAL PAYMENT

FISCAL REFERENCE NUMBER:1076

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$18,234,000**	**$2,320,000**
FEDERAL FUNDS	$9,306,000	$2,320,000
GENERAL FUND	$1,900,000	$0
OTHER FUNDS	$7,028,000	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$18,234,000**	**$2,320,000**
FEDERAL FUNDS	$9,306,000	$2,320,000
GENERAL FUND	$1,900,000	$0
OTHER FUNDS	$7,028,000	$0

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) 25-0011

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 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 2024-25. The most recent SPA 25-0011 to extend the NDPH Supplemental Fund Program through FY 2025-26 was submitted to CMS for approval in June 2025. The SPA proposes that carryover funds be matched with federal financial participation (FFP) and distributed to NDPHs in FY 2025-26. The SPA also proposes to restructure the payment methodology with expanded eligibility criteria for FY 2025-26 and sunset the NDPH Supplemental Fund Program as of June 30, 2026. However, close-out activities such as Affordable Care Act (ACA) adjustments will continue through FY 2026-27.

NDPH SUPPLEMENTAL PAYMENT

Reason for Change:
The change in FY 2025-26, from the prior estimate, is an increase due to:
- FY 2024-25 ACA adjustments increased based on more recent ACA data.

The change in FY 2026-27 from the prior estimate, is an increase due to:
- FY 2025-26 ACA adjustments increased based on more recent ACA data.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a net decrease due to:
- Increased expenditures occurring in FY 2025-26 compared to FY 2026-27 due to the distribution of retroactive carryover funds occurring in FY 2025-26, and no cash expenditures to hospitals occurring in FY 2026-27 due to program sunsetting on June 30, 2026.

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.

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. In addition, the FY 2025-26 non-federal share will be adjusted to distribute carryover funds due the enhanced federal funds provided by the Families First Coronavirus Response Act and ACA. SPA 25-011 proposes a methodology to match carryover funds with FFP and distribute to NDPHs in FY 2025-26. The SPA also proposes to sunset the NDPH Supplemental Fund program at the end of FY 2025-26.

3. The ACA allows for enhanced FMAP for newly eligible Medi-Cal beneficiaries. The ACA reimbursement methodology to draw the enhanced FMAP was approved by CMS in August 2017. 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 2024-25 ACA adjustment will be claimed in FY 2025-26, and the FY 2025-26 ACA adjustment will be claimed in FY 2026-27.

4. The ending balance shown is on a cash basis and does not necessarily mean that the remaining funds are available. The program sunsets on June 30, 2026, therefore, any remaining money in the fund will be subsequently transferred to the General Fund.

5. The estimated NDPH Supplemental payments and ending balance for FY 2025-26 are shown below:

NDPH SUPPLEMENTAL PAYMENT

FY 2025-26 NDPH Supplemental Fund Summary	SF
FY 2024-25 Ending Balance	$9,010,000
Appropriation (GF)	$1,900,000
Est. FY 2024-25 Interest Earned	$376,000
Funds Available	$11,286,000
Less: FY 2025-26 Cash Expenditures to Hospitals	($8,928,000)
Est. FY 2025-26 Remaining Balance	$2,359,000

FY 2025-26	TF	SF**	FF	ACA FF***	Return to SF*
FY 2025-26 Cash Expenditures to Hospitals**	$17,856,000	$8,928,000	$8,928,000	$0	$0
FY 2024-25 ACA FF Adjustment to Special Fund	$378,000	$0	($473,000)	$851,000	$378,000
Total	**$18,234,000**	**$8,928,000**	**$8,455,000**	**$851,000**	$378,000

6. The estimated NDPH Supplemental payments and ending balance for FY 2026-27 are shown below:

FY 2026-27 NDPH Supplemental Fund Summary	SF
FY 2025-26 Ending Balance	$2,359,000
Appropriation (GF)	$0
Est. FY 2025-26 Interest Earned	$0
Funds Available	$2,359,000
Less: FY 2026-27 Cash Expenditures to Hospitals	$0
Est. FY 2026-27 Remaining Balance	$2,359,000

FY 2026-27	TF	SF	FF	ACA FF	Return to SF*
FY 2025-26 ACA FF Adjustment to Special Fund	$2,320,000	$0	($2,901,000)	$5,221,000	$2,320,000
Total	**$2,320,000**	**$0**	**($2,901,000)**	**$5,221,000**	$2,320,000

NDPH SUPPLEMENTAL PAYMENT

*The Return to SF column is for display purposes only (see Methodology #3).

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)**

STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

FISCAL REFERENCE NUMBER:1616

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$15,425,000**	**$13,267,000**
FEDERAL FUNDS	$15,425,000	$13,267,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$15,425,000**	**$13,267,000**
FEDERAL FUNDS	$15,425,000	$13,267,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is due to:
- Updated FY 2025-26 interim payments based on actual FY 2025-26 Q1 and Q2 payments and updated data.
- Updated FY 2024-25 initial reconciliation amounts based on updated data.

STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

- Updated FY 2021-22 final reconciliation amounts based on updated data.

The change in FY 2026-27, from the prior estimate, is due to:
- Updated FY 2026-27 interim payments based on updated data.
- Updated FY 2025-26 initial reconciliation based on updated data.
- Updated FY 2022-23 final reconciliation based on updated data.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to:
- Increased interim payments are estimated to occur in FY 2026-27.
- Lower initial reconciliations are estimated to occur in FY 2026-27.
- Lower final reconciliation overpayments are estimated to occur in FY 2026-27.

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) Affordable Care Act (ACA) payments occur during initial reconciliations using as filed cost report data to calculate payments. The ACA allows for enhanced FMAP for newly eligible Medi-Cal members.
3. A final reconciliation payment, if necessary.

Program payment amounts are estimated to be:

FY 2025-26	TF	Regular FF	ACA FF	COVID-19 FF
Interim Payments				
FY 2025-26	$13,243,000	$13,243,000	$0	$0
Initial Reconciliation				
FY 2024-25	$4,467,000	$4,080,000	$387,000	$0
Final Reconciliation				
FY 2021-22	($2,285,000)	($1,975,000)	($65,000)	($245,000)
FY 2025-26 Total	**$15,425,000**	**$15,348,000**	**$322,000**	**($245,000)**

FY 2026-27	TF	Regular FF	ACA FF	COVID-19 FF
Interim Payments				
FY 2026-27	$13,787,000	$13,787,000	$0	$0
Initial Reconciliation				
FY 2025-26	$1,761,000	$1,204,000	$557,000	$0
Final Reconciliation				
FY 2022-23	($2,281,000)	($1,947,000)	($104,000)	($230,000)
FY 2026-27 Total	**$13,267,000**	**$13,044,000**	**$453,000**	**($230,000)**

STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

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

FISCAL REFERENCE NUMBER:1038

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$10,000,000**	**$10,000,000**
FEDERAL FUNDS	$5,000,000	$5,000,000
GENERAL FUND	$5,000,000	$5,000,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$10,000,000**	**$10,000,000**
FEDERAL FUNDS	$5,000,000	$5,000,000
GENERAL FUND	$5,000,000	$5,000,000
OTHER FUNDS	$0	$0

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 2025-26 from the prior estimate.

There is no change in FY 2026-27 from the prior estimate.

There is no change from FY 2025-26 to FY 2026-27 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

(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**

(Dollars in Thousands)

FY 2026-27	TF	GF	FF
CY 2026	$7,500	$3,750	$3,750
CY 2027	$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

FISCAL REFERENCE NUMBER:1039

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$8,000,000**	**$8,000,000**
FEDERAL FUNDS	$4,000,000	$4,000,000
GENERAL FUND	$4,000,000	$4,000,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$8,000,000**	**$8,000,000**
FEDERAL FUNDS	$4,000,000	$4,000,000
GENERAL FUND	$4,000,000	$4,000,000
OTHER FUNDS	$0	$0

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 2025-26 from the prior estimate.

There is no change in FY 2026-27 from the prior estimate.

There is no change from FY 2025-26 to FY 2026-27 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

(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**

(Dollars in Thousands)

FY 2026-27	TF	GF	FF
CY 2026	$6,000	$3,000	$3,000
CY 2027	$2,000	$1,000	$1,000
Total	**$8,000**	**$4,000**	**$4,000**

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

CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS

FISCAL REFERENCE NUMBER:86

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$7,087,000**	**$3,113,000**
FEDERAL FUNDS	$7,087,000	$3,113,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$7,087,000**	**$3,113,000**
FEDERAL FUNDS	$7,087,000	$3,113,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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 general

CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS

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 2025-26, from the prior estimate, is due to:

- CY 2025 interim payments revised based on updated estimates,
- CY 2024 interim payments revised based on actuals,
- CY 2024 interim reconciliation payments revised based on updated data and actuals,
- RY 2019-20 final reconciliation payments revised based on actuals,
- 2023 Bridge Period Interim reconciliation payments revised based on actuals,
- 2023 Bridge Period interim payments revised based on actuals,
- RY 2020-21 final reconciliation payments revised based on actuals, and
- RY 2022-23 interim payments added based on actuals.

The change in FY 2026-27, from the prior estimate, is due to:

- CY 2024 interim reconciliation payments revised based on updated estimates,
- CY 2025 interim reconciliation payments revised based on updated estimates,
- CY 2025 interim payments revised based on updated estimates,
- CY 2026 interim payments revised based on updated estimates, and
- RY 2021-22 final reconciliation payments revised based on updated estimates.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to:

- Decreased expenditures expected to occur in FY 2026-27 compared to FY 2025-26 due to lower interim payments and interim reconciliations.

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 enhanced FMAP for newly eligible Medi-Cal members. The ACA reimbursement methodology under this program was approved by CMS in August 2017.

   Assume interim ACA payments for RY 2022-23, 2023 Bridge Period, CY 2024, and CY 2025 will occur in FY 2025-26 and payments for CY 2024, CY 2025 and CY 2026 will occur in FY 2026-27.

CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS

4. Assume interim traditional payments for RY 2022-23, 2023 Bridge Period, CY 2024, and CY 2025 will occur in FY 2025-26 and payments for CY 2024, CY 2025 and 2026 will occur in FY 2026-27.

FY 2025-26	TF	Regular FFP	ACA FF	COVID-19 FF
CY 2025 Interim Payments	$2,212,000	$1,627,000	$585,000	$0
CY 2024 Interim Payments Q1 & Q2	$429,000	$197,000	$232,000	$0
2023 Bridge Period Interim Reconciliation	$4,832,000	$4,639,000	$25,000	$178,000
RY 2020-21 Final Reconciliation	($2,336,000)	($1,501,000)	($649,000)	($186,000)
CY 2024 Interim Reconciliation Q1 & Q2	$245,000	$245,000	$0	$0
RY 2019-20 Final Reconciliation	$933,000	$628,000	$159,000	$146,000
2023 Bridge Period Interim Payments	$625,000	$347,000	$265,000	$13,000
RY 2022-23 Interim Payments	$147,000	$80,000	$63,000	$4,000
Total	**$7,087,000**	**$6,262,000**	**$670,000**	**$155,000**

FY 2026-27	TF	Regular FFP	ACA FF	COVID-19 FF
CY 2025 Interim Payments	$121,000	$105,000	$16,000	$0
CY 2026 Interim Payments	$2,184,000	$1,607,000	$577,000	$0
CY 2024 Interim Payments	$208,000	$178,000	$30,000	$0
CY 2024 Interim Reconciliation Q3 & Q4	$1,124,000	$958,000	$166,000	$0
CY 2025 Interim Reconciliation Q1 & Q2	$709,000	$626,000	$83,000	$0
RY 2021-22 Final Reconciliation	($1,233,000)	($816,000)	($392,000)	($25,000)
Total	**$3,113,000**	**$2,658,000**	**$480,000**	**($25,000)**

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)

PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS

FISCAL REFERENCE NUMBER:2044

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$6,226,000**	**$6,954,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$6,226,000	$6,954,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$6,226,000**	**$6,954,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$6,226,000	$6,954,000
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the expenditures related to supplemental payments for medical pregnancy termination services and for the Evaluation and Management (E&M) portion of office visits under the Family Planning, Access, Care, Treatment (Family PACT) program.

Authority:
Proposition 56 (2016)
SPA 17-029
SPA 18-0031
SPA 19-0040
SPA 21-0033

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 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

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.

Enacted on July 4, 2025, House Resolution 1 (H.R. 1) (Public Law No. 119-21), Section 71113 “Federal Payments to Prohibited Entities,” prohibits the use of federal Medicaid funds for payments to a prohibited entity during a one-year period beginning on July 4, 2025. Litigation is ongoing, but H.R. 1 Section 71113 is currently in effect.

For medical pregnancy terminations in the Medi-Cal managed care delivery system, the Department requires managed care plans, or their delegated entities and subcontractors, to pay providers at least $400 for CPT-4 code 59840 and $700 for CPT-4 code 59841. In the FFS delivery system, the supplemental payment amount is $149.15 and $345.57 for CPT-4 codes 59840 and 59841 respectively. These FFS supplemental payments are in addition to the base payment level.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is an increase in managed care expenditures due to updated Calendar Year (CY) 2026 rates. The change in FY 2026-27, from the prior estimates, is an increase in managed care expenditures due to higher rates for CY 2026 and higher projected rates for CY 2027. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase in managed care expenditures due to higher rates for CY 2026 and higher projected rates for CY 2027.

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. Assume the combined costs for FY 2025-26 and FY 2026-26 are:

Fiscal Years	TF	GF	FF
FY 2025-26	$53,199,000	$22,819,000	$30,380,000
FY 2026-27	$53,618,000	$23,529,000	$30,089,000

4. FFS expenditures are display only and are captured in the FFS base. FFS expenditures for FY 2025-26 and FY 2026-27 are estimated to be:

PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS

FY 2025-26	TF	GF	FF
E&M Office Visits	$45,658,000	$15,278,000	$30,380,000
Medical Pregnancy Termination	$1,315,000	$1,315,000	$0
Total	$46,973,000	$16,593,000	$30,380,000
FY 2026-27	**TF**	**GF**	**FF**
E&M Office Visits	$45,220,000	$15,131,000	$30,089,000
Medical Pregnancy Termination	$1,444,000	$1,444,000	$0
Total	$46,664,000	$16,575,000	$30,089,000

5. MC expenditures for FY 2025-26 and FY 2026-27 are estimated to be:

FY 2025-26	TF	GF	FF
E&M Office Visits	$0	$0	$0
Medical Pregnancy Termination	$6,226,000	$6,226,000	$0
Total	**$6,226,000**	**$6,226,000**	**$0**
FY 2026-27	**TF**	**GF**	**FF**
E&M Office Visits	$0	$0	$0
Medical Pregnancy Termination	$6,954,000	$6,954,000	$0
Total	**$6,954,000**	**$6,954,000**	**$0**

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

FREE CLINICS AUGMENTATION

FISCAL REFERENCE NUMBER:2303

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$2,000,000**	**$2,000,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$2,000,000	$2,000,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$2,000,000**	**$2,000,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$2,000,000	$2,000,000
OTHER 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 2025-26 or FY 2026-27 from the prior estimate.

There is no change from FY 2025-26 to FY 2026-27 in the current estimate.

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 2025-26	$2,000	$2,000
FY 2026-27	$2,000	$2,000

FREE CLINICS AUGMENTATION

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

PROPOSITION 56 FUNDING

FISCAL REFERENCE NUMBER:2102

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$473,209,000	-$461,274,000
OTHER FUNDS	$473,209,000	$461,274,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$473,209,000	-$461,274,000
OTHER FUNDS	$473,209,000	$461,274,000

Purpose:
This policy change replaces General Fund expenditures for base rate increases for physician services with Proposition 56 funds and for specified supplemental payments, to the extent there is sufficient Proposition 56 revenue.

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), the Department increased base rates for physician services to incorporate amounts equivalent to the Prop 56 physician services supplemental payments effective for dates of services beginning January 1, 2024. These increased base payment levels exceed those in effect as of January 1, 2016.

The Budget Act of 2025 eliminated Dental supplemental payments effective July 1, 2026.

Reason for Change:
The change in FY 2025-26 and FY 2026-27, from the prior estimate, is due to updated expenditure projections for Prop 56 payments.

PROPOSITION 56 FUNDING

The change from FY 2025-26 to FY 2026-27, 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 2026-27.

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 and the rates for physician services are budgeted in the base policy changes. Subsequently, this policy change replaces the General Fund with Healthcare Treatment Fund for those rates and payments budgeted to be supported by Prop 56. In 2025-26, Prop 56 revenues are projected to be $473,209,000. This amount 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. The General Fund amount not paid by Prop 56 revenues is projected to total $136,149,000 in FY 2025-26.

FY 2025-26	Total Funds	General Fund	Proposition 56
PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS	$287,732,000	$287,732,000	$0
PROP 56 - MEDI-CAL FAMILY PLANNING	$149,724,000	$149,724,000	$0
PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	$22,819,000	$22,819,000	$0
Total of GF Dollars in Prop 56 PCs	$460,275,000	$460,275,000	$0
Prop 56 Funding Available for Physician Services Base Rate Increases	**$0**	**($473,209,000)**	**$473,209,000**
Totals	**$0**	**($473,209,000)**	**$473,209,000**

PROPOSITION 56 FUNDING

2. In 2026-27, Prop 56 revenues are projected to be $461,274,000. This amount 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. The General Fund amount not paid by Prop 56 revenues is projected to total $133,995,000 in FY 2026-27.

FY 2026-27	Total Funds	General Fund	Proposition 56
PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS	$30,787,000	$30,787,000	$0
PROP 56 - MEDI-CAL FAMILY PLANNING	$134,457,000	$134,457,000	$0
PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	$23,529,000	$23,529,000	$0
Total of GF Dollars in Prop 56 PCs	$188,773,000	$188,773,000	$0
Prop 56 Funding Available for Physician Services Base Rate Increases	**$0**	**($461,274,000)**	**$461,274,000**
Totals	**$0**	**($461,274,000)**	**$461,274,000**

Funding:
Healthcare Treatment Fund (4260-101-3305)
100% Title XIX GF (4260-101-0001)
100% Title XXI GF (4260-101-0001)

IGT ADMIN. & PROCESSING FEE

FISCAL REFERENCE NUMBER:1601

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$21,515,000	-$26,073,000
OTHER FUNDS	$21,515,000	$26,073,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$21,515,000	-$26,073,000
OTHER FUNDS	$21,515,000	$26,073,000

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 2025-26, from the prior estimate, is due to:

- Revised FY 2024-25 Support Costs and Reimbursement to the GF based on actuals.

The change in FY 2026-27 from the prior estimate, is due to:

- Revised FY 2025-26 Support Costs and Reimbursement to the GF based on more recent data.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to:

IGT ADMIN. & PROCESSING FEE

- Higher support costs in FY 2026-27 due to anticipated increases in annual merit salary adjustments and statewide salary increases.
- Higher interim payment and final settlement amounts are subject to the fee in FY 2026-27 due to higher direct and indirect graduate medical costs.

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 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	$163,000	$14,788,000
FY 2024-25 Final Settlement	$134,539,000	$6,727,000	$0	$6,727,000
Total	$433,561,000	$21,678,000	$163,000	$21,515,000

FY 2026-27	IGT Subject to the Fee	5% Admin Fee	Support Costs	Reimbursement to GF
FY 2025-26 Interim Payment	$362,020,000	$18,101,000	$179,000	$17,922,000
FY 2025-26 Final Settlement	$163,016,000	$8,151,000	$0	$8,151,000
Total	$525,036,000	$26,252,000	$179,000	$26,073,000

Fiscal Year	TF	GF	GME Special Fund Transfer
FY 2025-26	**$0**	**($21,515,000)**	**$21,515,000**
FY 2026-27	**$0**	**($26,073,000)**	**$26,073,000**

IGT ADMIN. & PROCESSING FEE

Funding:
100% State GF (4260-101-0001)
DPH Graduate Medical Education Special Fund (4260-601-8113)

GEMT SUPPLEMENTAL PAYMENT PROGRAM

FISCAL REFERENCE NUMBER:1661

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**-$9,594,000**	**-$1,632,000**
FEDERAL FUNDS	-$9,594,000	-$1,632,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**-$9,594,000**	**-$1,632,000**
FEDERAL FUNDS	-$9,594,000	-$1,632,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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

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 2025-26, from the prior estimate, is due to:

- FY 2018-19 through FY 2022-23 final reconciliations revised based on actuals and updated estimates.

The change in FY 2026-27, from the prior estimate, is due to:

- Addition of FY 2021-22 final reconciliations due to audited cost report appeals.
- FY 2022-23 final reconciliations revised based on updated data.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to:

- Higher recoupment values for final reconciliations are scheduled to occur in FY 2025-26 in comparison to FY 2026-27.

Methodology:

1. The Affordable Care Act (ACA) allows for enhanced FMAP for newly eligible Medi-Cal members. The ACA reimbursement methodology was approved by CMS in August 2017.

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 supplemental reimbursements sunset on December 31, 2022.

4. 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. All remaining cost report audits and final reconciliations are expected to be completed within FY's 2025-26 and 2026-27.

The estimated payments on a cash basis are:

GEMT SUPPLEMENTAL PAYMENT PROGRAM

FY 2025-26	Total FFP	Regular FFP	ACA	COVID-19 FF
FY 2018-19 Final Recon.	($1,980,000)	($635,000)	($1,345,000)	$0
FY 2019-20 Final Recon.	($2,484,000)	($848,000)	($1,587,000)	($49,000)
FY 2020-21 Final Recon.	($2,119,000)	($752,000)	($1,274,000)	($93,000)
FY 2021-22 Final Recon.	($2,446,000)	($731,000)	($1,624,000)	($91,000)
FY 2022-23 Final Recon.	($565,000)	($161,000)	($384,000)	($20,000)
Total FY 2025-26	**($9,594,000)**	**($3,127,000)**	**($6,214,000)**	**($253,000)**

FY 2026-27	Total FFP	Regular FFP	ACA	COVID-19 FF
FY 2021-22 Final Recon.	($1,067,000)	($331,000)	($695,000)	($41,000)
FY 2022-23 Final Recon.	($565,000)	($161,000)	($384,000)	($20,000)
Total FY 2026-27	**($1,632,000)**	**($492,000)**	**($1,079,000)**	**($61,000)**

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 VACCINE FUNDING ADJUSTMENT

FISCAL REFERENCE NUMBER:2363

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$11,893,000	$0
GENERAL FUND	-$11,893,000	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$11,893,000	$0
GENERAL FUND	-$11,893,000	$0
OTHER FUNDS	$0	$0

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:
Not Applicable

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

Reason for Change:
There is no change in FY 2025-26 and FY 2026-27 from the prior estimate.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to the completion of the funding adjustment in FY 2025-26.

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 October 2023 to September 2024 quarters are made in FY 2025-26.

3. The funding adjustments are completed in FY 2025-26.

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
October 2023 – September 2024	$0	($11,893)	$11,893
Total	**$0**	**($11,893)**	**$11,893**

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

COVID-19 END OF UNWINDING FLEXIBILITIES

FISCAL REFERENCE NUMBER:2218

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**-$1,437,539,000**	**-$3,788,312,000**
FEDERAL FUNDS	-$984,414,700	-$2,544,975,400
GENERAL FUND	-$453,124,300	-$1,243,336,600
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	86.7400%	53.6100%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**-$190,617,700**	**-$1,757,397,900**
FEDERAL FUNDS	-$130,533,390	-$1,180,614,090
GENERAL FUND	-$60,084,280	-$576,783,850
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the impact of ending COVID-19 public health emergency (PHE) unwinding flexibilities.

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 END OF UNWINDING FLEXIBILITIES

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 course of 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 were new policy solutions that helped DHCS streamline renewals and ease the burden on Medi-Cal members and counties as Medi-Cal members were redetermined within 12 months. Specifically, two of the 17 federal waivers are income-related waivers, known as zero income waivers and 100 percent federal poverty level (FPL) waiver, that have yielded significant retention in Medi-Cal caseload through the auto-renewal, or ex parte process. An additional waiver, called the stable income waiver, also contributed to coverage retention for Medi-Cal members in the Seniors, and Persons with Disabilities coverage groups. Per federal guidance released in May 2024, the federal waivers are available through June 30, 2025.

Reason for Change:

The change for FY 2025-26 and FY 2026-27 from the prior estimate, before the application of Percent Reflected In Base, is due to six additional months of actual data.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to the ramp up of disenrollments continuing as a result of the ending of flexibilities June 30, 2025.

Methodology:

1. 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 levels consistent with prior to the pandemic 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:

COVID-19 END OF UNWINDING FLEXIBILITIES

	FY 2025-26		FY 2026-27	
Aid Category Group	**Member Months**	**Average Cost Per Member Per Month**	**Member Months**	**Average Cost Per Member Per Month**
Newly (ACA Expansion)	-1,678,000	$627	-3,543,600	$652
Families and Children	-860,800	$348	-2,032,900	$361
Seniors	-326,600	$1,059	-807,600	$1,104
Total	**-2,865,500**	$592	**-6,384,000**	$617

2. After accounting for payment lags, the impact of unwinding flexibilities ending June 30, 2025, is shown below. This impact is highly uncertain.

(Dollars in Thousands)

Fiscal Year	**TF**	**GF**	**FF**
FY 2025-26	-$1,437,539	-$453,124	-$984,415
FY 2026-27	-$3,788,312	-$1,243,337	-$2,544,975

Funding:

(Dollars in Thousands)

FY 2025-26	**TF**	**GF**	**FF**
50% Title XIX / 50% GF (4260-101-0001 / 0890)	-$468,002	-$224,001	-$234,001
90% Title XIX / 10% GF (4260-101-0001 / 0890)	-$833,793	-$83,379	-$750,414
65% Title XXI / 35% GF (4260-101-0001 / 0890)	$0	$0	$0
100% State General Fund	-$135,744	-$135,744	$0
Total	**-$1,437,539**	**-$453,124**	**-$984,415**

FY 2026-27	**TF**	**GF**	**FF**
50% Title XIX / 50% GF (4260-101-0001 / 0890)	-$1,336,580	-$668,290	-$668,290
90% Title XIX / 10% GF (4260-101-0001 / 0890)	-$2,085,206	-$208,521	-$1,876,685
65% Title XXI / 35% GF (4260-101-0001 / 0890)	$0	$0	$0
100% State General Fund	-$366,526	-$366,526	$0
Total	**-$3,788,312**	**-$1,243,337**	**-$2,544,975**

STATE-ONLY CLAIMING ADJUSTMENTS - RETRO ADJ.

FISCAL REFERENCE NUMBER:2415

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	-$686,577,000	-$113,311,000
GENERAL FUND	$686,577,000	-$275,950,000
OTHER FUNDS	$0	$389,261,000
% REFLECTED IN BASE	52.4300%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	-$326,604,680	-$113,311,000
GENERAL FUND	$326,604,680	-$275,950,000
OTHER FUNDS	$0	$389,261,000

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.

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 estimated the FFP amounts subject to repayment that must be retroactively returned and updates to associated claiming methodologies for prospective use.

STATE-ONLY CLAIMING ADJUSTMENTS - RETRO ADJ.

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 2025-26, from the prior estimate, is due to:

- Pharmacy rebate repayments for periods from July 2020 through December 2021 were completed and updated to actual amounts.
- The mass adjustment for the estimated pharmacy claims for individuals with a blank immigration status indicator were updated based on actuals and completed in the Medi-Cal Rx checkwrite in the first quarter of Calendar Year 2026. The cost of the pharmacy blank indicator repayments are now fully captured in the fee-for-service (FFS) Base and are display only in this policy change in this Estimate.
- FFS supplemental payment amounts were updated to include additional quarters of adjustments.
- The FFS supplemental payment repayments will be paid using the General Fund (GF) in FY 2025-26 and program recoupments have been delayed to occur in FY 2026-27.

The change in FY 2026-27, from the prior estimate, is due to:

- Additional FFS supplemental payment adjustments paid using the GF are estimated in FY 2026-27.
- Program recoupments to repay the GF for FFS supplemental payments will occur in FY 2026-27.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to:

- Pharmacy rebate impacts are estimated to be lower in FY 2026-27.
- FFS supplemental payment program recoupments will repay the GF in FY 2026-27.

Methodology:

1. Estimated FFP repayments for Pharmacy Rebates in FY 2025-26 cover claims from July 2020 through December 2021 and repayments in FY 2025-26 cover claims from January 2022 through December 2021.

2. Repayments in FY 2025-26 related to pharmacy claims are for members with a missing immigration status indicator. This amount increased relative to the previous estimate to incorporate better data that became available after systems were updated to claim correctly.

3. Repayments of Federal Funds for FFS supplemental payment programs are estimated to be paid using General Fund in FY 2025-26 and FY 2026-27. The total repayment amount and state costs will be subject to change pending ongoing review and adjustment to claiming processes as well as the availability of various non-federal share sources for the repayments. Program recoupments to repay the General Fund will occur in FY 2026-27.

STATE-ONLY CLAIMING ADJUSTMENTS - RETRO ADJ.

4. The estimated net retroactive adjustments are:

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
Pharmacy rebates	$0	$28,484	($28,484)
Pharmacy claims (blank indicator) (In FFS Base)	$0	$360,000	($360,000)
FFS Supplemental Payments	$0	$298,093	($298,093)
Total	**$0**	**$686,577**	**($686,577)**

(Dollars in Thousands)

FY 2026-27	TF	GF	SF	IGT	Reimbursement	FF
Pharmacy rebates	$0	$1,888	$0	$0	$0	($1,888)
FFS Supplemental Payments	$0	($277,838)	$42,726	$137,844	$208,691	($111,423)
Total	**$0**	**($275,950)**	**$42,726**	**$137,844**	**$208,691**	**($113,311)**

Funding:
100% GF (4260-101-0001)
100% Title XIX FF (4260-101-0890)
100% Title XXI FF (4260-101-0890)
Reimbursement GF (4260-601-0995)
Capital Project Debt Fund (4260-102-0001)
DPH Graduate Medical Education Special Fund (4260-601-8113)
Private Hospital Supplemental Fund (4260-601-3097)
Medi-Cal Inpatient Payment Adjustment Fund (MIPA) (4260-606-0834)
NDPH Supplemental Fund (4260-601-3096)
Local Trauma Centers Fund (4260-601-0942142)
Hospital Quality Assurance Revenue Fund (4260-611-3158)

ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS

FISCAL REFERENCE NUMBER:1476

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$1,235,310,000**	**$1,325,058,000**
FEDERAL FUNDS	$1,235,310,000	$1,325,058,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$1,235,310,000**	**$1,325,058,000**
FEDERAL FUNDS	$1,235,310,000	$1,325,058,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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.

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.

ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS

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.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is an increase due to the inclusion of claims for the Affordable Care Act (ACA) newly population claimed at the enhanced Federal Medical Assistance Percentage (FMAP) and higher actual prior year expenditures.

The change in FY 2026-27, from the prior estimate, is an increase due to an estimated growth in utilization and updated payment timing.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to an expected increase in expenditures in FY 2026-27.

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

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	FF (ACA)	FF (non-ACA)	Total FF
FY 2025-26	$2,281,490	$1,046,180	$212,771	$1,022,539	**$1,235,310**
FY 2026-27	$2,627,776	$1,302,718	$25,133	$1,299,925	**$1,325,058**

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

BEHAVIORAL HEALTH BRIDGE HOUSING

FISCAL REFERENCE NUMBER:2354

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$281,087,000**	**$43,000,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$239,087,000	$0
OTHER FUNDS	$42,000,000	$43,000,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$281,087,000**	**$43,000,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$239,087,000	$0
OTHER FUNDS	$42,000,000	$43,000,000

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)]
Budget Act of 2025

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:
There is no change in FY 2025-26 and FY 2026-27, from the prior estimate.

The change from FY 2025-26 to FY 2026-27 in the current estimate, is a decrease due to no General Fund (GF) appropriations remain to be spent in FY 2026-27. In addition, FY 2026-27 only budgets the remaining Behavioral Health Services Fund (BHSF) appropriation.

Methodology:

1. Of the $957,936,000 GF appropriated for behavioral health bridge housing, assume $766,349,000 GF was estimated in FY 2024-25 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. The General Funds are reduced by $40,000,000 GF in FY 2024-25 and reduced by $45,000,000 GF in FY 2025-26.

BEHAVIORAL HEALTH BRIDGE HOUSING

Assume $85,000,000 BHSF is appropriated to the Department in FY 2025-26.

2. The table below displays the estimated spending and remaining funds by Appropriation Years.

   The estimated costs in FY 2025-26 and FY 2026-27 are as follows:

(Dollars in Thousands)

	TF	GF	BHSF
Appropriation Year 2022-23	$957,936	$957,936	$0
Prior Years	$766,349	$766,349	$0
Estimated in FY 2025-26	$191,587	$191,587	$0
Total Estimated Remaining	$0	$0	$0
Appropriation Year 2024-25	$47,500	$47,500	$0
Estimated in FY 2025-26	$47,500	$47,500	$0
Total Estimated Remaining	$0	$0	$0
Appropriation Year 2025-26	$85,000	$0	$85,000
Estimated in FY 2025-26	$42,000	$0	$42,000
Estimated in FY 2026-27	$43,000	$0	$43,000
Total Estimated Remaining	$0	$0	$0

3. The estimated costs in FY 2025-26 and FY 2026-27 are as follows:

(Dollars in Thousands)

FY 2025-26	TF	GF	BHSF
Appropriation Year 2022-23	$191,587	$191,587	$0
Appropriation Year 2024-25	$47,500	$47,500	$0
Appropriation Year 2025-26	$42,000	$0	$42,000
Total FY 2025-26	**$281,087**	**$239,087**	**$42,000**

FY 2026-27	TF	BHSF
Appropriation Year 2025-26	$43,000	$43,000
Total FY 2026-27	**$43,000**	**$43,000**

Funding:
100% GF (4260-101-0001)
100% Behavioral Health Services Fund (4260-101-3085)

SELF-DETERMINATION PROGRAM - CDDS

FISCAL REFERENCE NUMBER:2208

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$345,739,000**	**$441,206,000**
FEDERAL FUNDS	$345,739,000	$441,206,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$345,739,000**	**$441,206,000**
FEDERAL FUNDS	$345,739,000	$441,206,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is an increase due to the inclusion of claims for the Affordable Care Act (ACA) newly eligible population claimed at the enhanced Federal Medical Assistance Percentage (FMAP) and higher actual expenditures.

SELF-DETERMINATION PROGRAM - CDDS

The change in FY 2026-27, from the prior estimate, is an increase due to changes in the caseload and utilization assumptions, updated payment timing, and including claims for the ACA newly population claimed at the enhanced FMAP.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to anticipated utilization growth in FY 2026-27.

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

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	FF (ACA)	FF (non-ACA)	Total FF
FY 2025-26	$676,844	$331,105	$16,463	$329,276	**$345,739**
FY 2026-27	$810,370	$369,164	$8,529	$432,677	**$441,206**

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

QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES

FISCAL REFERENCE NUMBER:2329

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$155,373,000**	**$217,638,000**
FEDERAL FUNDS	$132,067,000	$170,903,000
GENERAL FUND	$23,306,000	$26,607,000
OTHER FUNDS	$0	$20,128,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$155,373,000**	**$217,638,000**
FEDERAL FUNDS	$132,067,000	$170,903,000
GENERAL FUND	$23,306,000	$26,607,000
OTHER FUNDS	$0	$20,128,000

Purpose:
This policy change 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 (WIC) 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 Section 9183
WIC Section 14132.57
State Plan Amendment (SPA) 22-0043

Interdependent Policy Changes:
Prop 35 - Provider Payment Increase Funding

Background:
Under existing law, the Department of Health Care Services (DHCS) is responsible for administering the Medi-Cal Specialty Mental Health Services (SMHS) 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 are currently covered in the SMHS, DMC-ODS, and DMC programs, and counties are required to provide or arrange the services anywhere in the community. However, these services are not 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, provided by on-call, multidisciplinary teams. Additionally, crisis intervention services do not meet the federal definition for qualifying community-based mobile crisis intervention services.

QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES

The Department received approval of SPA 22-0043 to add qualifying community-based mobile crisis intervention services, effective January 1, 2023, 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, 365 days a year 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 is provided outside a hospital or other facility setting and includes 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 Act provides states with the option of providing qualifying community-based mobile crisis intervention services during a five-year period, starting April 1, 2022, through March 31, 2027, including an opportunity for 12 fiscal quarters of 85 percent federal medical assistance percentage (FMAP) for qualifying services within the five-year period. DHCS' 12 fiscal quarters to claim 85 percent FMAP began on January 1, 2024, and will end on December 31, 2026. The ARP Act requires the additional FMAP 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 service. Beginning April 1, 2027, this benefit will become optional for counties.

Reason for Change:
The change in FY 2025-26 and FY 2026-27, from the prior estimate, is a decrease due to using actual accrual projections from FY 2024-25 and updated accrual projections for FY 2025-26 and FY 2026-27. In addition, the 988 State Suicide and Behavioral Health Crisis Services Fund is no longer included in FY 2026-27 as a potential source of funding. The Behavioral Health Services Fund (BHSF) funding is now included in FY 2026-27.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a net increase in the total fund due to projected growth in claims for FY 2026-27. In addition, BHSF funding is included in FY 2026-27.

Methodology:
1. To estimate the cost of qualifying community-based mobile crisis intervention services related to SMHS, the total FY 2024-25 approved claims for Mobile Crisis Services were used as the baseline. Annual costs are assumed to follow the trend observed in FY 2024-25 claims.

2. Beginning January 1, 2024, under the ARP Act, qualifying community-based mobile crisis intervention services are funded with 85% Federal Fund (FF) and 15% General Fund (GF) through December 31, 2026, and the benefit's current federal statutory expiration date is March 31, 2027. Beginning January 1, 2027, funding will switch to 50%/50% FMAP. Assume the non-federal share for claims from January 2027 to March 2027 will be paid using funding from the BHSF. Beginning April 1, 2027, when the benefit becomes optional, funding will switch to 50% FF and 50% county Intergovernmental Transfer (IGT). The non-federal share of the funding will become a county responsibility.

QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES

3. The accrual estimates based on actual claims for FY 2024-25 and projected for FY 2025-26, and FY 2026-27 are:

Accrual Basis	FY 2024-25	FY 2025-26	FY 2026-27
Mobile Crisis Response – SMHS	$102,803,000	$168,436,000	$234,068,000
Cohort 2	$1,155,000	$2,474,000	$3,793,000
Cohort 2 Supplemental	$0	$2,473,000	$2,473,000
Total	$103,958,000	$173,383,000	$240,334,000

4. Assume 67% of claims for mobile crisis intervention will be paid in the year services are provided and 33% in the subsequent year. The cash estimates for FY 2025-26 and FY 2026-27 are:

FY 2025-26	TF	GF	FF
Mobile Crisis Response – SMHS	$151,678,000	$22,752,000	$128,926,000
Cohort 2	$2,038,000	$305,000	$1,733,000
Cohort 2 Supplemental	$1,657,000	$249,000	$1,408,000
Total	**$155,373,000**	**$23,306,000**	**$132,067,000**

FY 2026-27	TF	GF	BHSF	FF
Mobile Crisis Response – SMHS	$211,823,000	$25,892,000	$19,603,000	$166,328,000
Cohort 2	$3,348,000	$407,000	$318,000	$2,623,000
Cohort 2 Supplemental	$2,467,000	$308,000	$207,000	$1,952,000
Total	**$217,638,000**	**$26,607,000**	**$20,128,000**	**$170,903,000**

Funding:
85% Title XIX FF/ 15% GF (4260-101-0001/0890)
50% Title XIX FF/ 50% GF (4260-101-0001/0890)
100% Behavioral Health Services Fund (4260-101-3085)

QAF WITHHOLD TRANSFER

FISCAL REFERENCE NUMBER:2092

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$9,624,000**	**$62,376,000**
FEDERAL FUNDS	$4,812,000	$31,188,000
GENERAL FUND	$4,812,000	$31,188,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$9,624,000**	**$62,376,000**
FEDERAL FUNDS	$4,812,000	$31,188,000
GENERAL FUND	$4,812,000	$31,188,000
OTHER FUNDS	$0	$0

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

Reason for Change:
The change in FY 2025-26, from the prior estimate, is due to:

- For HQAF, the FY 2025-26 new withholds pending transfer increased as an HQAF FFS cycle is scheduled to occur after the last withhold transfer for FY 2025-26.
- For LTC QAF, the FY 2025-26 new withholds pending transfer increased as withholds are coming in higher than previously expected.
- For GEMT QAF, the FY 2025-26 new withholds pending transfer decreased as withholds are coming in lower than previously expected.

The change in FY 2026-27 from the prior estimate, is due to:

- For HQAF, the prior year withholds transfers increased in FY 2026-27 as an HQAF FFS cycle is scheduled to occur after the last withhold transfer for FY 2025-26. In addition, the new withholds pending transfer decreased.
- For LTC QAF, the prior year withholds increased and the FY 2026-27 new withholds pending transfer increased as withholds are coming in higher than previously expected.
- For GEMT QAF, the prior year withholds decreased and the FY 2026-27 new withholds pending transfer decreased as withholds are coming in lower than previously expected.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to:

- For HQAF, the FY 2026-27 estimate increased as FY 2026-27 new withholds pending transfer decreased.
- For LTC QAF, the FY 2026-27 estimate increased when compared to FY 2025-26 as prior year withhold transfer amount contains an additional week due to the timing of the transfers.
- For GEMT QAF, the FY 2026-27 estimate increased as the FY 2026-27 prior year withhold transfers increased.

Methodology:

HQAF

1. Prior year FY 2024-25 HQAF withheld payments totaling $74.26 million Total Fund (TF) will be transferred in FY 2025-26.

2. An estimated $63.41 million TF in HQAF withholds will occur in FY 2025-26. These withholds are pending transfer in the next FY and offsets a portion of the $74.26 million HQAF withhold transfer.

3. An estimated $63.41 million TF of FY 2025-26 HQAF withheld payments will be paid in FY 2026-27. This prior year withhold transfer is offset by $1.71 million in withholds that are estimated to occur in FY 2026-27 but are pending transfer in FY 2027-28.

LTC QAF

4. Prior year FY 2024-25 LTC QAF withheld payments totaling $2.14 million TF will be transferred in FY 2025-26.

5. An estimated $3.37 million TF in LTC QAF withholds will occur in FY 2025-26. These withholds are pending transfer in the next FY and offsets a portion of the $2.14 million LTC QAF withhold transfer.

QAF WITHHOLD TRANSFER

6. An estimated $3.37 million of FY 2025-26 LTC QAF withheld payments will be paid in FY 2026-27. This prior year withhold transfer is offset by $2.69 million in withholds that are estimated to occur in FY 2026-27 but are pending transfer in FY 2027-28.

GEMT QAF

7. Prior year FY 2024-25 GEMT withheld payments totaling $0.008 million TF will be transferred in FY 2025-26.

8. An estimated $0.01 million in GEMT QAF withholds will occur in FY 2025-26. These withholds are pending transfer in the next fiscal year and offsets a portion of the $0.008 million GEMT QAF withhold transfer.

9. An estimated $0.01 million of FY 2025-26 GEMT QAF withheld payments will be paid in FY 2026-27. This prior year withhold transfer is offset by $0.01 million in withholds that are estimated to occur in FY 2026-27 but are pending transfer in FY 2027-28.

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
HQAF			
HQAF Prior Year Withhold Transfers	$74,262	$37,131	$37,131
HQAF FY 2025-26 New Withholds Pending Transfer	($63,408)	($31,704)	($31,704)
Subtotal HQAF for FY 2025-26	$10,854	$5,427	$5,427
LTC QAF			
LTC QAF Prior Year Withhold Transfers	$2,140	$1,070	$1,070
LTC QAF FY 2025-26 New Withholds Pending Transfer	($3,368)	($1,684)	($1,684)
Subtotal LTC QAF for FY 2025-26	($1,228)	($614)	($614)
GEMT QAF			
GEMT QAF Prior Year Withhold Transfers	$8	$4	$4
GEMT QAF FY 2025-26 New Withholds Pending Transfer	($10)	($5)	($5)
Subtotal GEMT QAF for FY 2025-26	($2)	($1)	($1)
Total FY 2025-26	**$9,624**	**$4,812**	**$4,812**

QAF WITHHOLD TRANSFER

(Dollars in Thousands)

FY 2026-27	TF	GF	FF
HQAF			
HQAF Prior Year Withhold Transfers	$63,408	$31,704	$31,704
HQAF FY 2026-27 New Withholds Pending Transfer	($1,706)	($853)	($853)
Subtotal HQAF for FY 2026-27	$61,702	$30,851	$30,851
LTC QAF			
LTC QAF Prior Year Withhold Transfers	$3,368	$1,684	$1,684
LTC QAF FY 2026-27 New Withholds Pending Transfer	($2,694)	($1,347)	($1,347)
Subtotal LTC QAF for FY 2026-27	$674	$337	$337
GEMT QAF			
GEMT QAF Prior Year Withhold Transfers	$10	$5	$5
GEMT QAF FY 2026-27 New Withholds Pending Transfer	($10)	($5)	($5)
Subtotal GEMT QAF for FY 2026-27	$0	$0	$0
Total FY 2026-27	**$62,376**	**$31,188**	**$31,188**

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

CYBHI - FEE SCHEDULE THIRD PARTY ADMINISTRATOR

FISCAL REFERENCE NUMBER:2424

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$39,500,000**	**$50,900,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$39,500,000	$0
OTHER FUNDS	$0	$50,900,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$39,500,000**	**$50,900,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$39,500,000	$0
OTHER FUNDS	$0	$50,900,000

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 multi-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, disability health 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 educational agencies (LEAs) and public institutions of higher education (IHEs), including California Community Colleges, California State Universities, and Universities of California may participate in the CYBHI Fee Schedule program BH network as providers of reimbursable services.

CYBHI - FEE SCHEDULE THIRD PARTY ADMINISTRATOR

There are significant operational complexities around provider management and claims submission for the school-based/school-linked providers. Although many LEA districts participate in the LEA Billing Option Program (BOP), LEAs, and IHEs do not currently have billing infrastructure necessary to submit claims to multiple Medi-Cal managed care plans, commercial health plans, and disability health insurance plans in each county. Almost none of the school-based providers have any experience with billing commercial or disability health insurance 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 provider and practitioner credentialing and provider network 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.

Reason for Change:
The change from the previous estimate, for FY 2025-26, is a decrease due to updated actuals and revised projections. The change from the previous estimate, for FY 2026-27, is a decrease due to updated payment timings. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to revised projections based on processing volumes.

Methodology:

Estimated dollars for FY 2025-26 and FY 2026-27 are as follows:

Fiscal Year	TF	SF	FF
FY 2025-26	$39,500,000	$39,500,000	$0
FY 2026-27	$50,900,000	$50,900,000	$0

Funding:
100% General Fund (4260-101-0001)
100% BH Schoolsite Fee Schedule Admin Fund (4260-101-3451)

ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS

FISCAL REFERENCE NUMBER:1232

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$94,506,000**	**$77,099,000**
FEDERAL FUNDS	$94,506,000	$77,099,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$94,506,000**	**$77,099,000**
FEDERAL FUNDS	$94,506,000	$77,099,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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 and the federal funds are on a cash basis in the Department's budget.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is an increase due to updated data on utilization and higher prior year expenditures.

The change in FY 2026-27, from the prior estimate, is a decrease due to a lower estimate of prior year expenditures in FY 2026-27.

ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease due to lower expenditures estimated in FY 2026-27.

Methodology:

1. FY 2025-26 includes a portion of payments for FY 2023-24 and FY 2024-25 expenditures. FY 2026-27 includes a portion of payments for FY 2024-25 and FY 2025-26 expenditures.

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

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	FFP Regular
FY 2025-26	$189,012	$94,506	**$94,506**
FY 2026-27	$154,198	$77,099	**$77,099**

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

EQUITY & PRACTICE TRANSFORMATION PAYMENTS

FISCAL REFERENCE NUMBER:2346

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$59,200,000**	**$27,300,000**
FEDERAL FUNDS	$39,525,950	$18,220,000
GENERAL FUND	$19,674,050	$9,080,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$59,200,000**	**$27,300,000**
FEDERAL FUNDS	$39,525,950	$18,220,000
GENERAL FUND	$19,674,050	$9,080,000
OTHER FUNDS	$0	$0

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:
N/A

Background:
The Department administers the Equity and Practice Transformation (EPT) Payments Program, which supports 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 provides payments to primary care practices to do the following: advance health equity; address gaps in preventive, childhood, birth-related, and behavioral health care measures; 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 performance on EPT deliverables and measures.

The payment calculations for 2024-2026 were revised following updated guidance received from CMS in March 2025 and are now in accordance with their guidelines based on the Medi-Cal member count from November 2024, excluding D-SNP members.

The Statewide Learning Collaborative (SLC) portion of the policy change is being moved to the new FRN 2652 EPTP – Statewide Learning Collaborative policy change, as per compliance guidance. However, when determining dollars spent in prior years, the Statewide Learning Collaborative is still being budgeted towards this policy change.

EQUITY & PRACTICE TRANSFORMATION PAYMENTS

DHCS is currently evaluating the appropriate use of any remaining unspent funds. At this time, unused funds may be considered as part of future reconciliation processes, subject to ongoing evaluation and policy considerations.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is due to updated actual payments for the CY 2025 service period included in this estimate and an increase in FMAP from previous assumptions.

The change in FY 2026-27, from the prior estimate, is due to an increase in FMAP from previous assumptions.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to the remaining program payments being anticipated to be exhausted during FY 2026-27.

Methodology:
1. The Budget Act for FY 2022-23 provides $193.5 million TF ($70 million GF), available for expenditure through June 30, 2027. The table below displays the estimated spending by Appropriation Year:

EQUITY & PRACTICE TRANSFORMATION PAYMENTS

Prior Years			
FY 2023-24	**TF**	**GF**	**FF**
Statewide Learning Collaborative	$2,800,000	$1,400,000	$1,400,000
Initial Planning Payments	$25,000,000	$12,500,000	$12,500,000
Health Equity and Practice Transformation Payments	$0	$0	$0
Total FY 2023-24	**$27,800,000**	**$13,900,000**	**$13,900,000**
FY 2024-25	**TF**	**GF**	**FF**
Statewide Learning Collaborative	$5,400,000	$2,700,000	$2,700,000
Health Equity and Practice Transformation Payments	$11,600,000	$3,900,000	$7,700,000
Total FY 2024-25	**$17,000,000**	**$6,600,000**	**$10,400,000**
Estimated in FY 2025-26			
FY 2025-26	**TF**	**GF**	**FF**
Health Equity and Practice Transformation Payments	$59,200,000	$19,700,000	$39,500,000
Total FY 2025-26	**$59,200,000**	**$19,700,000**	**$39,500,000**
Estimated in FY 2026-27			
FY 2026-27	**TF**	**GF**	**FF**
Health Equity and Practice Transformation Payments	$27,300,000	$9,100,000	$18,200,000
Total FY 2026-27	**$27,300,000**	**$9,100,000**	**$18,200,000**
Total Appropriation Year 2022-23	**$131,300,000**	**$49,300,000**	**$82,000,000**
Estimated Remaining	**$62,200,000**	**$20,700,000**	**$41,500,000**

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)

MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG

FISCAL REFERENCE NUMBER:2097

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$44,217,000**	**$36,143,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$0	$0
OTHER FUNDS	$44,217,000	$36,143,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$44,217,000**	**$36,143,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$0	$0
OTHER FUNDS	$44,217,000	$36,143,000

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

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 2025-26 and FY 2026-27, from the prior estimate, due to updated payment timings. There is a decrease from FY 2025-26 to FY 2026-27 in the current estimate, due to projecting lower expenditures in FY 2026-27 based on more recent actuals.

Methodology:

1. Cohort 1 is expected to receive $11.0 million each year for five years, with payments beginning in FY 2020-21. Cohort 2 is expected to receive $10.1 million each year for five years, with payments beginning in FY 2021-22. Cohort 3 is expected to receive $10.8 million each year for five years, with payments beginning in FY 2022-23. Cohort 4 is expected to receive $11.1 million each year for five years, with payments beginning in FY 2023-24. Cohort 5 is expected to receive $13.3 million each year for five years, with payments beginning in FY 2024-25.

2. The contract for the administrative costs is approximately $1.8 million in FY 2025-26 and $1.3 million FY 2026-27, 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.

4. The estimated program expenditures for FY 2025-26 and FY 2026-27 are:

Fiscal Years	TF	SF
FY 2025-26	**$44,217,000**	**$44,217,000**
FY 2026-27	**$36,143,000**	**$36,143,000**

Funding:
100% Prop 56 Loan Repayment Program (4260-601-3375)

PROPOSITION 36 FUNDING

FISCAL REFERENCE NUMBER:2549

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$50,000,000**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$50,000,000	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$50,000,000**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$50,000,000	$0
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the one-time funding for Proposition 36 implementation activities.

Authority:
Homelessness, Drug Addiction, and Theft Reduction Act of 2024 (Proposition 36)

Interdependent Policy Changes:
Not Applicable

Background:
In November 2024, voters approved the Homelessness, Drug Addiction, and Theft Reduction Act of 2024 (Proposition 36), to reform laws that have increased homelessness, drug addiction, and theft throughout California. Proposition 36 allows people who possess illegal drugs to be charged with a “treatment-mandated felony,” instead of a misdemeanor, in some cases. This applies to people who (1) possess certain drugs (such as fentanyl, heroin, cocaine, or methamphetamine) and (2) have two or more past convictions for some drug crimes (such as possessing or selling drugs). Individuals would receive mental health or substance use disorder treatment. Those who complete treatment would have their charges dismissed. Those who do not complete treatment could serve up to three years in state prison.

A one-time allocation of $50 million will be available for the Department of Health Care Services (DHCS) to provide non-competitive grants to county behavioral health departments to support the implementation of Proposition 36. Grant funding will be utilized for authorized treatment services in addition to activities to support planning and capacity building needed to expand and accelerate services. Allowable expenditures include capital for housing and treatment; hiring, training, and development of policies and procedures; support for information technology infrastructure costs; and changes needed for reporting data, and case tracking. DHCS executed a contract with the Sierra Health Foundation: Center for Health Program Management (The Center) to support statewide administration of the Proposition 36 county grant program. The Center will assist with county contracting, payment processing, data reporting, and technical assistance functions.

PROPOSITION 36 FUNDING

Reason for Change:
There is no change in FY 2025-26 and FY 2026-27, from the prior estimate.

The change in the current estimate, from FY 2025-26 to FY 2026-27, is due to the one-time allocation being fully expended in FY 2025-26.

Methodology:
1. Assume $50 million General Fund (GF) is provided in FY 2025-26.

FY 2025-26	TF	GF
Proposition 36	$50,000,000	$50,000,000

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

CALAIM - PATH WPC

FISCAL REFERENCE NUMBER:2439

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$21,627,000**	**$0**
FEDERAL FUNDS	$10,594,000	$0
GENERAL FUND	$0	$0
OTHER FUNDS	$11,033,000	$0
% REFLECTED IN BASE	0.0000%	0%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$21,627,000**	**$0**
FEDERAL FUNDS	$10,594,000	$0
GENERAL FUND	$0	$0
OTHER FUNDS	$11,033,000	$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.

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

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.

<u>Support for Sustaining Reentry Demonstration Initiative Services Through Transition to Managed Care</u>
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 launched 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.

Reason for Change:
The change from the prior estimate, for FY 2025-26, is a decrease due to a reduced final payment. There is no change from the prior estimate for FY 2026-27. The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease due to all payments being completed in December 2025.

Methodology:
1. The Department has awarded eight former WPC Lead Entities to receive PATH WPC Services and Transition to Managed Care Mitigation Initiative funding. Funding was provided through an invoicing process.

2. The Department payment was made through an Intergovernmental Transfer process. The Department informed the WPC Lead Entity when their invoice had been approved. The former WPC Lead Entity had seven days to wire 50% of their approved invoice amount to the Department. The Department provided the remaining 50% federal match amount. The total 100% approved invoice amount was paid back to the former WPC Lead Entity.

3. On a cash basis, PATH WPC Program costs are estimated to be:

(Dollars in Thousands)

Fiscal Year	TF	SF	FF
FY 2025-26	$21,627	$10,594	$11,033

CALAIM - PATH WPC

Funding:
(Dollars in Thousands)

FY 2025-26	TF	SF	FF
100% Title XIX FF (4260-101-0890)	$11,033	$0	$11,033
Whole Person Care Pilot Special Fund (4260-601-8107)	$10,594	$10,594	$0
Total	**$21,627**	**$10,594**	**$11,033**

MINIMUM WAGE INCREASE FOR HCBS WAIVERS

FISCAL REFERENCE NUMBER:1975

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$52,271,000**	**$93,906,000**
FEDERAL FUNDS	$25,404,000	$45,639,000
GENERAL FUND	$26,867,000	$48,267,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	77.5100%	43.9100%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$11,755,700**	**$52,671,900**
FEDERAL FUNDS	$5,713,360	$25,598,920
GENERAL FUND	$6,042,390	$27,072,960
OTHER FUNDS	$0	$0

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)
Labor Code Section 1182.12(c)(1)

Interdependent Policy Changes:
Assisted Living Waiver Expansion

Background:
SB 3 required 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. Section 1182.12 (c)(1) of the Labor Code outlines that once the minimum wage reaches $15 per hour in 2023, the minimum wage will continue to increase, annually, based on the lesser of 3.5% or the California Consumer Price Index (CCPI), contingent on funding availability.

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 eligible Medi-Cal 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.

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

MINIMUM WAGE INCREASE FOR HCBS WAIVERS

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 2025-26 and FY 2026-27, is a decrease due to updated rates, enrollments, and claims data. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to capturing the January 1, 2025, January 1, 2026, and January 1, 2027, rate increases in FY 2026-27.

Methodology:
1. Beginning January 1, 2025, the minimum wage increased from $16.00 to $16.50 per hour. Beginning January 1, 2026, the minimum wage increased from $16.50 to $16.90 per hour.

2. Beginning January 1, 2027, assume the minimum wage will increase annually, based on the lesser of 3.5% or the CCPI.

3. Beginning January 1, 2027, the minimum wage will increase from $16.90 to $17.44 per hour.

4. The estimated fiscal year costs are as follows:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2025-26	$52,271	$26,867	$25,404
FY 2026-27	$93,906	$48,267	$45,639

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

CARE ACT

FISCAL REFERENCE NUMBER:2396

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$13,804,000**	**$22,481,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$13,804,000	$22,481,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$13,804,000**	**$22,481,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$13,804,000	$22,481,000
OTHER 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, Statutes of 2023)
SB 42 (Chapter 640, Statutes of 2024)
SB 1400 (Chapter 647, Statutes of 2024)
SB 1323 (Chapter 646, Statutes of 2024)
SB 27 (Chapter 528, Statutes of 2025)

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 implemented by December 1, 2024.

CARE ACT

SB 35 includes new notification requirements for the county behavioral health agencies effective with the implementation of the CARE Act.

SB 42 includes new administrative requirements related to outreach and engagement of individuals referred to the CARE Act for county behavioral health agencies effective September 27, 2024.

SB 1400 expands data collection and reporting requirements for county behavioral health agencies effective January 1, 2025.

SB 1323 requires the court, if the restoration of the defendant's mental competence is not in the interests of justice, to hold a hearing to consider granting mental health diversion or other programs such as CARE, to the defendant charged with a felony.

SB 27 expands CARE eligibility, clarifies criteria language, streamlines court referrals, permits earlier court-involved referrals and updates other non-substantial technical provisions.

$6 million General Fund (GF) is included in FY 2024-25, and $3 million GF funding is included in FY 2025-26 and ongoing to the California Health and Human Services Agency for outreach contracts.

Reason for Change:
The change in FY 2025-26 and FY 2026-27, from the prior estimate, is a decrease due to using actual expenditures resulting in lower accrual amounts and cash estimates.

The change from FY 2025-26 to FY 2026-27 in the current estimate, is an increase due to an anticipated increase in payments for CARE Act activities based on expected growth in claims.

Methodology:
1. The estimated accrual costs for CARE Act activities and Technical Assistance for FY 2024-25, FY 2025-26, and FY 2026-27 are reflected in the tables below.

(Dollars in Thousands)

FY 2024-25	TF	GF
CARE Act Activities	$5,203	$5,203
Technical Assistance	$6,000	$6,000
Total	$11,203	$11,203

(Dollars in Thousands)

FY 2025-26	TF	GF
CARE Act Activities	$12,671	$12,671
Technical Assistance	$3,000	$3,000
Total	$15,671	$15,671

CARE ACT

(Dollars in Thousands)

FY 2026-27	TF	GF
CARE Act Activities	$21,751	$21,751
Technical Assistance	$3,000	$3,000
Total	$24,751	$24,751

2. Assume on a cash basis for FY 2025-26, the Department will pay 25% of FY 2024-25 claims and 75% of FY 2025-26 claims. On a cash basis for FY 2026-27, the Department will pay 25% of FY 2025-26 claims and 75% of FY 2026-27 claims. For technical assistance, the annual amounts will be fully expended in the same year on a cash basis. The estimated costs for FY 2025-26 and FY 2026-27 are:

(Dollars in Thousands)

FY 2025-26	TF	GF
CARE Act Activities	$10,804	$10,804
Technical Assistance	$3,000	$3,000
Total	**$13,804**	**$13,804**

(Dollars in Thousands)

FY 2026-27	TF	GF
CARE Act Activities	$19,481	$19,481
Technical Assistance	$3,000	$3,000
Total	**$22,481**	**$22,481**

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

INDIAN HEALTH SERVICES

FISCAL REFERENCE NUMBER:111

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$18,278,000**	**$16,905,000**
FEDERAL FUNDS	$12,185,500	$11,270,000
GENERAL FUND	$6,092,500	$5,635,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	79.7900%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$3,694,000**	**$16,905,000**
FEDERAL FUNDS	$2,462,690	$11,270,000
GENERAL FUND	$1,231,290	$5,635,000
OTHER FUNDS	$0	$0

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

Reason for Change:
The change from the prior estimate, for FY 2025-26 and FY 2026-27, is a decrease due to a smaller CY 2026 and CY 2027 rate increase than previously estimated based on the final rate information for CY 2026. The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease due to the rate increase captured in FY 2026-27 being lower than the rate increase captured in FY 2025-26.

Methodology:
1. Effective CY 2025, the updated per visit rate payable to the Indian health clinics increased $82, from $719 to $801. The annual rate increase is estimated at $13,845,000 TF.

2. Effective CY 2026, the updated per visit rate payable to the Indian health clinics increased by $25, from $801 to $826. The retroactive rate increase from January through June 2026 is estimated at $4,432,000 TF, and the annual rate increase is estimated at $8,864,000 TF.

3. It is estimated, effective CY 2027, the updated per visit rate payable to the Indian health clinics will increase by $67, from $826 to $893. The retroactive rate increase from January through June 2027 is estimated at $12,473,000 TF.

4. On a cash basis, the FY 2025-26 and FY 2026-27 estimates are:

Rate Increase	FY 2025-26	FY 2026-27
CY 2025 Rate Increase	$13,845,000	$0
Retro Jan-June 2026 Incr.	$4,432,000	$0
CY 2026 Rate Increase	$0	$4,432,000
Retro Jan-June 2027 Incr.	$0	$12,473,000
Total Rate Increase	**$18,277,000**	**$16,905,000**

*Totals may differ due to rounding.

Fiscal Year	TF	GF	FF
FY 2025-26	**$18,277,000**	**$6,093,000**	**$12,184,000**
FY 2026-27	**$16,905,000**	**$5,635,000**	**$11,270,000**

*Totals may differ due to rounding.

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

INFANT DEVELOPMENT PROGRAM

FISCAL REFERENCE NUMBER:2009

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$34,868,000**	**$27,727,000**
FEDERAL FUNDS	$34,868,000	$27,727,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$34,868,000**	**$27,727,000**
FEDERAL FUNDS	$34,868,000	$27,727,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the federal match provided to the California Department of Developmental Services (CDDS) for Infant Development Program (IDP) services for infants and toddlers ages 0 to 3 with or at risk of developmental disabilities.

Authority:
Interagency Agreement 11-88601

Interdependent Policy Changes:
Not Applicable

Background:
On October 9, 2015, State Plan Amendment (SPA) 11-040 was approved by the Centers for Medicare and Medicaid Services to extend Medi-Cal coverage for IDP services provided to Medi-Cal eligible infants and toddlers ages 0 to 3 with or at risk of developmental delay under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, retroactive to October 1, 2011. This SPA authorizes the Department to claim federal financial participation (FFP) for the provision of IDP services by the state's Regional Center network of nonprofit providers to persons with developmental disabilities.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is an increase due to updated actual expenditures.

The change in FY 2026-27, from the prior estimate, is an increase due to updated expenditure estimates assuming continuing growth in population and service utilization.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease due to lower estimated expenditures in FY 2026-27.

INFANT DEVELOPMENT PROGRAM

Methodology:

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

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	FF
FY 2025-26	$69,736	$34,868	**$34,868**
FY 2026-27	$55,454	$27,727	**$27,727**

Funding:

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

BACKFILL LOST TITLE X FAMILY PLANNING FUNDING

FISCAL REFERENCE NUMBER:2550

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$15,000,000**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$15,000,000	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$15,000,000**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$15,000,000	$0
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the costs to backfill the loss of federal Title X funding for family planning.

Authority:
AB 102 (Chapter 5, Statutes of 2025)

Interdependent Policy Changes:
Not Applicable

Background:
The Department implemented a backfill for the loss of federal Title X family planning funding to maintain and support the delivery of equitable, affordable, high quality, client-centered family planning services to patients with low-incomes across the state.

Reason for Change:
There is no change from the prior estimate for FY 2025-26 or FY 2026-27. There is a decrease from FY 2025-26 to FY 2026-27, in the current estimate, due to a one-time payment being disbursed in September 2025.

Methodology:
1. A payment was issued in September 2025 to backfill for the loss of federal Title X family planning funding.

2. The impact for FY 2025-26 is shown below:

BACKFILL LOST TITLE X FAMILY PLANNING FUNDING

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2025-26	$15,000	$15,000	$0
Total	$15,000	$15,000	$0

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

ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS

FISCAL REFERENCE NUMBER:1526

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$15,559,000**	**$13,742,000**
FEDERAL FUNDS	$8,439,000	$7,506,000
GENERAL FUND	$7,120,000	$6,236,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$15,559,000**	**$13,742,000**
FEDERAL FUNDS	$8,439,000	$7,506,000
GENERAL FUND	$7,120,000	$6,236,000
OTHER FUNDS	$0	$0

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.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is an increase due to updated actual prior year expenditures in FY 2025-26.

ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS

The change in FY 2026-27, from the prior estimate, is a decrease due to lower prior year expenditures that are anticipated in FY 2026-27.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease due to lower prior year expenditures that are anticipated in FY 2026-27.

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 2025-26	$1,320	$7,120	$16,879	$1,320	**$7,120**	**$8,439**
FY 2026-27	$1,269	$6,236	$15,011	$1,269	**$6,236**	**$7,506**

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

MISC. ONE-TIME PAYMENTS

FISCAL REFERENCE NUMBER:2502

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$12,550,000**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$12,550,000	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$12,550,000**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$12,550,000	$0
OTHER FUNDS	$0	$0

Purpose:
This policy change includes the costs of various miscellaneous one-time payments as directed by the Legislature.

Authority:
Budget Act of 2025 [SB 105 (Chapter 104, Statutes of 2025]

Interdependent Policy Changes:
Not Applicable

Background:
The Budget Act of 2025 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:
There is no change in FY 2025-26 and FY 2026-27, from the prior estimate.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to funding for all items expiring at the end of FY 2025-26.

MISC. ONE-TIME PAYMENTS

Methodology:

1. The following items from the Budget Act of 2025—totaling $12,550,000—are to be distributed by the Department of Health Care Services in FY 2025-26:
   - $1,250,000 for Equality California to support the healthcare of transgender individuals and families.
   - $750,000 for Equality California to support health access and education.
   - $300,000 for the El Centro de Amistad for infrastructure.
   - $5,000,000 for the County of Humboldt for support of the Mad River Behavioral Health Triage Center.
   - $750,000 to the County of Humboldt for support of the Sorrel Leaf Healing Center.
   - $3,500,000 to the County of Sonoma for the Alexander Valley Healthcare Center Project.
   - $1,000,000 to the City and County of San Francisco for the new oncology clinic and chemotherapy center for Chinese Hospital.

2. The estimated costs in FY 2025-26 are as follows:

(Dollars in Thousands)

FY 2025-26	TF	GF
Misc. One-Time Payments	$12,550	$12,550
Total FY 2025-26	**$12,550**	**$12,550**

Funding:

100% GF (4260-101-0001)

CYBHI - URGENT NEEDS AND EMERGENT ISSUES

FISCAL REFERENCE NUMBER:2375

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$10,100,000**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$10,100,000	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$10,100,000**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$10,100,000	$0
OTHER 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)
Child Mind Institute (CMI) Contract #22-20444
Sacramento Office of Education (SCOE) Contract #22-20432
The Children’s Partnership Contract #22-20435
California Health and Human Services Agency, Office of Youth and Community Restoration Contract #24-40088
CMI Contract #25-50314

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.

CYBHI - URGENT NEEDS AND EMERGENT ISSUES

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 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, $29,000,000 in FY 2024-25, and $2,000,000 in FY 2025-26 from the General Fund as part of a multiyear plan to provide $177 million from the General Fund for the following:

- Leveraging of Emerging Technologies to Develop Next Generation Digital Supports for Remote Mental Health Assessment and Intervention (Next Generation Digital Therapeutics)
- School-Based Peer Mental Health Demonstration Project (High School Peer-to-Peer Program)
- Capacity Building Investments for Organizations Serving Justice-Involved Youth

Reason for Change:
There is no change from the prior estimate for FY 2025-26 and FY 2026-27. The change in the current estimate, from FY 2025-26 to FY 2026-27, is a decrease due to contracted services concluding in FY 2025-26.

Methodology:
1. The Budget Act for FY 2022-23 provided $120,500,000 in FY 2022-23, available through June 30, 2025, $25,500,000 in FY 2023-24, $29,000,000 in FY 2024-25, and $2,000,000 in FY 2025-26. The table below displays the estimated spending and remaining funds by Appropriation Year:

CYBHI - URGENT NEEDS AND EMERGENT ISSUES

	TF	GF	FF
Appropriation Year 2022-23	$120,500,000	$120,500,000	
Prior Years	$120,500,000	$120,500,000	$0
Total Estimated Remaining	$0	$0	$0
Appropriation Year 2023-24	$25,500,000	$25,500,000	
Prior Years	$25,500,000	$25,500,000	$0
Total Estimated Remaining	$0	$0	$0
Appropriation Year 2024-25	$29,000,000	$29,000,000	$0
Prior Years	$29,000,000	$29,000,000	$0
Estimated in FY 2025-26	$0	$0	$0
Total Estimated Remaining	$0	$0	$0
Appropriation Year 2025-26	$2,000,000	$2,000,000	$0
Estimated in FY 2025-26	$10,100,000	$10,100,000	$0
Total Estimated Remaining	$0	$0	$0

Fiscal Year	**TF**	**GF**	**FF**
FY 2025-26	**$10,100,000**	**$10,100,000**	**$0**

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

CALHOPE

FISCAL REFERENCE NUMBER:2355

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$5,000,000**	**$5,000,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$0	$0
OTHER FUNDS	$5,000,000	$5,000,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$5,000,000**	**$5,000,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$0	$0
OTHER FUNDS	$5,000,000	$5,000,000

Purpose:
This policy change estimates the costs for the CalHOPE program.

Authority:
Budget Act of 2025
California Consortium of Urban Indian Health (CCUIH) Contract #25-50342
Mental Health Association of San Francisco (MHASF) Contract #25-50313
Interagency Agreement (IA) 26-10161

Interdependent Policy Changes:
Not Applicable

Background:
The CalHOPE program is a critical component of California’s crisis continuum of care. The CalHOPE Peer-run Warm Line, operated by the Mental Health Association of San Francisco, is available, free of charge, to all Californians of all ages via telephone and text. It connects callers with trained peers (i.e., individuals with lived experience of mental health and/or substance use disorders) who have persevered through struggles with stress, anxiety, depression—emotions triggered by circumstances and events in everyday life. The peer counselors listen with compassion, provide non-judgmental support, and guide callers to additional resources that can provide hope and help them cope. The contract with Mental Health Association of San Francisco (MHSF) to operate the CalHOPE Warm Line will end on June 30, 2026, contract amendments are in progress to extend the contract’s end date to June 30, 2027.

The CalHOPE Red Line, a peer support program operated by the California Consortium for Urban Indian Health (CCUIH), is a phone, live chat, and video chat service providing national, state, and county resources, referrals, and trauma-informed support for Urban Indian and Tribal populations. These include resources related to stress, anxiety, social services, and financial resources. The contract with CCUIH to operate the CalHOPE Red Line will end on June 30, 2026, contract amendments are in progress to extend the contract’s end date to June 30, 2027.

CALHOPE

The peer-based warm line model is an evidence-based and community-defined model that reaches people in need of resources and support at a pivotal time in their lives and can, in many cases, prevent issues from escalating to a crisis point and utilization of scarce crisis support services. Additionally, the CalHOPE Warm Line is cited in many materials and websites related to emotional support for fires and other disasters.

The CalHOPE program complements the digital behavioral health services portfolio under the Children and Youth Behavioral Health Initiative (CYBHI). While many of the CalHOPE resources are currently being sustained via the CYBHI virtual services platform and/or will be integrated into Soluna and BrightLife Kids, as applicable, there is an ongoing need for services offered by the CalHOPE Warm Line and Red Line because they offer services to Californians of all ages across the state; whereas, the CYBHI provides services to children, youth and young adults ages 0-26.

Reason for Change:
There is no change in FY 2025-26 from the prior estimate.

The change in FY 2026-27, from the prior estimate, is due to the Department's receipt of funding from the California Department of Public Health (CDPH) through an interagency agreement.

There is no change from FY 2025-26 to FY 2026-27 in the current estimate.

Methodology:
1. A total of $120 million was appropriated for CalHOPE for expenditure over two years, consisting of $65.38 million General Fund (GF) and $47.53 million Behavioral Health Services Fund (BHSF). In addition, the Budget Act of 2022 appropriated an additional one-time $30 million ($16.42 GF and $13.58 million BHSF) to support the CalHOPE Warm Line. These funds were fully expended or encumbered by the end of FY 2024-25.

2. For FY 2025-26, one-time funding of $5 million BHSF was appropriated for the CalHOPE program.

3. For FY 2026-27, the Department will be contracting with the CDPH through an IA to continue the CalHOPE Warm Line and Red Line. The Department will receive $5 million from CDPH through the IA.

4. The estimated payments, on a cash basis, for FY 2025-26 and FY 2026-27 are:

(Dollars in Thousands)

FY 2025-26	TF	BHSF
CalHOPE	$5,000	$5,000
Total FY 2025-26	**$5,000**	**$5,000**

(Dollars in Thousands)

FY 2026-27	TF	Reimbursement
CalHOPE	$5,000	$5,000
Total FY 2026-27	**$5,000**	**$5,000**

CALHOPE

Funding:
100% Behavioral Health Services Fund (4260-101-3085)
Reimbursement (4260-601-0995)

ASSET LIMIT INCREASE & ELIM. - CNTY BH FUNDING

FISCAL REFERENCE NUMBER:2443

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$5,688,000**	**$4,720,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$5,688,000	$4,720,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$5,688,000**	**$4,720,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$5,688,000	$4,720,000
OTHER 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)
Budget Act of 2025

Interdependent Policy Changes:
Not Applicable

Background:
Prior to July 1, 2022, Medi-Cal members who were not subject to the Modified Adjusted Gross Income (MAGI) rules had to meet an asset limit of $2,000. 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 MAGI eligibility requirements to $130,000 and then 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.

The Budget Act of 2025 re-establishes the asset limit test at $130,000, effective January 1, 2026. Payments will be provided to counties for the non-federal share of specialty mental health and substance use disorder services provided to the additional Medi-Cal members enrolled, as a result of the asset limit test increase and elimination.

ASSET LIMIT INCREASE & ELIM. - CNTY BH FUNDING

Reason for Change:
The change in FY 2025-26 and FY 2026-27, from the prior estimate, is an increase due to using updated claims data from FY 2023-24.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease, due to the reinstatement of the asset limit at $130,000, effective January 1, 2026. The re-instatement reduces the number of individuals who qualify for full scope Medi-Cal Benefits and associated behavioral health services.

Methodology:

1. The estimated accrual costs associated with the Asset Limit Increase and Elimination by program for FY 2024-25, FY 2025-26, and FY 2026-27 are shown below:

Asset Limit Increase and Elimination	FY 2024-25	FY 2025-26	FY 2026-27
SMHS	$5,309,000	$4,405,000	$3,429,000
DMC	$19,000	$16,000	$12,000
DMC-ODS (Required Services)	$360,000	$299,000	$233,000
Total	$5,688,000	$4,720,000	$3,674,000

2. On a cash basis, the FY 2024-25 payments totaling $5,688,000 General Fund (GF) are estimated to be paid in FY 2025-26. The FY 2025-26 payments totaling $4,720,000 GF are estimated to be paid in FY 2026-27.

FY 2025-26	TF	GF
FY 2024-25	$5,688,000	$5,688,000
Total FY 2025-26	**$5,688,000**	**$5,688,000**

FY 2026-27	TF	GF
FY 2025-26	$4,720,000	$4,720,000
Total FY 2026-27	**$4,720,000**	**$4,720,000**

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

WPCS WORKERS' COMPENSATION

FISCAL REFERENCE NUMBER:1866

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$620,000**	**$620,000**
FEDERAL FUNDS	$310,000	$310,000
GENERAL FUND	$310,000	$310,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$620,000**	**$620,000**
FEDERAL FUNDS	$310,000	$310,000
GENERAL FUND	$310,000	$310,000
OTHER FUNDS	$0	$0

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 2025-26 and FY 2026-27. There is no change from FY 2025-26 to FY 2026-27 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

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 2025-26 and FY 2026-27.

Fiscal Year	TF	GF	FF
FY 2025-26	$620,000	$310,000	$310,000
FY 2026-27	$620,000	$310,000	$310,000

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

IMD ANCILLARY SERVICES

FISCAL REFERENCE NUMBER:35

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	-$57,766,000	-$51,474,000
GENERAL FUND	$57,766,000	$51,474,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	-$57,766,000	-$51,474,000
GENERAL FUND	$57,766,000	$51,474,000
OTHER FUNDS	$0	$0

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

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 2025-26, from the prior estimate, is an increase in costs due to:

- Including a revised FFS repayment for the January- March 2024 quarter,
- Shifting the October – December 2025 managed care repayment from FY 2025-26 to FY 2026-27, and
- Including actual resolved deferrals returned to the GF and an additional quarter of projected deferrals in FY 2025-26.

There is no dollar change in FY 2026-27, from the prior estimate, however, the managed care repayment for October – December 2025 shifted from FY 2025-26 to FY 2026-27 and the repayment for October -December 2026 is not estimated to occur in FY 2026-27.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease in costs due to:

- FY 2025-26 includes some actual repayments whereas FY 2026-27 repayments are based on estimates,
- FY 2025-26 estimate includes six quarters of FFS repayments whereas the FY 2026-27 estimate includes four quarters of FFS repayments,
- Projected FFS quarterly repayments differ from FY 2025-26 to FY 2026-27, and
- FY 2025-26 includes more quarters of deferral repayments.

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 deferrals received for FFY 2025 Q1 through FFY 2025 Q4. The Department estimates to repay $8 million per quarter for FFY 2026 Q1 through FFY 2027 Q1 in FY 2025-26 and FY 2026-27.

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 2025-26 and FY 2026-27 are based on actual repayment amounts for the last twenty-five 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

IMD ANCILLARY SERVICES

repaid based on the quarterly deferral letter. The managed care estimated repayment amounts for FY 2025-26 and FY 2026-27 are based on estimates of the past quarters.

5. For FY 2025-26, the Department estimates to repay ineligible FFS claims from January 2024 through June 2025 and ineligible managed care claims from October 2024 through September 2025.

6. For FY 2026-27, the Department estimates to repay ineligible FFS claims from July 2025 through June 2026 and ineligible managed care claims from October 2025 through September 2026.

7. The estimated IMD repayments are:

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
Fee-For-Service (FFS)			
FY 2023-24 Q3 (Jan- Mar 2024)	$0	$3,297	($3,296)
FY 2023-24 Q4 (Apr-Jun 2024)	$0	$4,242	($4,242)
Subtotal FY 2023-24	$0	$7,539	($7,539)
FY 2024-25 Q1 (Jul-Sep 2024)	$0	$1,156	($1,156)
FY 2024-25 Q2 (Oct-Dec 2024)	$0	$2,855	($2,855)
FY 2024-25 Q3 (Jan-Mar 2025)	$0	$4,380	($4,380)
FY 2024-25 Q4 (April-June 2025)	$0	$5,171	($5,171)
Subtotal FY 2024-25	$0	$13,562	($13,562)
Subtotal FFS	$0	$21,101	($21,101)
Managed Care			
FY 2024-25 Q2 (Oct-Dec 2024)	$0	$600	($600)
FY 2024-25 Q3 (Jan-Mar 2025)	$0	$285	($285)
FY 2024-25 Q4 (April-June 2025)	$0	$1,350	($1,350)
FY 2025-26 Q1 (Jul- Sep 2025)	$0	$1,350	($1,350)
Subtotal Managed Care	$0	$3,585	($3,585)
Deferral Repayments			

IMD ANCILLARY SERVICES

FFY 2025 Quarter 1 (Oct-Dec 2024)	$0	$8,000	($8,000)
FFY 2025 Quarter 2 (Jan-Mar 2025)	$0	$8,000	($8,000)
FFY 2025 Quarter 3 (Apr-Jun 2025)	$0	$8,000	($8,000)
FFY 2025 Quarter 4 (Jul-Sep 2025)	$0	$8,000	($8,000)
FFY 2026 Quarter 1 (Oct-Dec 2025)	$0	$8,000	($8,000)
Resolved Deferrals	$0	($6,920)	$6,920
Subtotal Deferrals	$0	$33,080	($33,080)
Total FY 2025-26	**$0**	**$57,766**	**($57,766)**

IMD ANCILLARY SERVICES

(Dollars in Thousands)

FY 2026-27	**TF**	**GF**	**FF**
Fee-For-Service (FFS)			
FY 2025-26 Q1 (Jul-Sep 2025)	$0	$1,834	($1,834)
FY 2025-26 Q2 (Oct-Dec 2025)	$0	$2,800	($2,800)
FY 2025-26 Q3 (Jan-Mar 2026)	$0	$4,324	($4,324)
FY 2025-26 Q4 (April-June 2026)	$0	$5,116	($5,116)
Subtotal FY 2025-26	$0	$14,074	($14,074)
Subtotal FFS	$0	$14,074	($14,074)
Managed Care			
FY 2025-26 Q2 (Oct- Dec 2025)	$0	$1,350	($1,350)
FY 2025-26 Q3 (Jan- Mar 2026)	$0	$1,350	($1,350)
FY 2025-26 Q4 (April-June 2026)	$0	$1,350	($1,350)
FY 2026-27 Q1 (Jul-Sep 2026)	$0	$1,350	($1,350)
Subtotal Managed Care	$0	$5,400	($5,400)
Deferral Repayments			
FFY 2026 Quarter 2 (Jan-Mar 2026)	$0	$8,000	($8,000)
FFY 2026 Quarter 3 (Apr-Jun 2026)	$0	$8,000	($8,000)
FFY 2026 Quarter 4 (Jul-Sep 2026)	$0	$8,000	($8,000)
FFY 2027 Quarter 1 (Oct-Dec 2026)	$0	$8,000	($8,000)
Subtotal Deferrals	$0	$32,000	($32,000)
Total FY 2026-27	**$0**	**$51,474**	**($51,474)**

Funding:
100% General Fund (4260-101-0001)
Title XIX FFP (4260-101-0890)

CIGARETTE AND TOBACCO SURTAX FUNDS

FISCAL REFERENCE NUMBER:1087

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$87,385,000	-$92,561,000
OTHER FUNDS	$87,385,000	$92,561,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$87,385,000	-$92,561,000
OTHER FUNDS	$87,385,000	$92,561,000

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

Methodology:

FY 2025-26	
Hospital Services Account	$48,640,000
Physicians' Services Account	$13,894,000
Unallocated Account	$24,851,000
Total CTPS/Prop. 99	**$87,385,000**
GF	**($87,385,000)**
Net Impact	**$0**

FY 2026-27	
Hospital Services Account	$52,996,000
Physicians' Services Account	$15,144,000
Unallocated Account	$24,421,000
Total CTPS/Prop. 99	**$92,561,000**
GF	**($92,561,000)**
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)

HOSPITAL QAF - CHILDREN'S HEALTH CARE

FISCAL REFERENCE NUMBER:1760

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$84,698,000	-$1,710,833,000
OTHER FUNDS	$84,698,000	$1,710,833,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$84,698,000	-$1,710,833,000
OTHER FUNDS	$84,698,000	$1,710,833,000

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

The Department is awaiting federal approval of the subsequent HQAF program period (HQAF IX) which includes payments for dates of service January 1, 2025, through December 31, 2025, resubmitted to the Centers for Medicare and Medicaid Services (CMS) in March 2026 via State Plan Amendments (SPAs) 25-0012 and 25-0013.

The Department began developing the subsequent program period (HQAF X) in FY 2025-26 Q1 which will include payments for the period of January 1, 2026, through December 31, 2026.

H.R. 1, enacted on July 4, 2025, contains provisions affecting the permissible size and structure of health care-related taxes. H.R. 1 also authorizes the federal Health and Human Services Secretary to approve a transition period of up to three years for impacted taxes. The Department has considered potential impacts of H.R. 1 on the HQAF and is awaiting further federal regulatory action and/or guidance.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is a decrease in savings due to:

- The HQAF VI Children’s Net Benefit reconciliation payment was shifted from FY 2026-27 to FY 2025-26 and was recalculated based on updated payment data.
- The HQAF IX Cycles 1 to 4 Children’s Health Care Coverage payments were shifted from FY 2025-26 to FY 2026-27 and payment amounts were updated based on revised data.

The change in FY 2026-27 from the prior estimate, is a net increase in savings due to:

- The HQAF VI Net Benefit reconciliation payment was shifted from FY 2026-27 to FY 2025-26 and was recalculated based on updated payment data.
- The HQAF IX Cycles 1 to 4 Children’s Health Care Coverage payments were shifted from FY 2025-26 to FY 2026-27 and payment amounts were updated based on revised data.
- Assume only one cycle of the HQAF X Children’s Health Care Coverage payment will be processed in FY 2026-27. The HQAF X Children’s Health Care Coverage payment amount was updated based on revised data.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase in savings due to:

- The HQAF VII Net Benefit reconciliation is expected to occur in FY 2026-27 and the payment amount is subject to change.
- The HQAF IX Cycles 1 to 4 Children’s Health Care Coverage payments are expected to occur in FY 2026-27 and the payment amounts were updated based on revised data.
- Assume only one cycle of the HQAF X Children’s Health Care Coverage payment will be processed in FY 2026-27. The HQAF X Children’s Health Care Coverage payment amounts were updated based on revised data.

Methodology:

1. Payments for children’s health care are estimated through the service period ending December 31, 2026, 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.

HOSPITAL QAF - CHILDREN'S HEALTH CARE

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 resubmitted version of the HQAF IX Fee and Payment model which is awaiting CMS approval. Payment timing and amounts will change.

6. HQAF X estimated payments are based on the resubmitted version of the HQAF IX Fee and Payment model which is pending CMS approval. Payment timing and amounts will change.

7. On an accrual basis, annual funds for children's health care coverage are estimated to be:

(Dollars in Thousands)

CY	Authority	HQAF VIII Period (24 months)	Remaining Amount
CY 2024	Proposition 52	10/01/24 to 12/31/24	$20,000

(Dollars in Thousands)

CY	Authority	HQAF IX Period (Pending)	Amount
CY 2025	Proposition 52	01/01/25 to 12/31/25	$1,330,000

(Dollars in Thousands)

CY	Authority	HQAF X Period (Pending)	Amount
CY 2026	Proposition 52	01/01/26 to 12/31/26	$1,330,000

8. Four quarters of HQAF IX Children's Health Care coverage payments totaling an estimated $1,330,000,000 are expected to be paid in FY 2026-27.

9. One quarter of HQAF X Children's Health Care coverage payments totaling an estimated $332,500,000 is expected to be paid in FY 2026-27. The remaining CY 2026 HQAF X payments of $997,500,000 are expected to be collected and budgeted after FY 2026-27.

10. HQAF VI Children's Health Care coverage savings for the FY 2019-20 through FY 2021-22 reconciliation of $64,698,000 is estimated to be transferred from the Hospital Quality Assurance Revenue Fund to the General Fund (GF) in FY 2025-26. This amount is subject to change pending final approval.

11. HQAF VII Children's Health Care coverage reconciliation for the CY 2022 is estimated at $48,333,000 and is anticipated to be transferred from the Hospital Quality Assurance Revenue Fund to the General Fund (GF) in FY 2026-27. This payment timing and projected amount are subject to change.

12. The remaining HQAF VIII Cycle 8 Children's Health Care coverage payment of $20,000,000 was postponed. The payment is scheduled to be paid to the General Fund in Quarter 3 of FY 2025-26.

HOSPITAL QAF - CHILDREN'S HEALTH CARE

13. On a cash basis, the payments to health care coverage for children and the funding adjustment are:

(Dollars in Thousands)

FY 2025-26	TF	GF	Hosp. QA Rev Fund
HQAF VI FY 2019-20 to FY 2021-22 Net Benefit Reconciliation	$0	($64,698)	$64,698
HQAF VIII Oct 2024-Dec 2024	$0	($20,000)	$20,000
Total FY 2025-26	**$0**	**($84,698)**	**$84,698**

(Dollars in Thousands)

FY 2026-27	TF	GF	Hosp. QA Rev Fund
HQAF VII CY 2022 Net Benefit Reconciliation	$0	($48,333)	$48,333
Calendar Year 2025	$0	($1,330,000)	$1,330,000
Calendar Year 2026	$0	($332,500)	$332,500
Total FY 2026-27	**$0**	**($1,710,833)**	**$1,710,833**

Funding:
100% GF (4260-101-0001)
100% Hospital Quality Assurance Revenue Fund (4260-611-3158)

CMS DEFERRED CLAIMS

FISCAL REFERENCE NUMBER:2034

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	-$477,700,000	-$200,000,000
GENERAL FUND	$477,700,000	$200,000,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	-$477,700,000	-$200,000,000
GENERAL FUND	$477,700,000	$200,000,000
OTHER FUNDS	$0	$0

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.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is due to:

- Updating FFY 2025 Q4 repayments based on the actual deferrals for this quarter,
- Estimating FFY 2026 Q1 repayments will shift from FY 2026-27 to FY 2025-26, and
- Including actual resolved deferrals returned to the General Fund (GF) in FY 2025-26.

The change in FY 2026-27, from the prior estimate, is due to increasing the quarterly deferrals

CMS DEFERRED CLAIMS

projection based on anticipated deferrals.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to:

- FY 2025-26 includes actual deferrals for FFY 2025 Q1 through FFY 2025 Q4 and one additional quarter of projected deferrals while FY 2026-27 includes four quarters of projected deferrals, and
- Actual resolved deferrals returned to the GF in FY 2025-26.

Methodology:

1. The Department received CMS deferrals for FFY 2015 Quarter 1 through FFY 2025 Quarter 4.

2. In FY 2025-26, the Department estimates to repay a total of $484.303 million FF, which includes actual CMS deferrals issued for FFY 2025 Quarter 1 through FFY 2025 Quarter 4 and the estimated FFY 2026 Quarter 1 deferral.

3. In FY 2026-27 the Department estimates to repay $50 million per quarter for FFY 2026 Quarter 2 through FFY 2027 Quarter 1.

4. The Department has recovered $6.6 million in actual resolved deferrals in FY 2025-26.

5. The Department will repay the following estimated deferred claims:

(Dollars in Thousands)

FY 2025-26	**Total Estimated Repayment**
FFY 2025 Quarter 1 (Oct-Dec 2024)	$49,391
FFY 2025 Quarter 2 (Jan-Mar 2025)	$58,117
FFY 2025 Quarter 3 (Apr-Jun 2025)	$165,005
FFY 2025 Quarter 4 (Jul-Sep 2025)	$161,790
FFY 2026 Quarter 1 (Oct-Dec 2025)	$50,000
Subtotal Estimated Repayments	$484,303
Estimated Resolved Deferrals	($6,603)
Total FY 2025-26	**$477,700**

CMS DEFERRED CLAIMS

(Dollars in Thousands)

FY 2026-27	Total Estimated Repayment
FFY 2026 Quarter 2 (Jan-Mar 2026)	$50,000
FFY 2026 Quarter 3 (Apr-Jun 2026)	$50,000
FFY 2026 Quarter 4 (Jul-Sep 2026)	$50,000
FFY 2027 Quarter 1 (Oct-Dec 2026)	$50,000
Subtotal Estimated Repayments	$200,000
Estimated Resolved Deferrals	$0
Total FY 2026-27	**$200,000**

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

INDIAN HEALTH SERVICES FUNDING SHIFT

FISCAL REFERENCE NUMBER:2156

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$28,729,000	$30,919,500
GENERAL FUND	-$28,729,000	-$30,919,500
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$28,729,000	$30,919,500
GENERAL FUND	-$28,729,000	-$30,919,500
OTHER FUNDS	$0	$0

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

Reason for Change:
The change from the prior estimate, for FY 2025-26 and FY 2026-27, is a decrease in General Fund (GF) savings based on two additional quarters of actual expenditures, one of which was lower than previously estimated. The change from FY 2025-26 to FY 2026-27, 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 2025-26, it is estimated the Department will spend $57,458,000 TF ($28,729,000 GF). In FY 2026-27, it is estimated the Department will spend $61,839,000 TF ($30,920,000 GF).

3. Estimated expenditures for FY 2025-26 and FY 2026-27 are in the table below.

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
IHS FY 2025-26 Base exp. (50% GF / 50% FF)	($57,458)	($28,729)	($28,729)
IHS total expenditures (100% FF)	$57,458	$0	$57,458
FY 2025-26 Total	**$0**	**($28,729)**	**$28,729**
FY 2026-27	**TF**	**GF**	**FF**
IHS FY 2026-27 Base exp. (50% GF / 50% FF)	($61,839)	($30,920)	($30,919)
IHS total expenditures (100% FF)	$61,839	$0	$61,839
FY 2026-27 Total	**$0**	**($30,920)**	**$30,920**

*Totals may differ due to rounding.

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

MEDICAL PROVIDER INTERIM PAYMENT LOAN

FISCAL REFERENCE NUMBER:2503

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$2,541,324,000	$0
OTHER FUNDS	$2,541,324,000	$0
% REFLECTED IN BASE	0.0000%	0%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$2,541,324,000	$0
OTHER FUNDS	$2,541,324,000	$0

Purpose:
This policy change estimates transactions related to the Medical Providers Interim Payment (MPIP) Fund loan from the General Fund.

Authority:
Government Code Section 16531.1

Interdependent Policy Changes:
Not Applicable

Background:
Government Code Section 16531.1 allows the Department 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.

In March 2025, the Department determined it would not have sufficient General Fund authority to continue making necessary payments in the Medi-Cal program through the end of the 2024-25 fiscal year. The Department received a loan to the MPIP fund which allows the Department to continue making payments while various other funding sources come in.

In January 2026, the Department determined it would not have sufficient General Fund authority to continue making necessary payments in the Medi-Cal program through the end of the 2025-26 fiscal year. In April 2026, the Department activated a loan to the MPIP fund to allow the Department to continue making payments.

MEDICAL PROVIDER INTERIM PAYMENT LOAN

Reason for Change:
There is no change from the prior estimate for FY 2025-26 or FY 2026-27.

The change between fiscal years in the current estimate is due to the Department expecting to utilize FY 2024-25 MPIP loan funds in FY 2025-26, whereas there is no projected use or repayment of MPIP loan funds in FY 2026-27.

Methodology:

The Department had the ability to access $3.44 billion in MPIP funds for FY 2024-25. The November 2025 budget assumes $1.89 billion was used in FY 2024-25 and $1.54 billion is available for use in FY 2025-26. Repayment of the FY 2024-25 MPIP loan is expected to occur in annual General Fund installments beginning in FY 2027-28, until the loan is fully repaid.

The Budget Act of 2025 provides for an additional $1.0 billion in MPIP authority in FY 2025-26.

Funding:

(in thousands)

Fiscal Year	FY 2025-26	FY 2026-27
FY 2024-25 MPIP loan		
100% GF (4260-101-0001)	($1,541,324)	$0
100% MPIP (4260-601-0201)	$1,541,324	$0
Additional Loan Authority (Budget Act of 2025)		
100% GF (4260-101-0001)	($1,000,000)	$0
100% MPIP (4260-601-0201)	$1,000,000	$0
Total Funds	**$0**	**$0**

HEALTH CARE SVCS. FINES AND PENALTIES

FISCAL REFERENCE NUMBER:2484

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$20,400,000	-$12,502,000
OTHER FUNDS	$20,400,000	$12,502,000
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$20,400,000	-$12,502,000
OTHER FUNDS	$20,400,000	$12,502,000

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 (GF).

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), eliminated the Major Risk Medical Insurance Program and used the funds to support the Medi-Cal Program.

Reason for Change:
There is no change from the prior estimate for FY 2025-26. The change from the prior estimate, for FY 2026-27, is an increase in GF due to an additional transfer occurring in FY 2026-27. The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease due to a lower transfer amount than the previous fiscal year.

Methodology:
1. Funds are transferred from the Healthcare Services Fines and Penalties Fund (3311) to the GF.

(Dollars in Thousands)

Fiscal Year	TF	GF	SF	FF
FY 2025-26	$0	**($20,400)**	**$20,400**	$0
FY 2026-27	$0	**($12,502)**	**$12,502**	$0

Funding:
Health Care Services Fines and Penalties Fund (4260-101-3311)
Title XIX GF (4260-101-0001)

HR 1 - UIS EMERGENCY ACA FMAP ADJUSTMENT

FISCAL REFERENCE NUMBER:2551

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**-$51,500,000**
FEDERAL FUNDS	$0	-$158,278,000
GENERAL FUND	$0	$106,778,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**-$51,500,000**
FEDERAL FUNDS	$0	-$158,278,000
GENERAL FUND	$0	$106,778,000
OTHER FUNDS	$0	$0

Purpose:
This item estimates loss of federal funds and increased state costs resulting from a reduction in the federal medical assistance percentage (FMAP) from 90 percent to 50 percent for emergency services for certain members with unsatisfactory immigration status (UIS).

Authority:
H.R. 1, 119th Cong., Section 71110 (2025)

Interdependent Policy Changes:
Not Applicable

Background:
UIS members qualify for federal financial participation (FFP) for emergency services. Currently, UIS members that would qualify for Medi-Cal under the ACA expansion, if not for their immigration status, are eligible for federal funding for emergency services at the 90 percent enhanced FMAP. Other UIS members are eligible for FFP for emergency services at the standard of 50 percent FMAP.

H.R. 1 reduces the FMAP available for emergency services for UIS members that would be part of the ACA expansion population if not for their immigration status from 90 percent to 50 percent, effective October 1, 2026.

Reason for Change:
This is a new policy change as a result of the approval of H.R. 1.

Methodology:

1. This Policy Change includes only the effect on Fee-For-Service expenditures. The effect on all other types of service is included in their base or regular policy changes.
2. Assume this change in Federal funding will begin October 1, 2026, on a date of payment basis.

HR 1 - UIS EMERGENCY ACA FMAP ADJUSTMENT

3. The loss in Federal funding in FY 2026-27 is estimated to be -$158,278,000. This includes a reduction in Federal funding for Disproportionate Share Hospitals (DPHs) of -$51,500,000. The corresponding increase in unreimbursed CPE costs for DPHs is not included in the Medi-Cal Estimate or Budget.

Fiscal Year	TF	GF	FF	CF*
FY 2026-27	-$51,500,000	$106,778,000	-$158,278,000	$51,500,000

* County Funds are not included in the Total Fund.

Funding:

FY 2026-27	TF	GF	FF
ACA UIS ER 50% FFP/50% GF (4260-101-0001 / 0890)	$266,945,000	$133,472,500	$133,472,500
ACA 90% FFP / 10% GF (4260-101-0001 / 0890)	-$266,945,000	-$26,694,500	-$240,250,500
Fed. Share Only T19 (4260-101-0890)	-$51,500,000	$0	-$51,500,000
Total	**-$51,500,000**	**$106,778,000**	**-$158,278,000**

ELIMINATE DENTAL FOR ADULT UIS

FISCAL REFERENCE NUMBER:2563

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**-$360,827,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$0	-$360,827,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**-$360,827,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$0	-$360,827,000
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the impact of eliminating non-emergency dental benefits for Unsatisfactory Immigration Status (UIS) members aged 19 and older.

Authority:
Budget Act of 2025
W&IC § 14007.8(l)

Interdependent Policy Changes:
Not Applicable

Background:
Since January 1, 2024, pursuant to Welfare and Institutions Code (W&IC) § 14007.8, income-eligible individuals without satisfactory immigration status are eligible for full-scope Medi-Cal benefits. This provision was part of a broader initiative to extend full-scope Medi-Cal coverage to all income-eligible adults aged 26 through 49, regardless of immigration status.

The elimination of dental benefits for the UIS population, aged 19 and older, will take effect on July 1, 2026. The UIS population, aged 19 and older, will continue to have access to restricted-scope emergency dental coverage, UIS members who are pregnant, within 12 months postpartum, or are former foster care youth will retain dental coverage.

Reason for Change:
There is no change from the previous estimate for FY 2025-26. The change from the prior estimate, for FY 2026-27, is an increase in savings due to updated check write and member data. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase in savings due to the elimination of non-emergency dental benefits for UIS members aged 19 and older starting July 1, 2026.

Methodology:

1. Assume implementation will be no sooner than July 1, 2026.

ELIMINATE DENTAL FOR ADULT UIS

2. The impact of a full year of eliminating payments for dental benefits for UIS members aged 19 and older, assuming a lag in payment timing for services from the prior year is shown below:

Fiscal Year	TF	GF	FF
FY 2026-27	($360,827,000)	($360,827,000)	$0

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

RESIDENCY VERIFICATION IMPROVEMENTS

FISCAL REFERENCE NUMBER:2531

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**-$418,230,000**
FEDERAL FUNDS	$0	-$291,870,000
GENERAL FUND	$0	-$126,360,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**-$418,230,000**
FEDERAL FUNDS	$0	-$291,870,000
GENERAL FUND	$0	-$126,360,000
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the impact of implementing improvements to residency verification processes related to eligibility and enrollment in the Medi-Cal program. This includes implementing an expansion of current work efforts related to the quarterly Public Assistance Reporting Information System (PARIS) Interstate Program Matches and the Residency Verification Program (RVP).

Authority:
AB 102 (Chapter 5, Statutes of 2025)
Social Security Act, Title XIX 1903(r)(3)
Social Security Act, Section 402 and 1137 (42 U.S.C. 602 and 42 U.S.C. 1320b-7)
Contract 25-50052
Contract 23-30285 A01
Welfare & Institutions Code 14013.5 and 14043.5
Welfare & Institutions Code 14005.39

Interdependent Policy Changes:
Not Applicable

Background:
Federal statute requires California to participate in the PARIS Interstate data sharing and match process under Social Security Act, Title XIX 1903(r)(3). The Department is the designated single state public assistance agency to facilitate data matching and operates the PARIS Interstate program under Sections 402 and 1137 of the Social Security Act, 42 U.S.C. 602 and 42 U.S.C. 1320b-7. Each quarter, the Department sends records of individuals receiving Medi-Cal to the federal government for data matching. The federal government then returns a match file with individuals receiving concurrent benefits in California and at least one other state.

The Welfare & Institutions Code 14005.39 requires the termination of Medi-Cal benefits without a redetermination if a Medi-Cal member is determined ineligible for Medi-Cal due to change of state residency. RVP performs periodic data matching with another vendor, LexisNexis Risk Solutions, to identify Medi-Cal members who are potentially living out-of-state.

RESIDENCY VERIFICATION IMPROVEMENTS

For PARIS Interstate and RVP, Maximus will utilize data provided by the Department and send residency verification letters to individuals who have active concurrent benefits or potentially reside out-of-state, requiring attestation under penalty of perjury that they reside in California. Members who fail to reply or confirm out-of-state residency will have their benefits closed and Maximus will mail a Notice of Action letter to the address on file.

A contract with Maximus US Services, Inc. (Contract No. 25-50052) was made effective July 1, 2025, and LexisNexis Risk Solutions FL, Inc. (Contract No. 23-30285-A01) was made effective January 1, 2024, to help continue these efforts. These contract costs are budgeted in the OTLICP, MCAP, Special Populations Admin Costs policy change.

Reason for Change:
There is no change for FY 2025-26 from the prior estimate. There is an increase in cost savings for FY 2026-27, from the prior estimate, due updating the estimated costs per member. There is an increase from FY 2025-26 to FY 2026-27, in the current estimate, due to the implementation date for these cost savings occurring in FY 2026-27.

Methodology:

1. Assume implementation will be no sooner than January 1, 2027.

2. The impact of implementing residency verification improvements is shown below:

(Dollars in Thousands)

Fiscal Years	TF	GF	FF
FY 2026-27	($418,230)	($126,360)	($291,870)
Total	**($418,230)**	**($126,360)**	**($291,870)**

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

QUALITY SANCTIONS

FISCAL REFERENCE NUMBER:2497

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**-$1,460,000**	**-$2,000,000**
FEDERAL FUNDS	-$730,000	-$1,000,000
GENERAL FUND	-$730,000	-$1,000,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**-$1,460,000**	**-$2,000,000**
FEDERAL FUNDS	-$730,000	-$1,000,000
GENERAL FUND	-$730,000	-$1,000,000
OTHER FUNDS	$0	$0

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 for the Medi-Cal Managed Care Accountability Set (MCAS) Quality Sanctions program. These sanctions will continue annually. These amounts will be recouped and deposited into the General Fund.

Reason for Change:
The change in FY 2025-26 and FY 2026-27, from the prior estimate, is due to decreased recoupments as a result of improved Managed Care Plan (MCP) performance on MCAS quality measures.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to increased recoupments from MCPs operating in counties that were previously not subject to minimum quality performance requirements.

Methodology:
1. Assume one collection period for each Calendar Year. The timing of the collection of appealed sanctions is dependent on the hearing results.

FY 2025-26	TF	GF	FF
Estimated CY 2024 Collected Sanctions	($1,460,000)	($730,000)	($730,000)
Total	**($1,460,000)**	**($730,000)**	**($730,000)**

QUALITY SANCTIONS

FY 2026-27	TF	GF	FF
Estimated CY 2025 Collected Sanctions	($2,000,000)	($1,000,000)	($1,000,000)
Total	**($2,000,000)**	**($1,000,000)**	**($1,000,000)**

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

ASSISTED LIVING WAIVER EXPANSION

FISCAL REFERENCE NUMBER:2054

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**-$953,000**	**$9,413,000**
FEDERAL FUNDS	-$458,000	$4,523,000
GENERAL FUND	-$495,000	$4,890,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	31.0400%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**-$657,200**	**$9,413,000**
FEDERAL FUNDS	-$315,840	$4,523,000
GENERAL FUND	-$341,350	$4,890,000
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the cost to increase the capacity of the Assisted Living Waiver (ALW).

Authority:
SB 840 (Chapter 29, Statutes of 2018)

Interdependent Policy Changes:
Not Applicable

Background:
The ALW offers services in an assisted living facility or public subsidized housing 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 ALW was renewed for a new five-year term, effective March 1, 2024, through February 28, 2029, and reached the 7,500-slot capacity in FY 2024-25. 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 from the prior estimate, for FY 2025-26 and FY 2026-27, is a net decrease in savings due to updated skilled nursing facility (SNF) rates. There is a net decrease in savings from FY 2025-26 to FY 2026-27, in the current estimate, due to a lower FY 2026-27 SNF rate, which captures less net savings.

Methodology:
1. Assume 2,220 members will transition in FY 2025-26 and 1,801 members in FY 2026-27.

ASSISTED LIVING WAIVER EXPANSION

2. Assume 60% of members come from long-term SNFs and 40% of members come from the community.

3. Beginning January 1, 2025, assume ALW costs increased due to the minimum wage increase from $16.00 to $16.50 an hour. Beginning January 1, 2026, assume ALW costs increased due to the minimum wage increase from $16.50 to $16.90 an hour. Beginning January 1, 2027, assume an increase in ALW costs due to the minimum wage increase from $16.90 to $17.31 an hour. Prospective wage increases are budgeted in the Minimum Wage Increase for HCBS Waivers policy change.

4. Assume an average of 147 members will enroll per month in FY 2025-26 and 120 members in FY 2026-27.

5. Assume the average annual cost for waiver services is $64,688.

6. Assume the average annual cost in an SNF is $109,754 in FY 2025-26 and $102,593 in FY 2026-27.

FY 2025-26	TF	GF	FF
Total Cost from Waiver Services	$61,982,000	$32,204,000	$29,778,000
Total Savings from SNF Transitions	($62,935,000)	($32,699,000)	($30,236,000)
Net Impact	**($953,000)**	**($495,000)**	**($458,000)**

FY 2026-27	TF	GF	FF
Total Cost from Waiver Services	$193,901,000	$100,745,000	$93,156,000
Total Savings from SNF Transitions	($184,488,000)	($95,855,000)	($88,633,000)
Net Impact	**$9,413,000**	**$4,890,000**	**$4,523,000**

*Totals may differ due to rounding.

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

HCBA WAIVER EXPANSION

FISCAL REFERENCE NUMBER:2010

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**-$10,118,000**	**-$28,808,000**
FEDERAL FUNDS	-$5,016,000	-$14,280,000
GENERAL FUND	-$5,102,000	-$14,528,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	33.3400%	11.7100%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**-$6,744,700**	**-$25,434,600**
FEDERAL FUNDS	-$3,343,670	-$12,607,810
GENERAL FUND	-$3,400,990	-$12,826,770
OTHER FUNDS	$0	$0

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 an HCBA Waiver for a new five-year term, from January 1, 2023, through December 31, 2027. The new waiver term included 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

Under the new waiver term, the waiver:

- Describes services that are eligible for telehealth,
- 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 2025-26 and FY 2026-27, is a decrease in savings due to updated enrollment data trending lower than previously estimated. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase in savings due to the additional savings being realized from more members transitioning from a skilled nursing facility (SNF) to the HCBA waiver in FY 2026-27.

Methodology:
1. Assume there are 9,566 members in the HCBA Waiver in FY 2024-25.

2. Assume the annual cost per member is $24,472.

3. Assume 486 new members will transition in FY 2025-26 and 540 in FY 2026-27.

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 $9,146 in FY 2025-26 and $8,549 in FY 2026-27.

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
Waiver Costs	$6,016	$3,034	$2,982
Savings from SNF	($16,134)	($8,136)	($7,998)
Net Cost	**($10,118)**	**($5,102)**	**($5,016)**
FY 2026-27	**TF**	**GF**	**FF**
Waiver Costs	$19,051	$9,608	$9,443
Savings from SNF	($47,859)	($24,136)	($23,723)
Net Cost	**($28,808)**	**($14,528)**	**($14,280)**

*Totals may differ due to rounding.

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

COUNTY SHARE OF OTLICP-CCS COSTS

FISCAL REFERENCE NUMBER:1906

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**-$17,000,000**	**-$17,000,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$17,000,000	-$17,000,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**-$17,000,000**	**-$17,000,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$17,000,000	-$17,000,000
OTHER 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. Under OTLICP, county shares remain the same. Effective October 1, 2025, OTLICP SB75 emergency is funded with 50% FFP, 25% GF, and 25% county funds.

Reason for Change:
There is an increase for FY 2025-26 and 2026-27, from the prior estimate, due to updated projections. There is no change from FY 2025-26 to FY 2026-27 in the current estimate.

COUNTY SHARE OF OTLICP-CCS COSTS

Methodology:

1. The county share reimbursement for OTLICP-CCS in FY 2025-26, at 17.5% for quarter 1, and 25% quarter 2 through 4, is estimated to be $17,000,000.

2. The county share reimbursement for OTLICP-CCS in FY 2026-27, at 25% for quarter 1 through 4, is estimated to be $17,000,000.

3. The county share of OTLICP-CCS costs is estimated in the table below:

Fiscal Year	TF	GF	CF*
FY 2025-26	**$17,000,000**	**$17,000,000**	($17,000,000)
FY 2026-27	**$17,000,000**	**$17,000,000**	($17,000,000)

*County Funds are not included in the Total Fund.

Funding:
100% Title XXI State GF (4260-101-0001)

COUNTY BH RECOUPMENTS

FISCAL REFERENCE NUMBER:2343

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**-$85,546,000**	**-$85,547,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$85,546,000	-$85,547,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**-$85,546,000**	**-$85,547,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	-$85,546,000	-$85,547,000
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates county recoupments 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). These recoupments replenish General Fund (GF) used to reimburse the Centers for Medicare and Medicaid Services (CMS).

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 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

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 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 in FY 2025-26, from the prior estimate, is due to a one quarter payment lag for SMHS UIS and Drug Medi-Cal UIS recoupments. There is no lag for psychiatric inpatient recoupments.

The change in FY 2026-27, from the prior estimate, is due to rounding.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to rounding.

Methodology:

1. Recoupments for both psychiatric inpatient claims and Medi-Cal members with UIS began in FY 2024-25 in Quarter 3 and are projected to continue through FY 2025-26 through FY 2027-28.

2. Psychiatric inpatient claim recoupments total $190,277,000. Actual recoupments were $63,426,000 in FY 2024-25, with an additional $63,425,000 estimated for FY 2025-26, and $63,426,000 for FY 2026-27.

3. Recoupment for claims related to Medi-Cal members with UIS total $66,362,000. Actual collections were $16,590,000 in FY 2024-25. An additional $22,121,000 is estimated to be recouped in FY 2025-26 and $22,121,000 is estimated for FY 2026-27. The remaining balance of $5,530,000 will be paid in FY 2027-28.

4. The Department will recoup funds over a four-year period. FY 2025-26 through FY 2027-28 amounts reflect the estimated recoupment schedule. Amounts may differ due to rounding.

COUNTY BH RECOUPMENTS

(Dollars in Thousands)

Recoupment Schedule	Total	Psychiatric Inpatient	Specialty Mental Health UIS	Drug Medi-Cal UIS
FY 2024-25 – Q3 (Collected)	$42,773	$31,713	$10,690	$370
FY 2024-25 – Q4 (Collected)	$37,243	$31,713	$5,345	$185
Subtotal for FY 24-25 (Collected)	$80,016	$63,426	$16,035	$555
FY 2025-26 – Q1	$21,386	$15,856	$5,345	$185
FY 2025-26 – Q2	$21,386	$15,856	$5,345	$185
FY 2025-26 – Q3	$21,386	$15,856	$5,345	$185
FY 2025-26 – Q4	$21,388	$15,857	$5,346	$185
Subtotal for FY 25-26	$85,546	$63,425	$21,381	$740
FY 2026-27 - Q1	$21,386	$15,856	$5,345	$185
FY 2026-27 - Q2	$21,386	$15,856	$5,345	$185
FY 2026-27 - Q3	$21,387	$15,857	$5,345	$185
FY 2026-27 - Q4	$21,388	$15,857	$5,346	$185
Subtotal for FY 26-27	$85,547	$63,426	$21,381	$740
FY 2027-28 - Q1	$5,530	$0	$5,345	$185
Subtotal for FY 27-28	$5,530	$0	$5,345	$185
Total	$256,639	$190,277	$64,142	$2,220

5. The cash estimates for FY 2025-26 and FY 2026-27 are:

(Dollars in Thousands)

BH Recoupments	TF	GF
FY 2025-26	**($85,546)**	**($85,546)**
FY 2026-27	**($85,547)**	**($85,547)**

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

MCP NETWORK ADEQUACY & TIMELY ACCESS SANCTIONS

FISCAL REFERENCE NUMBER:2558

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**-$3,500,000**
FEDERAL FUNDS	$0	-$1,750,000
GENERAL FUND	$0	-$1,750,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**-$3,500,000**
FEDERAL FUNDS	$0	-$1,750,000
GENERAL FUND	$0	-$1,750,000
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the fiscal impact of sanctions collected from managed care plans (MCPs) for non-compliance with Network Adequacy and Timely Access to Care.

Authority:
Welfare & Institutions (W&I) Code 14197.7

Interdependent Policy Changes:
Not Applicable

Background:
In Calendar Year (CY) 2024, the Department began developing the policy and operational framework to begin sanctioning MCPs. As part of the California State Auditor’s recommendation, the Department committed to sanctioning MCP’s non-compliance with Network Adequacy and Timely Access to Care starting CY 2025.

All Plan Letter (APL) 25-006 (Timely Access Requirements) and APL 25-007 (Enforcement Actions: Corrective Action Plans, Administrative and Monetary Sanctions) were released in early CY 2025 and outlined the expectations for MCPs to meet Network Adequacy and Timely Access to Care standards and identified the enforcement actions to be taken based on the level of non-compliance.

Starting FY 2026-27, the Department will begin the process of issuing sanctions for non-compliance and will continue annually. These amounts will be recouped and deposited into the General Fund.

Reason for Change:
There is no change from the prior estimate for both FY 2025-26 and FY 2026-27. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase in sanctions collected due to the issuing of sanctions beginning in FY 2026-27 and not FY 2025-26.

MCP NETWORK ADEQUACY & TIMELY ACCESS SANCTIONS

Methodology:

1. Assume CY 2025 sanctions will be collected in FY 2026-27 and are estimated to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2026-27	($3,500)	($1,750)	($1,750)

Funding:

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

HR 1 - REDUCED RETROACTIVE MEDI-CAL TIMEFRAMES

FISCAL REFERENCE NUMBER:2553

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**-$34,562,000**
FEDERAL FUNDS	$0	-$19,899,950
GENERAL FUND	$0	-$14,662,050
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**-$34,562,000**
FEDERAL FUNDS	$0	-$19,899,950
GENERAL FUND	$0	-$14,662,050
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the cost to implement the federally mandated reduction of retroactive Medi-Cal coverage under House Resolution 1 (H.R. 1) from three months before an individual's application date to one month for the Affordable Care Act (ACA) Modified Adjusted Gross Income (MAGI) New Adult Group and two months for all other eligible groups, in accordance with enacted federal law.

Authority:
H.R. 1, 119th Cong., Section 71112 (2025)

Interdependent Policy Change:
Not Applicable

Background:
Currently, retroactive Medi-Cal coverage allows eligible individuals to receive Medi-Cal benefits for covered medical services received up to three months prior to the month of application if they would have been otherwise eligible during those retroactive months.

Reason for Change:
There is no change from the prior estimate for FY 2025-26. The change for FY 2026-27, from the prior estimate, is an increase in savings due to updated claims data. The change from FY 2025-26 to FY 2026-27, in the current estimate, is a savings increase due to the policy implementing in FY 2026-27.

Methodology:

1. Assume the policy implements no sooner than January 1, 2027.

2. Assume H.R. 1 reduces retroactive Medi-Cal coverage from three months to one month for Adult Expansion population and two months for all other eligible groups.

HR 1 - REDUCED RETROACTIVE MEDI-CAL TIMEFRAMES

3. Total estimated savings for FY 2026-27 are:

Fiscal Year	TF	GF	FF
FY 2026-27	($34,562,000)	($14,662,000)	($19,900,000)

Funding:

FY 2026-27	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	($19,955,000)	($9,977,000)	($9,978,000)
65% Title XXI / 35% GF (4260-101-0001/0890)	($1,151,000)	($403,000)	($748,000)
ACA 90% FFP/10% GF (2020 and later)	($10,127,000)	($1,013,000)	($9,114,000)
100% State GF (4260-101-0001)	($3,269,000)	($3,269,000)	$0
Title XIX 100% FFP	($60,000)	$0	($60,000)
Total	**($34,562,000)**	**($14,662,000)**	**($19,900,000)**

HR 1 - RESTRICTED FEDERAL FUNDING FOR CERTAIN QNCS

FISCAL REFERENCE NUMBER:2554

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**-$13,612,000**
FEDERAL FUNDS	$0	-$681,668,000
GENERAL FUND	$0	$668,056,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**-$13,612,000**
FEDERAL FUNDS	$0	-$681,668,000
GENERAL FUND	$0	$668,056,000
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the cost of the federally mandated narrowing of Qualified Non-Citizen (QNC) eligibility for federally funded Medicaid.

Authority:
H.R. 1, 119th Cong., Section 71109 (2025)

Interdependent Policy Change:
Not Applicable

Background:
Currently, the QNC eligibility for federally funded Medicaid applies to, but is not limited to, the following lawfully present immigration statuses:

- Lawful Permanent Residents (LPRs).
- Cuban or Haitian Entrants.
- Migrants legally residing in the United States and its territories under the Compact of Free Association (COFA), such as citizens of Micronesia, the Marshall Islands, or Palau.
- Conditional Entrant granted before April 1980.
- Paroled into the United States for one year or more.
- Battered non-citizen, or parent or child of a battered non-citizen.
- Refugees.
- Asylees.
- Amerasian Immigrants.
- Individuals granted withholding of deportation or removal.

Medi-Cal members in these immigration statuses are eligible for full scope Medicaid, and California receives a Federal Medical Assistance Percentage based on this premise.

Additionally, the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA), among its many other provisions, gave states the option to provide Medi-Cal benefits to eligible children (under the age of 21) and pregnant individuals who are “lawfully residing” in the United States as defined for Medi-Cal eligibility purposes. As a result, California provides full scope

HR 1 - RESTRICTED FEDERAL FUNDING FOR CERTAIN QNCS

Medi-Cal benefits or pregnancy-related Medi-Cal benefits to eligible lawfully present children under the age of 21 and to lawfully present pregnant individuals.

Effective October 1, 2026, H.R.1, referred to by the Centers for Medicaid & Medicaid (CMS) as the Working Familiar Tax Cut (WFTC) Legislation, narrows QNC eligibility for federally funded Medicaid. Consequently, members with certain immigration statuses, including but not limited to those listed below, will no longer be eligible for federally funded Medi-Cal:

- Conditional Entrant granted before April 1980.
- Paroled into the United States for one year or more.
- Battered non-citizen, or parent or child of a battered non-citizen.
- Refugees.
- Asylees.
- Amerasian Immigrants.
- Individuals granted withholding of deportation or removal.

The narrow QNC eligibility for federally funded Medicaid will apply to individuals residing in any of the 50 U.S. states, the District of Columbia, or U.S. territories, and who are:

- LPRs who are exempt from the five-year bar or are subject to and have met the five-year bar,
- Cuban or Haitian Entrants, and
- Migrants legally residing in the United States and its territories under the COFA, such as citizens of Micronesia, the Marshall Islands, or Palau.

This provision excludes the lawfully present pregnant individuals and lawfully present children under age 21 covered under the CHIPRA.

Reason for Change:
This is a new policy change.

Methodology:

1. Assume the policy implements no sooner than October 1, 2026.

2. Assume that beginning October 1, 2026, these members will no longer qualify for federally funded full-scope Medi-Cal and will transition to receiving state-only full-scope with no dental coverage through December 31, 2026. Beginning, January 1, 2027, these members will transition from the managed care to the fee-for-service delivery system. And finally, effective July 1, 2027, these members will transition to restricted scope coverage under the Medi-Cal program which is limited to emergency and pregnancy related services.

3. Beginning October 1, 2026, HR 1 reduces the federal medical assistance percentage for UIS Federal Emergency ACA costs from 90% FF to 50% FF. The impact of this change is incorporated into the dollars of this policy change. For policy change specific impacts, see the HR 1 - UIS Emergency ACA FMAP Adjustment policy change (FRN 2551).

HR 1 - RESTRICTED FEDERAL FUNDING FOR CERTAIN QNCS

4. Total estimated costs for FY 2026-27 are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2026-27	($13,612)	$668,056	($681,668)

Funding:
100% GF (4260-101-0001)
100% Title XIX FFP (4260-101-0890)
ACA 50/50 ER UIS (4260-101-0890/0001)

HR 1 - FED WORK & COMMUNITY ENGAGEMENT REQUIREMENT

FISCAL REFERENCE NUMBER:2555

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**-$357,564,000**
FEDERAL FUNDS	$0	-$267,250,800
GENERAL FUND	$0	-$90,313,200
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**-$357,564,000**
FEDERAL FUNDS	$0	-$267,250,800
GENERAL FUND	$0	-$90,313,200
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the cost to implement federally mandated work requirements under House Resolution 1 (H.R. 1) for the Affordable Care Act Modified Adjusted Gross Income (MAGI) New Adult Group population, in accordance with enacted federal law.

Authority:
H.R. 1, 119th Cong., Section 71119 (2025)

Interdependent Policy Change:
HR 1 – ACA Adult Exp Group 6-Month Redetermination

Background:
Currently, Medi-Cal does not require individuals to participate in work or community engagement activities to maintain eligibility. Federal legislation signed in July 2025 introduced new work and community engagement requirements for the MAGI New Adult Group population, effective January 1, 2027. Under this new policy, eligible individuals will need to meet 80 hours of a work or community engagement activity or qualify for an exemption to obtain or maintain Medi-Cal coverage.

Reason for Change:
There is no change from the prior estimate for FY 2025-26. The change for FY 2026-27, from the prior estimate, is a decrease in savings due to revised population estimates and due to assuming more members will qualify for exemptions. The change from FY 2025-26 to FY 2026-27, in the current estimate, is a savings increase due to the policy implementing in FY 2026-27.

Methodology:

1. Assume the policy implements no sooner than January 1, 2027.

2. Beginning October 1, 2026, HR 1 reduces the federal medical assistance percentage for Unsatisfactory Immigration Status (UIS) Federal Emergency ACA costs from 90% FF to 50% FF. The impact of this change is incorporated into the dollars of this policy change. For Fee-

HR 1 - FED WORK & COMMUNITY ENGAGEMENT REQUIREMENT

for-Service impacts, see the HR 1 - UIS Emergency ACA FMAP Adjustment policy change (FRN 2551).

3. Assume members in the MAGI New Adult Group population are estimated to be impacted by work requirements and may lose their Medi-Cal eligibility. Exemptions and members subject to work requirements are listed below:

Total starting M1s (data reflecting January 2026 Month of Eligibility)	**4,774,242**
Exemptions from Work Requirements:	
Parent/Caretakers with children under 14	(528,175)
High county unemployment rates	(390,103)
Medically Frail *(In progress)*	(716,088)
American Indian/Alaskan Native	(7,834)
Parents/Caretaker of a disabled individual	TBD
Disabled Veteran	(1,534)
Meeting Supplemental Nutrition Assistance Program work requirements (ABAWD)	(532,427)
Medically Frail: Intellectual/Developmental Disability Waiver Programs *(In progress. Still pending: Assisted Living Waiver, Home and Community Based Alternatives, Medi-Cal Waiver Program, Multipurpose Senior Services Program)*	(1,424)
Inmate of a public institution	TBD
Recently released from a public institution (90 days)	TBD
Total Exemptions	**(2,177,585)**
Meeting Work Requirements:	
Income of at least $580/month	(478,286)
80 hours of work	TBD
80 hours of work program	TBD
80 hours of community service	TBD
At least half-time enrollment in educational program	TBD
80 hours combo	TBD
Total M1s who meet a Work Requirement Exemption or are Income Compliant	**(2,655,871)**
M1s who do not meet a Work Requirement Exemption or are not Income Compliant (Subject to Work Requirements)	**2,118,371**
Assume 50% of M1s who **are subject to work requirements** are disenrolled due to failure to comply/return necessary verifications to comply with work requirements.	**1,059,186**

HR 1 - FED WORK & COMMUNITY ENGAGEMENT REQUIREMENT

4. Total estimated costs for FY 2026-27 are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2026-27	($357,564)	($90,313)	($267,251)

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

PHARMACY PAYMENT METHODOLOGY - USUAL AND CUSTOMARY

FISCAL REFERENCE NUMBER:2557

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**-$8,641,000**	**-$8,566,000**
FEDERAL FUNDS	-$102,351,100	-$5,016,200
GENERAL FUND	$93,710,100	-$3,549,800
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**-$8,641,000**	**-$8,566,000**
FEDERAL FUNDS	-$102,351,100	-$5,016,200
GENERAL FUND	$93,710,100	-$3,549,800
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the repayment of federal funds to the Centers of Medicare and Medicaid Services (CMS) for pharmacy claims that were not priced under the approved Usual and Customary (U&C) pricing methodology and the savings from the ongoing reduced reimbursements following system corrections.

Authority:
State Plan Amendment (SPA) 17-002
Welfare & Institutions (W&I) code 14105.45

Interdependent Policy Changes:
Not Applicable

Background:
The CMS approved SPA 17-002 for pharmacy reimbursement methodology requires reimbursement for covered outpatient drugs to be the lower of:

1. The drug’s ingredient cost plus a professional dispensing fee, or
2. The pharmacy’s usual and customary (U&C) charge.

In early 2024, the Department identified a pricing logic error in Medi-Cal Rx claims processing where the lower U&C charges were not always used according to the approved pharmacy methodology. The error began with the implementation of the Medi-Cal Rx on January 1, 2022, due to changes in claims logic from the prior CA-MMIS system.

The Department implemented necessary policy and system logic changes on July 18, 2025, to ensure compliance with State Plan pharmacy reimbursement methodology for covered outpatient drugs, which will now appropriately consider the U&C charge field submitted by the provider to determine the appropriate pharmacy reimbursement rate.

PHARMACY PAYMENT METHODOLOGY - USUAL AND CUSTOMARY

Reason for Change:
The change in FY 2025-26, from the prior estimate, is due to an updated CMS repayment cost budgeted to the General Fund following CMS review of the Department's repayment plan.

There is no change in FY 2026-27 from the prior estimate.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to the Department's completion of the updated repayment to CMS.

Methodology:
1. The after percent in base impact of the CMS repayment and annual savings, for FY 2025-26 and FY 2026-27, are as follows:

FY 2025-26	TF	GF	FF
CMS Repayment	$0	$97,335,000	($97,335,000)
Ongoing Savings (not in FFS Base)	($8,641,000)	($3,625,000)	($5,016,000)
Total	**($8,641,000)**	**$93,710,000**	**($102,351,000)**

FY 2026-27	TF	GF	FF
Ongoing Savings (not in FFS Base)	($8,566,000)	($3,550,000)	($5,016,000)
Total	**($8,566,000)**	**($3,550,000)**	**($5,016,000)**

2. The before percent in base impact of the CMS repayment and annual savings, for FY 2025-26 and FY 2026-27, are as follows:

FY 2025-26	TF	GF	FF
CMS Repayment	$0	$97,335,000	($97,335,000)
Ongoing Savings	($53,040,000)	($22,248,000)	($30,792,000)
Total	**($53,040,000)**	**$75,087,000**	**($128,127,000)**

FY 2026-27	TF	GF	FF
Ongoing Savings	($53,040,000)	($21,980,000)	($31,060,000)
Total	**($53,040,000)**	**($21,980,000)**	**($31,060,000)**

3. Assume that the after percent in base impact of $8.6 million TF for FY 2025-26 and $8.6 million TF for FY 2026-27 includes after percent in base ongoing savings. The after percent in base impact represents the dollars budgeted in this PC; these dollars have not been incorporated into the fee-for-service base.

4. Assume that the before percent in base impact is $53 million TF in FY 2025-26 and FY 2026-27. There are no changes to the before percent in base impact estimated from the prior estimate to the current estimate for FY 2025-26 and FY 2026-27.

5. Assume the Department will repay CMS approximately $97.3 million GF for overpayments made between January 1, 2022, and July 17, 2025.

PHARMACY PAYMENT METHODOLOGY - USUAL AND CUSTOMARY

6. Total estimated CMS repayment, without the CMS deferral, is $97.3 million GF and is anticipated to be completed in FY 2025-26. Assume that the repayment is not incorporated into the fee-for-service base.

7. On July 24, 2025, CMS issued deferral letters for Federal Fiscal Year (FFY) 2025 Quarter 1, Quarter 2, and Quarter 3, requesting repayment of approximately $6.77 million per quarter for the Medi-Cal Rx pricing errors that led to pharmacy overpayments. The CMS deferral amounts are budgeted in the CMS Deferred Claims policy change.

8. The necessary policy and system logic changes were implemented on July 18, 2025. Assume annual savings are estimated at $53 million TF.

9. Total net impact of the CMS repayment and annual savings, for FY 2025-26 and FY 2026-27, are as follows:

FY 2025-26	TF	GF	FF
CMS Repayment	$0	$97,335,000	($97,335,000)
Ongoing Savings	($8,641,000)	($3,625,000)	($5,016,000)
Total	**($8,641,000)**	**$93,710,000**	**($102,351,000)**

FY 2026-27	TF	GF	FF
Ongoing Savings	($8,566,000)	($3,550,000)	($5,016,000)
Total	**($8,566,000)**	**($3,550,000)**	**($5,016,000)**

Funding:

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	($3,356,000)	($1,678,000)	($1,678,000)
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	($3,592,000)	($359,000)	($3,233,000)
65% Title XXI FF / 35% GF (4260-101-0001/0890)	($162,000)	($57,000)	($105,000)
100% GF (4260-101-0001)	$95,804,000	$95,804,000	$0
100% Title XIX (4260-101-0890)	($97,335,000)	$0	($97,335,000)
Total	**($8,641,000)**	**$93,710,000**	**($102,351,000)**

PHARMACY PAYMENT METHODOLOGY - USUAL AND CUSTOMARY

FY 2026-27	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	($3,232,000)	($1,616,000)	($1,616,000)
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	($3,674,000)	($367,000)	($3,307,000)
65% Title XXI FF / 35% GF (4260-101-0001/0890)	($144,000)	($50,000)	($94,000)
100% Title GF (4260-101-0001)	($1,516,000)	($1,516,000)	$0
Total	**($8,566,000)**	**($3,550,000)**	**($5,016,000)**

PROP 35 - PROVIDER PAYMENT INCREASES

FISCAL REFERENCE NUMBER:2458

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$3,057,624,000**
FEDERAL FUNDS	$0	$1,552,024,000
GENERAL FUND	$0	$1,505,600,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$3,057,624,000**
FEDERAL FUNDS	$0	$1,552,024,000
GENERAL FUND	$0	$1,505,600,000
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the costs associated with increasing provider payments, pursuant to Proposition 35, effective January 1, 2025.

This policy change was previously titled "Medi-Cal Provider Payment Increases 2025 & Later."

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 federal approval, and specifies how revenues from the tax are to be allocated. 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, increased payments to Medi-Cal providers, and existing Medi-Cal costs. Proposition 35 creates additional funds from which MCO tax revenues are appropriated and spent.

The non-federal share of these 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 – Provider Payment Increase Funding policy change for the shift from the GF to item 4260-601-3443.

PROP 35 - PROVIDER PAYMENT INCREASES

Reason for Change:
There is no change in FY 2025-26 from the prior estimate.

The change in FY 2026-27 from the prior estimate, is due to updated projections and alignment with the latest Proposition 35 spending plan.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to the Proposition 35 payments starting in FY 2026-27 and an updated estimate of the Proposition 35 funding.

Methodology:
1. Cash basis amounts are based on accrual amounts and these amounts will be revised following finalization and approval of program specifications including payment mechanisms and timing.

2. On a cash basis, the total FY 2026-27 costs are estimated to be:

(Dollars in Thousands)

FY 2026-27	TF	GF	FF
Prop 35 - Provider Payment Increases	$3,057,624	$1,505,600	$1,552,024
Total	**$3,057,624**	**$1,505,600**	**$1,552,024**

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

IMPROVEMENTS AND EFFICIENCIES

FISCAL REFERENCE NUMBER:2569

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**-$170,000,000**
FEDERAL FUNDS	$0	-$102,000,000
GENERAL FUND	$0	-$68,000,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**-$170,000,000**
FEDERAL FUNDS	$0	-$102,000,000
GENERAL FUND	$0	-$68,000,000
OTHER FUNDS	$0	$0

Purpose:
This policy estimates the savings achieved through the implementation of various improvements and efficiencies.

Authority:
Budget Act of 2026

Interdependent Policy Changes:
Not Applicable

Background:
The Department will implement various improvements and efficiencies in the Medi-Cal program that result in ongoing savings. Savings in FY 2026-27 reflect the establishment of utilization management for applied behavioral analysis and transportation benefits and elimination of the quality incentive component of the quality withhold and incentive program for Medi-Cal managed care, which will result in savings in future years. The Department is also continuing the effort to identify efficiencies in other select areas of Medi-Cal.

Reason for Change:
There is no change from the prior estimate for FY 2025-26. The change for FY 2026-27 is an increase in savings due to updated projections. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase in savings due to implementation of the various improvements and efficiencies beginning in FY 2026-27.

Methodology:
1. Savings are estimated to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2026-27	($170,000)	($68,000)	($102,000)

IMPROVEMENTS AND EFFICIENCIES

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

AUDIT SETTLEMENTS

FISCAL REFERENCE NUMBER:110

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	-$57,239,000	$0
GENERAL FUND	$57,239,000	$0
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	-$57,239,000	$0
GENERAL FUND	$57,239,000	$0
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the payments for audit settlements due to the Centers for Medicare and Medicaid Services (CMS).

Authority:
Public Law 95-452
42, Code of Federal Regulations 433.302

Interdependent Policy Changes:
Not Applicable

Background:
Internal Audits oversees the issuance of final audit reports by external entities. The final audit reports will typically contain audit findings and recommendations which can include unallowable amounts owed by the Department. Office of Compliance-Internal Audits (OOC-IA) reaches out to Divisions within the Department periodically to ensure findings and recommendations identified in an audit are addressed and corrective action is taken, including whether the Department will repay or appeal reported overpayments. OOC-IA works with Divisions to ensure the timely determination of amounts owed and to identify anticipated repayment dates.

This policy change is only utilized in estimates where there are audit settlements to be repaid in the budgeted Fiscal Years.

Reason for Change:
The change from the prior estimate, for FY 2025-26, is an increase due to additional audit findings requiring repayment. There is no change from the prior estimate for FY 2026-27. The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease due to settlements being one-time payments.

AUDIT SETTLEMENTS

Methodology:
List of audit settlements anticipated to be repaid in FY 2025-26:

No	Audit Number	Audit Title & Status	Program Responsible	Original Audit Amount	Adjusted Amount
1	Office of Inspector General (OIG) - Capitation Payments Audit (C22-07)	To determine whether the Department made unallowable capitation payments on behalf of members assigned multiple Client Index Numbers (CINs). Following the OIGs recommendation, the Department analyzed duplicate CINs covering the period of February 2020 to December 2023.	Managed Care Operations Division	$9,439,000	$9,439,000
2	OIG – California Reporting Federal Share of Medi-Cal Overpayments Audit (25-08)	To determine if California reported and returned the correct federal share of Medicaid overpayments. The audit reviewed cases finalized between October 1, 2022, and September 30, 2023. The final audit report was completed in April 2026. OIG verbally indicated that the Department should repay federal funds to the CMS as soon as possible.	Third-Party Liability Reporting Division	$47,800,000	$47,800,000
				Total	**$57,239,000**

Fiscal Year	TF	GF	FF
FY 2025-26	**$0**	**$57,239,000**	**($57,239,000)**

AUDIT SETTLEMENTS

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

MEASLES, MUMPS, RUBELLA, VARICELLA (MMRV) VACCINES

FISCAL REFERENCE NUMBER:2570

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$3,076,000**	**$14,451,000**
FEDERAL FUNDS	$1,591,100	$7,474,350
GENERAL FUND	$1,484,900	$6,976,650
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$3,076,000**	**$14,451,000**
FEDERAL FUNDS	$1,591,100	$7,474,350
GENERAL FUND	$1,484,900	$6,976,650
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the costs for Medi-Cal reimbursement of the combination Measles, Mumps, Rubella, Varicella (MMRV) vaccine for Medi-Cal members under the age of four.

Authority:
Welfare & Institutions (W&I) code 14132.995
Assembly Bill (AB) 144 (Chapter 105, Statutes of 2025)

Interdependent Policy Changes:
Not Applicable

Background:
On September 18, 2025, the U.S. Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP) voted to no longer recommend the combination Measles, Mumps, Rubella, Varicella (MMRV) vaccine for children under the age of four. As a result of the CDC's/ACIP's recommendation, the MMRV vaccine is also no longer covered under the federal Vaccines for Children (VFC) program for this population.

Pursuant to the mandate in AB 144 and based upon the California Department of Public Health's (CDPH) MMRV recommendation, Medi-Cal will continue to cover the combination MMRV vaccine for Medi-Cal members under the age of four, even if it is not recommended by the CDC/ACIP and not covered by the federal VFC program. This policy change applies to the Medi-Cal and California Children's Services (CCS) programs, inclusive of both the managed care and fee-for-service delivery systems.

Reason for Change:
This is a new policy change.

MEASLES, MUMPS, RUBELLA, VARICELLA (MMRV) VACCINES

Methodology:

1. The effective date is assumed to be December 12, 2025. Assume the implementation and payments begin no later than May 1, 2026.

2. Assume payments will be retroactive back to December 2025.

3. Assume that Medi-Cal will pay for approximately 52,000 MMRV vaccines annually.

4. Assume the MMRV vaccine ingredient fee reimbursement by eligible medical providers is $289.17 per dose.

5. Previously Medi-Cal paid VFC providers a vaccine administration fees of $9 to administer the MMRV vaccine. The vaccine administration fee is expected to increase to $15.95 for Medi-Cal pharmacy claims and $18.76 for Medi-Cal medical claims.

6. Total costs are estimated to be:

FY 2025-26	TF	GF	FF
MMRV Vaccines (Lagged)	$3,076,000	$1,485,000	$1,591,000

FY 2026-27	TF	GF	FF
MMRV Vaccines (Lagged)	$14,451,000	$6,977,000	$7,474,000

Funding:

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$2,722,000	$1,361,000	$1,361,000
65% Title XXI FF / 35% GF (4260-101-0001/0890)	$354,000	$124,000	$230,000
Total	**$3,076,000**	**$1,485,000**	**$1,591,000**

FY 2026-27	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$12,792,000	$6,396,000	$6,396,000
65% Title XXI FF / 35% GF (4260-101-0001/0890)	$1,659,000	$581,000	$1,078,000
Total	**$14,451,000**	**$6,977,000**	**$7,474,000**

DMPH GME IGT ADMIN. & PROCESSING FEE

FISCAL REFERENCE NUMBER:2572

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$0	-$230,000
OTHER FUNDS	$0	$230,000
% REFLECTED IN BASE	0%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$0	-$230,000
OTHER FUNDS	$0	$230,000

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 public entities for the Graduate Medical Education Payments (GME) to District and Municipal Public Hospitals (DMPHs).

Authority:
SB 246 (Chapter 308, Statutes of 2025)
Welfare and Institutions Code (WIC) 14105.291
State Plan Amendment (SPA) 26-0002

Interdependent Policy Changes:
Not Applicable

Background:
SB 246 , enacted on October 3, 2025, added WIC14105.291 for the Department to make new Medi-Cal GME payments to DMPHs participating in the Medi-Cal managed care program, no sooner than January 1, 2026. The department is submitting State Plan Amendment (SPA) 26-0002 to the Centers for Medicare and Medicaid Services in State Fiscal Year 2025-26 Quarter 3, with an effective date of January 1, 2026. The Department will budget the GME DMPH payments to the DMPHs and their affiliated governmental entities; intergovernmental transfers (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 and for General Fund (GF) savings. Fees assessed in excess of the support costs will result in a savings to the GF.

Reason for Change:
This is a new policy change.

DMPH GME IGT ADMIN. & PROCESSING FEE

Methodology:

1. Assume the fee for GME payments will be 5% of the aggregate nonfederal share, which is calculated at 50% Federal Medical Assistance Percentage (FMAP) of the Total Funds (TF) from the Graduate Medical Education Payments to DMPHs policy change.

2. The reimbursement to the GF will be the 5% administrative fee amount less any support costs.

3. 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.

4. Beginning FY 2026-27, GME support costs may be calculated and reimbursed through GME administrative fees.

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 2026-27	IGT Subject to the Fee	5% Admin Fee	Support Costs	Reimbursement to GF
FY 2025-26 Interim Payment	$3,808,000	$190,000	$0	($190,000)
FY 2025-26 Final Settlement	$803,000	$40,000	$0	($40,000)
Total	$4,611,000	$230,000	$0	($230,000)

Fiscal Year	TF	GF	DMPH GME Special Fund Transfer
FY 2026-27	**$0**	**($230,000)**	**$230,000**

Funding:

100% State GF (4260-101-0001)
DMPH Graduate Medical Education IGT Fund (4260-601-8144)

GRADUATE MEDICAL EDUCATION PAYMENTS TO DMPHS

FISCAL REFERENCE NUMBER:2573

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$24,910,000**
FEDERAL FUNDS	$0	$12,455,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$12,455,000
% REFLECTED IN BASE	0%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$24,910,000**
FEDERAL FUNDS	$0	$12,455,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$12,455,000

Purpose:
This policy change estimates the direct and indirect graduate medical education (GME) payments to the District and Municipal Public Hospitals (DMPHs) in recognition of the Medi-Cal managed care share of GME costs.

Authority:
SB 246 (Chapter 308, Statutes of 2025)
Welfare and Institutions Code (WIC) 14105.291
State Plan Amendment (SPA) 26-0002

Interdependent Policy Changes: DMPH
GME IGT Admin. & Processing Fee

Background:
SB 246, enacted on October 3, 2025, added WIC 14105.291 for the Department to make new Medi-Cal GME payments to DMPHs participating in the Medi-Cal managed care program, no sooner than January 1, 2026. The department is submitting State Plan Amendment (SPA) 26-0002 to the Centers for Medicare and Medicaid Services in State Fiscal Year 2025-26 Quarter 3, with an effective date of January 1, 2026. The Department will budget the GME DMPH payments to the DMPHs and their affiliated governmental entities; intergovernmental transfers (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 and for General Fund (GF) savings. Fees assessed in excess of the support costs will result in a savings to the GF. The IGT savings will be budgeted in the DMPH GME IGT Admin. & Processing Fee policy change.

Reason for Change:
This is a new policy change.

GRADUATE MEDICAL EDUCATION PAYMENTS TO DMPHS

Methodology:

1. The Department anticipates securing federal approval for SPA 26-0002in FY 2025-26, Quarter 4, with retroactive payments beginning in FY 2026-27, Quarter 1. Interim payments are estimated to be made at 50% Federal Medical Assistance Percentage (FMAP).

2. The direct GME payments include costs incurred by DMPHs 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.

3. The indirect medical education (IME) payments include costs incurred by DMPHs 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.

4. The GME and IME annual distribution amounts are calculated based on the methodologies outlined in SPA 26-0002.

    - FY 2025-26 payments were calculated based on FY 2023-24 cost report data and are estimated at $7.6 million Total Funds (TF).
    - FY 2026-27 payments were calculated based on FY 2023-24 cost report data and a 3% increase and are estimated at $15.7 million TF.

5. 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.

6. The IGTs referenced in this policy change are not the basis for the 5% administrative fee for GME 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.

7. Assume all two quarters of FY 2025-26 interim payments will be paid in FY 2026-27.

8. Assume FY 2025-26 final settlements will occur in FY 2026-27.

9. Assume all four quarters of FY 2026-27 interim payments will be paid in FY 2026-27.

(Dollars in Thousands)

FY 2026-27	TF	IGT	FF
FY 2025-26 Final Settlement	$1,606	$803	$803
FY 2025-26 Interim Payment Q3-Q4	$7,616	$3,808	$3,808
FY 2026-27 Interim Payment Q1-Q4	$15,688	$7,844	$7,844
Total	**$24,910**	**$12,455**	**$12,455**

GRADUATE MEDICAL EDUCATION PAYMENTS TO DMPHS

Funding:
100% Title XIX FFP (4260-101-0890)
100% DMPH Graduate Medical Education IGT Fund (4260-601-8144)

RETRO PAYMENTS TO COUNTIES FOR STATE-ONLY BH SVCS

FISCAL REFERENCE NUMBER:2574

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$20,000,000**	**$165,000,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$20,000,000	$165,000,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$20,000,000**	**$165,000,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$20,000,000	$165,000,000
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the retroactive payments and the ongoing impacts for behavioral health services for state only Medi-Cal members.

Authority:
Drug Medi-Cal Organized Delivery System Waiver (DMC-ODS)
Title 22, California Code of Regulations 51341.1 and 51516.1
Welfare & Institutions Code 14680-14685.1
California Advancing and Innovating Medi-Cal (CalAIM) 1915(b) Waiver
Article XIII, Section 36(c)(4) of the California Constitution
AB 128 (Chapter 21, Statutes of 2021)
SB 184, (Chapter 47, Statutes of 2022)

Interdependent Policy Changes:
Specialty Mental Health Services (SMHS) for Adults
Drug Medi-Cal State Plan Services
Drug Medi-Cal Organized Delivery System Waiver
Prop 35 – Provider Payment Increase Funding
Prop 35 – Provider Payment Increases

Background:
California implemented several full-scope Medi-Cal expansions regardless of immigration status. Prior to these expansions, California provided restricted-scope Medi-Cal coverage (emergency and pregnancy-related services only) to low-income adults who were not eligible for full-scope Medi-Cal due to immigration status. Federal financial participation (FFP) is available, regardless of immigration status, for emergency and pregnancy-related services

The 2011 Realignment realigned financial responsibility to counties for public safety programs, including Medi-Cal Behavioral Health programs. Proposition 30 generally requires the state to provide funding to counties when a new state policy established after September 30, 2012, increases county costs. As required by Proposition 30, mandatory DMC State Plan, DMC-ODS and SMHS services were to be provided to the expansion populations and funded with 100

RETRO PAYMENTS TO COUNTIES FOR STATE-ONLY BH SVCS

percent General Fund (GF), with the State providing funding for increased costs to deliver mandatory Medi-Cal Behavioral Health Services to these members.

The age 50+ older adult and 26-49 adult expansions were not programmed correctly in the Short-Doyle/Medi-Cal claims processing system, resulting in the denial of claims and the State owing counties for these payments for behavioral health services that were provided to these UIS members.

Reason for Change:
This is a new policy change.

Methodology:
1. Assume $5,000,000 GF a month ongoing for State Only member costs starting March 2026.

2. The Department estimates using GF for a one-time repayment of $105,000,000 in FY 2026-27 to pay for mandatory behavioral health services claims provided to certain State Only Medi-Cal members that were erroneously denied.

3. Below are cash tables for the payments for FY 2025-26 and FY 2026-27:

(Dollars in Thousands)

FY 2025-26	TF	GF
BH State Only Payments	$20,000	$20,000
Total	**$20,000**	**$20,000**

FY 2026-27	TF	GF
BH State Only Payments	$60,000	$60,000
Retroactive BH State Only Payments	$105,000	$105,000
Total	**$165,000**	**$165,000**

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

HR 1 - DEATH MASTER FILE AUTOMATION

FISCAL REFERENCE NUMBER:2575

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**-$32,665,000**
FEDERAL FUNDS	$0	-$22,796,050
GENERAL FUND	$0	-$9,868,950
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**-$32,665,000**
FEDERAL FUNDS	$0	-$22,796,050
GENERAL FUND	$0	-$9,868,950
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the savings from automating disenrollments for deceased Medi-Cal members identified by the Social Security Administration’s Death Master File (DMF) via California Statewide Automated Welfare System (CalSAWS) in alignment with House Resolution 1 (H.R. 1).

Authority:
H.R. 1, 119th Cong., Section 71104 (2025)
Welfare & Institutions Code 14005.39
Contract 23-30285 A01

Interdependent Policy Changes:
Not Applicable

Background:
Starting January 1, 2027, H.R. 1 mandates that states use the Death Master File (DMF) to automatically disenroll deceased Medi-Cal members without needing further verification. Similarly, California Welfare & Institutions Code 14005.39 requires terminating benefits immediately if a county confirms a member's death.

Every quarter, the Department matches data with LexisNexis Risk Solutions to identify Medi-Cal members listed as deceased by the DMF. These matches are then provided to County Eligibility Workers for review and reconciliation in both the Medi-Cal Eligibility Database System (MEDS) and CalSAWS.

Implementing automation in CalSAWS is expected to greatly reduce the administrative workload of County Eligibility Workers who receive deceased member notices every quarter. If deceased members are not reviewed and reconciled between MEDS and CalSAWS, they remain in the CalSAWS system and we continue paying for identified deceased members.

HR 1 - DEATH MASTER FILE AUTOMATION

This automation will streamline operations, ensuring resources are used more efficiently, allowing counties to concentrate on complex cases rather than routine verifications. Additionally, it will remove the need to include DMF as a part of the LexisNexis Risk Solutions contract.

Reason for Change:
This is a new policy change.

Methodology:
1. Implementation is assumed to occur January 1, 2027.

2. Estimated savings for this effort for FY 2026-27 are:

(Dollars in Thousands)

Fiscal Years	TF	GF	FF
FY 2026-27	($32,665)	($9,869)	($22,796)

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
65% Title XXI / 35% GF (4260-101-0001/0890)
ACA 90% FFP/10% GF (2020 and later)

MANAGED CARE RISK CORRIDORS

FISCAL REFERENCE NUMBER:2576

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**-$41,718,000**	**-$485,055,000**
FEDERAL FUNDS	-$27,797,500	-$220,911,290
GENERAL FUND	-$13,920,500	-$264,143,710
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**-$41,718,000**	**-$485,055,000**
FEDERAL FUNDS	-$27,797,500	-$220,911,290
GENERAL FUND	-$13,920,500	-$264,143,710
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the costs or savings from the implementation of all managed care risk corridors.

Authority:
Welfare & Institutions (W&I) Code 14182.18
W&I Code 14197.2
Title 42, Code of Federal Regulations, 438.8
Cal MediConnect (CMC) Three-Way Contract
All Plan Letter (APL) 23-008
APL 23-008
APL 23-014
APL 23-016
APL 23-017
APL 23-019
Consolidated Appropriations Act of 2023
California Advancing and Innovating Medi-Cal (CalAIM) Initiative, W&I Code, 14301.11
Families First Coronavirus Response Act

Interdependent Policy Changes:
Proposition 56 Funding

Background:
Coordinated Care Initiative (CCI) Risk Mitigation (Previously captured in FRN 2135)
Risk mitigation strategies were put in place for Cal MediConnect (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.

Prop 56 Risk Mitigation (Previously captured in FRN 2333)
For the calendar year (CY) 2022 and CY 2023 rating periods, there are a subset of Proposition 56 directed payment programs that were subject to one of three two-sided risk corridors. The

MANAGED CARE RISK CORRIDORS

first risk corridor applies to 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 for CY 2022; the program ended June 30, 2022, and is no longer calculated for CY 2023.

Dental MLR Risk Corridor (Previously captured in FRN 2356)
The Medi-Cal Dental Managed Care (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 requires DMC plans to remit necessary funds that do not meet the 85% threshold.

Enhanced Care Management (ECM) Risk Corridor (Previously captured in FRN 2452)
Effective January 1, 2022, the Department implemented a new ECM benefit in the Medi-Cal managed care delivery system. To protect the Medi-Cal managed care plans (MCPs) and the State against excessive gains/losses due to the implementation of the new ECM benefit, the Department has established a two-sided, symmetrical risk corridor for each year from the CY 2022 rating period through the CY 2026 rating period, subject to the Centers for Medicare and Medicaid Services approval.

CalAIM Major Organ Transplant Risk (MOT) Corridor (Previously captured in FRN 1788)
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 reduced complexity and ensured continuity of care without burdening 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 established a two-sided, symmetrical risk corridor for the CY 2022 through CY 2024 rating periods.

COVID-19 Risk Corridor (Previously captured in FRN 1788)
As a result of the unprecedented effects of the COVID-19 pandemic, Section 14301.11 of the W&I Code established a two-sided risk corridor for rating periods occurring 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 was 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.

Unsatisfactory Immigration Status (UIS) Risk Corridor
For the CY 2024 rating period, the department utilized 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 was utilized for the San Benito County capitation rates. This risk corridor is related to the shift from voluntary managed care to mandatory managed care.

Reason for Change:
This is a new policy change. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase in recoupments due to a larger number of net recoupments anticipated to occur in FY 2026-27.

Methodology:
1. CCI Risk Mitigation: Assume all payments and recoupments attributable to CMC eligibles and non-CMC eligibles for the 2.5 percent member mix threshold for 2014 through 2022 will

MANAGED CARE RISK CORRIDORS

occur in FY 2026-27. Assume all CMC payments and recoupments for Demonstration Year one through eight will occur in FY 2026-27. 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 in FY 2026-27. $63.7 million TF ($31.9 million GF) is estimated to be paid in FY 2026-27.

2. Prop 56 Risk Mitigation: For the CY 2022 rating period, $14.53 million TF ($4.65 million GF) was recouped in FY 2025-26. For the CY 2023 rating period, $14.30 million TF ($5.42 million GF) was recouped in FY 2025-26, and $11.87 million TF ($4.50 million GF) is estimated to be recouped in FY 2026-27.

3. Dental Managed Care MLR Risk Mitigation: The Department estimates total recoupments of $4.9 million TF ($2.1 million GF) in FY 2026-27. This amount is associated with the CY 2024 rating period.

4. ECM Risk Corridor: Total estimated recoupments for CY 2024 are $90.0 million TF in FY 2026-27 ($35.1 million GF).

5. MOT Risk Corridor: Total recoupments of $12.9 million TF ($3.8 million GF) in FY 2025-26.

6. COVID-19 Risk Corridor: Total recoupments of $11.9 million TF ($4.2 million GF) in FY 2026-27.

7. UIS Risk Corridor: Total estimated recoupments for CY 2024 are $430 million TF in FY 2026-27 ($250 million GF).

8. FY 2025-26 and FY 2026-27 total managed care risk corridor payments/(recoupments) are estimated to be:

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
Prop 56 Risk Mitigation	($28,828)	($10,062)	($18,766)
MOT Risk Corridor	($12,890)	($3,858)	($9,032)
Total FY 2025-26	**($41,718)**	**($13,920)**	**($27,798)**

(Dollars in Thousands)

FY 2026-27	TF	GF	FF
CCI Risk Mitigation	$63,734	$31,867	$31,867
Prop 56 Risk Mitigation	($11,874)	($4,499)	($7,375)
DMC MLR Risk Mitigation	($4,935)	($2,159)	($2,776)
ECM Risk Corridor	($90,000)	($35,146)	($54,854)
COVID-19 Risk Corridor	($11,981)	($4,207)	($7,774)
UIS Risk Corridor	($430,000)	($250,000)	($180,000)
Total FY 2026-27	**($485,055)**	**($264,144)**	**($220,911)**

MANAGED CARE RISK CORRIDORS

Funding:
50% Title XIX FF / 50% GF (4260-101-0001/0890)
65% Title XXI FF / 35% GF (4260-101-0001/0890)
76.5% Title XXI FF / 23.5% GF (4260-101-0001/0890)
88% Title XXI FF / 12% GF (4260-101-0001/0890)
ACA 90/10 (2020 and later) (4260-101-0890)
ACA 93/7 (2019) (4260-101-0890)
100% GF (4260-101-0001)
Title XIX 100% FF (4260-101-0890)
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)

MEDI-CAL RX FRAUD, WASTE, & ABUSE PREVENTION

FISCAL REFERENCE NUMBER:2579

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**-$14,586,000**	**-$35,002,000**
FEDERAL FUNDS	-$8,467,800	-$20,496,900
GENERAL FUND	-$6,118,200	-$14,505,100
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0.0000%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**-$14,586,000**	**-$35,002,000**
FEDERAL FUNDS	-$8,467,800	-$20,496,900
GENERAL FUND	-$6,118,200	-$14,505,100
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the increased savings beyond existing Fraud, Waste and Abuse (FWA) savings realized in Medi-Cal Rx.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
The Department contracts Medi-Cal Rx program integrity services to Prime Therapeutics, resulting in cost-savings for the State. The Department negotiated improvements to program integrity services in April 2025, resulting in additional savings starting as early as October 1, 2025 and ongoing thereafter.

Reason for Change:
This is a new policy change.

Methodology:
1. Annual savings are estimated at $35 million TF.

2. Assume implementation began no later than October 1, 2025.

3. Total estimated savings for improvement initiatives, on a cash basis, are as follows:

FY 2025-26	TF	GF	FF
Medi-Cal Rx Fraud, Waste, and Abuse Prevention	($14,586,000)	($6,118,000)	($8,468,000)
Total	**($14,586,000)**	**($6,118,000)**	**($8,468,000)**

MEDI-CAL RX FRAUD, WASTE, & ABUSE PREVENTION

FY 2026-27	TF	GF	FF
Medi-Cal Rx Fraud, Waste, and Abuse Prevention	($35,002,000)	($14,505,000)	($20,497,000)
Total	**($35,002,000)**	**($14,505,000)**	**($20,497,000)**

Funding:

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	($5,666,000)	($2,833,000)	($2,833,000)
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	($6,063,000)	($606,000)	($5,457,000)
65% Title XXI FF / 35% GF (4260-101-0001/0890)	($274,000)	($96,000)	($178,000)
100% GF (4260-101-0001)	($2,583,000)	($2,583,000)	$0
Total	**($14,586,000)**	**($6,118,000)**	**($8,468,000)**

FY 2026-27	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	($13,206,000)	($6,603,000)	($6,603,000)
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	($15,013,000)	($1,501,000)	($13,512,000)
65% Title XXI FF / 35% GF (4260-101-0001/0890)	($588,000)	($206,000)	($382,000)
100% GF (4260-101-0001)	($6,195,000)	($6,195,000)	$0
Total	**($35,002,000)**	**($14,505,000)**	**($20,497,000)**

UIS MEMBER TRANSITION TO FFS

FISCAL REFERENCE NUMBER:2577

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**-$618,994,000**
FEDERAL FUNDS	$0	-$112,176,000
GENERAL FUND	$0	-$506,818,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**-$618,994,000**
FEDERAL FUNDS	$0	-$112,176,000
GENERAL FUND	$0	-$506,818,000
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the costs and savings of transitioning full-scope coverage for members with unsatisfactory immigration status (UIS) from the Managed Care delivery system to the Fee-For-Service (FFS) delivery system.

Authority:
State Medicaid Director Letter (SMD) #25-003

Interdependent Policy Changes:
Not Applicable

Background:
The Department provides full-scope Medi-Cal coverage without dental to eligible individuals regardless of immigration status. For UIS members, the Department claims federal funding for emergency and pregnancy-related services on a fee-for-service basis only in the FFS delivery system and for capitation rates developed for emergency and pregnancy-related services only in the Managed Care delivery system.

On September 30, 2025, the Centers for Medicare & Medicaid Services (CMS) advanced a new interpretation of section 1903(v) of the Social Security Act (SSA) that prohibits states from claiming federal funds for emergency Medicaid coverage provided to UIS members ineligible for full Medicaid benefits through risk-based Medicaid managed care capitation payments.

SSA section 1903(v) authorizes federal Medicaid payments to states for medical assistance furnished to “aliens ineligible for full Medicaid benefits,” defined as individuals who are not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law, only when such care and services are necessary for the treatment of an emergency medical condition (referred to as “emergency Medicaid”), and provided that UIS members meet all other eligibility requirements for Medicaid under the state plan. CMS interprets SSA section 1903(v) to apply only to specific payments made for care and services necessary for the treatment of an emergency medical condition actually furnished (i.e., rendered), and to not apply to Medicaid managed care payments including risk-based capitation payments.

UIS MEMBER TRANSITION TO FFS

CMS signaled that it would take enforcement action with respect to this guidance starting the first rating period beginning on or after one year following the date of publication, i.e., January 1, 2027, for California.

Reason for Change:
This is a new policy change. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase in savings due to the implementation date expected to be in FY 2026-27.

Methodology:
1. The estimated costs and savings are:

(Dollars in Thousands)

FY 2026-27	TF	GF	FF
100% State GF (4260-101-0001)	($506,135)	($506,818)	$0
Title XIX 100% (4260-101-0890)	($112,176)	$0	($112,176)
Total	**($618,994)**	**($506,818)**	**($112,176)**

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

OVERPAYMENTS FOR REPRODUCTIVE HEALTH

FISCAL REFERENCE NUMBER:2582

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	-$30,000,000
GENERAL FUND	$0	$30,000,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	-$30,000,000
GENERAL FUND	$0	$30,000,000
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the repayment of federals funds claimed for reproductive health services.

Authority:
H.R. 1, 119th Cong., Section 71113 (2025)

Interdependent Policy Change:
Not Applicable

Background:
H.R. 1, Section 71113 (2025), enacted on July 4, 2025, prohibits FFP for providers that meet the definition of a “prohibited entity.” The Department will repay federal funds claimed for reproductive health services pursuant to this provision.

Reason for Change:
This is a new policy change.

Methodology:
1. Assume the costs for FY 2026-27, are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2026-27	$0	$30,000	($30,000)

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

2027 MCO TAX CAPITATION PAYMENTS

FISCAL REFERENCE NUMBER:2585

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$539,050,000**
FEDERAL FUNDS	$0	$313,372,000
GENERAL FUND	$0	$225,678,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$539,050,000**
FEDERAL FUNDS	$0	$313,372,000
GENERAL FUND	$0	$225,678,000
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the initial payments of the capitation rate increments associated with the proposed Managed Care Organization (MCO) Tax imposed on Medi-Cal managed care plans.

Authority:
[Proposed TBL]

Interdependent Policy Changes:
2027 MCO Tax Funding Adjustment – Capitation

Background:
The Department proposes Trailer Bill Language to continue an alternative MCO tax effective January 1, 2027. The alternative MCO tax will be imposed uniformly on enrollment, without regard to whether the enrollee is a Medi-Cal enrollee.

Reason for Change:
This is a new policy change.

Methodology:

1. Capitation payments related to the 2027 MCO Tax are initially paid from the General Fund (GF). The GF is then reimbursed by 2027 MCO Tax revenue through a funding adjustment. The funding adjustment is budgeted in the 2027 MCO Tax Funding Adjustment – Capitation policy change.

2. Assume implementation as of January 1, 2027, and a one-month payment lag for all plans subject to the MCO tax.

2027 MCO TAX CAPITATION PAYMENTS

3. The costs of capitation payments related to the imposition of the 2027 MCO Tax are expected to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2026-27	$539,050	$225,678	$313,372

*Totals may differ due to rounding

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

2027 MCO TAX FUNDING ADJUSTMENT - CAPITATION

FISCAL REFERENCE NUMBER:2586

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$0	-$135,407,000
OTHER FUNDS	$0	$135,407,000
% REFLECTED IN BASE	0%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$0	-$135,407,000
OTHER FUNDS	$0	$135,407,000

Purpose:
This policy change estimates the adjustment of funds from the Managed Care Organization (MCO) Tax Fund to the General Fund (GF) for the non-federal share of capitation rate increments associated with the MCO tax imposed on Medi-Cal managed care plans.

Authority:
[Proposed TBL]

Interdependent Policy Changes:
2027 MCO Tax Capitation Payments

Background:
The Department proposes Trailer Bill Language to continue an alternative MCO Tax effective January 1, 2027. The alternative MCO tax will be imposed uniformly on enrollment, without regard to whether the enrollee is a Medi-Cal enrollee.

Reason for Change:
This is a new policy change.

Methodology:
1. The non-federal share of capitation payments is first reflected in the Two Plan Model, County Organized Health Systems and Single Plan Model, Geographic Managed Care, and Regional Model.
2. The adjustments to the GF and 2027 MCO Tax Fund are estimated to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	2027 MCO Tax Fund
FY 2026-27	$0	($135,407)	$135,407

2027 MCO TAX FUNDING ADJUSTMENT - CAPITATION

Funding:
100% GF (4260-101-0001)
2027 MCO Tax Fund

2027 MCO TAX FUNDING ADJUSTMENT – GENERAL SUPPORT

FISCAL REFERENCE NUMBER:2587

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**-$92,927,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$0	-$584,028,000
OTHER FUNDS	$0	$491,101,000
% REFLECTED IN BASE	0%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**-$92,927,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$0	-$584,028,000
OTHER FUNDS	$0	$491,101,000

Purpose:
This policy change estimates the adjustment of funds from the 2027 Managed Care Organization (MCO) Tax Fund to the General Fund (GF) to support the non-federal share of Medi-Cal managed care rates for health care services furnished to children, adults, seniors, and persons with disabilities, and persons dually eligible for the Medi-Cal and Medicare programs.

Authority:
[Proposed TBL]

Interdependent Policy Changes:
Not Applicable

Background:
The Department proposes Trailer Bill Language to continue an alternative MCO tax effective January 1, 2027. The alternative MCO tax will be imposed uniformly on enrollment, without regard to whether the enrollee is a Medi-Cal enrollee.

Reason for Change:
This is a new policy change.

Methodology:
1. The non-federal share of capitation payments is first reflected in the Two Plan Model, County Organized Health Systems and Single Plan Model, Geographic Managed Care, and Regional Model Base PCs.

2. The adjustments to the GF and 2027 MCO Tax Fund are estimated to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	2027 MCO Tax Fund
FY 2026-27	($92,927)	($584,028)	$491,101

2027 MCO TAX FUNDING ADJUSTMENT – GENERAL SUPPORT

Funding:
100% GF (4260-101-0001)
2027 MCO Tax Fund

FULL REINSTATEMENT OF ASSET LIMIT

FISCAL REFERENCE NUMBER:2588

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**-$431,400,000**
FEDERAL FUNDS	$0	-$215,700,000
GENERAL FUND	$0	-$215,700,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**-$431,400,000**
FEDERAL FUNDS	$0	-$215,700,000
GENERAL FUND	$0	-$215,700,000
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the impact of reinstituting the Medi-Cal Asset Limit to consider resources, including property and other assets, when determining Medi-Cal eligibility for applicants or members whose eligibility is not based on modified adjusted gross income (MAGI) financial methods.

Authority:
Budget Act of 2026

Interdependent Policy Changes:
Reinstatement of Asset Limit

Background:
The Medi-Cal program's asset limits have historically aligned with those of the federal Supplemental Security Income (SSI) program. However, in 2021, California passed Assembly Bill (AB) 133 (Chapter 143, Statutes of 2021) to modify these limits through a two-phased approach: Phase I increased the asset limits, and Phase II eliminated them entirely.

To implement these changes, the Department sought federal approval to disregard up to $130,000 in nonexempt property for a single-member household, and an additional $65,000 for each additional household member, up to a maximum of ten members, effective July 1, 2022. Beginning January 1, 2024, all assets were fully disregarded in determining Medi-Cal eligibility.

Pursuant to the Budget Act of 2025, the Department sought federal approval to reinstate asset limits to disregard up to $130,000 in nonexempt property for a single-member household, and an additional $65,000 for each additional household member, with an effective date of no sooner than January 1, 2026. The Centers for Medicare and Medicaid Services approved California’s State Plan Amendment to implement the asset limits, no sooner than January 1, 2026. The implementation was conditioned on the Director of Health Care Services determining that systems had been programmed and they communicated that determination in writing to the Department of Finance, and no sooner than January 1, 2026. This determination of system readiness was made and communicated to the Department of Finance on December 19, 2025.

FULL REINSTATEMENT OF ASSET LIMIT

Pursuant to the Budget Act of 2026, the Department will now seek federal approval to reinstate asset limits to disregard up to $2,000 per individual and $3,000 per couple in countable assets.

Reason for Change:
This is a new policy change.

Methodology:
1. Assume implementation will begin no sooner than January 1, 2027.

2. The incremental impact of fully reinstating the Medi-Cal Asset limit is shown below:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2026-27	($431,400)	($215,700)	($215,700)

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

ELIMINATE MEDI-CAL OPTIONAL BENEFIT - ACUPUNCTURE

FISCAL REFERENCE NUMBER:2522

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**-$13,600,000**
FEDERAL FUNDS	$0	-$8,200,000
GENERAL FUND	$0	-$5,400,000
OTHER FUNDS	$0	$0
% REFLECTED IN BASE	0%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**-$13,600,000**
FEDERAL FUNDS	$0	-$8,200,000
GENERAL FUND	$0	-$5,400,000
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the elimination of the acupuncture services benefit.

Authority:
Budget Act of 2026

Interdependent Policy Changes:
Not Applicable

Background:
The Department proposes to eliminate the acupuncture services benefit beginning January 2027.

Reason for Change:
This is a new policy change.

ELIMINATE MEDI-CAL OPTIONAL BENEFIT - ACUPUNCTURE

Methodology:

1. Assume the acupuncture services benefit is eliminated starting no sooner than January 1, 2027.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2026-27	($13,600)	($5,400)	($8,200)

Funding:

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

MCO TAX REVENUE TO SUPPORT MEDI-CAL

FISCAL REFERENCE NUMBER:2590

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$181,637,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$0	-$1,700,000,000
OTHER FUNDS	$0	$1,881,637,000
% REFLECTED IN BASE	0%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$181,637,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$0	-$1,700,000,000
OTHER FUNDS	$0	$1,881,637,000

Purpose:
This policy change estimates additional Proposition 35 MCO Tax funding to support increases in managed care and other payments relative to calendar year 2024 for hospital, community clinic, behavioral health, and other services.

Authority:
Protect Access to Health Care Act of 2024 (Proposition 35)

Interdependent Policy Changes:
Not Applicable

Background:
The Department proposes to support increases in managed care and other payments relative to calendar year 2024 for hospital, community clinic, behavioral health, and other services.

Reason for Change:
This is a new policy change.

Methodology:

1. The amount of MCO tax revenue estimated to support payment growth in the Medi-Cal program is:

(Dollars in Thousands)

FY 2026-27	TF	GF	SF (3442 Fund)
MCO Tax Revenue to Support Medi-Cal	$181,637	($1,700,000)	$1,881,637
Total	**$181,637**	**($1,700,000)**	**$1,881,637**

Funding:
Protect Access to Health Care Fund (4260-601-3442)
100% GF (4260-101-0001)

2027 MCO TAX FUNDING ADJUSTMENT – TRI

FISCAL REFERENCE NUMBER:2591

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$0	-$81,242,000
OTHER FUNDS	$0	$81,242,000
% REFLECTED IN BASE	0%	0.0000%
IMPACT ON TOP OF BASE		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$0	-$81,242,000
OTHER FUNDS	$0	$81,242,000

Purpose:
This policy change estimates the adjustment of funds from the Managed Care Organization (MCO) Tax Fund to the General Fund (GF) for the non-federal share of Targeted Rate Increases for primary care, obstetric, and non-specialty mental health services.

Authority:
[Proposed TBL]

Interdependent Policy Changes:
Not Applicable

Background:
The Department proposes Trailer Bill Language to continue an alternative MCO tax effective January 1, 2027. The alternative MCO tax will be imposed uniformly on enrollment, without regard to whether the enrollee is a Medi-Cal enrollee.

In 2024, DHCS implemented targeted rate increases for primary care, obstetric, and non-specialty mental health services to at least 87.5% of Medicare rates.

Reason for Change:
This is a new policy change.

Methodology:

1. The non-federal share of capitation payments is first reflected in the Two Plan Model, County Organized Health Systems and Single Plan Model, Geographic Managed Care, and Regional Model Base PCs.

2. This policy change adjusts GF spending on these rate increases with spending from the 2027 MCO Tax Fund for services after January 1, 2027.

2027 MCO TAX FUNDING ADJUSTMENT – TRI

3. The adjustments to the GF and 2027 MCO Tax Fund are estimated to be:

(Dollars in Thousands)

FY 2026-27	TF	GF	2027 MCO Tax Fund (3492)
Total	**$0**	**($81,242)**	**$81,242**

Funding:
2027 MCO Tax Fund (4260-601-3492)
100% GF (4260-101-0001)

TABLE OF CONTENTS

COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION

The County and Other Local Assistance 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 County and Local Assistance Administrative costs and Fiscal Intermediary (FI) costs associated with the processing of claims.

COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION FUNDING SUMMARY.. COVER PAGE

MEDI-CAL COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION POLICY CHANGES 1-243

- POLICY CHANGE INDEX 1-3
- COUNTY ADMIN 4
- DHCS-OTHER 18
- DHCS-MEDICAL FI 156
- DHCS-HEALTH CARE OPT 180
- DHCS-DENTAL FI 186
- OTHER DEPARTMENTS 192

May 2026 Medi-Cal Estimate

ADMINISTRATION
FUNDING SUMMARY

The display below summarizes the amounts for all County and Other Local Assistance Administration policy changes into one category titled Administration.

FY 2025-2026 Estimate:	Total Funds	Federal Funds	General Funds	Other State Funds
Administration	$7,475,070,000	$4,775,529,000	$2,579,630,000	$119,911,000

FY 2026-2027 Estimate:	Total Funds	Federal Funds	General Funds	Other State Funds
Administration	$8,532,965,000	$6,455,561,000	$1,838,000,000	$239,404,000

MEDI-CAL COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION POLICY CHANGE INDEX

FRN.	POLICY CHANGE TITLE
	COUNTY ADMIN
1704	COUNTY ADMINISTRATION ALLOCATION
214	SAWS
217	CALWORKS APPLICATIONS
1598	CASE MANAGEMENT FOR OTLICP
213	LOS ANGELES COUNTY HOSPITAL INTAKES
215	SAVE
1835	ENHANCED FEDERAL FUNDING
2580	HR 1 - COUNTY ADMINISTRATION ALLOCATION
	DHCS-OTHER
2389	CALAIM - PATH
1721	COUNTY SPECIALTY MENTAL HEALTH ADMIN
1757	INTERIM AND FINAL COST SETTLEMENTS-SMHS
230	CCS PROGRAM COUNTY ADMINISTRATIVE BUDGET
2289	CYBHI - BH SERVICES AND SUPPORTS PLATFORM
2167	MEDI-CAL RX - ADMINISTRATIVE COSTS
1963	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES
235	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES
1813	DRUG MEDI-CAL COUNTY ADMINISTRATION
2517	CALAIM-BH-CONNECT WORKFORCE INITIATIVE
2491	BH TRANSFORMATION FUNDING FOR COUNTY BH DEPTS.
231	POSTAGE & PRINTING
2288	CALAIM - POPULATION HEALTH MANAGEMENT
1722	SMH MAA
2398	CALAIM - BH - CONNECT DEMONSTRATION ADMIN
1937	ACTUARIAL COSTS FOR RATE DEVELOPMENT
1551	MEDI-CAL RECOVERY CONTRACTS
252	ENTERPRISE DATA ENVIRONMENT
1748	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS
1137	MITA
2505	ELECTRONIC VISIT VERIFICATION M&O COSTS
2402	EMSA - CALIFORNIA POISON CONTROL SYSTEM SVCS.
2152	HCBA WAIVER ADMINISTRATIVE COST
1932	PAVE SYSTEM
1318	CAPMAN
1720	PASRR
1370	PUBLIC HEALTH REGISTRIES SUPPORT
1732	SDMC SYSTEM M&O SUPPORT
2002	ELECTRONIC ASSET VERIFICATION PROGRAM

MEDI-CAL COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION POLICY CHANGE INDEX

FRN.	POLICY CHANGE TITLE
	DHCS-OTHER
2447	CALAIM - JUSTICE INVOLVED MAA
1452	PROTECTION OF PHI DATA
2414	BHSF - PROVIDER ACES TRAININGS
2467	MOBILE VISION SERVICES
1982	MEDCOMPASS SOLUTION
1824	NEWBORN HEARING SCREENING PROGRAM
2334	COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE
2206	DRUG MEDI-CAL PARITY RULE ADMINISTRATION
1972	PACES
2413	CALAIM - INMATE PRE-RELEASE PROGRAM ADMIN
2358	STATEWIDE VERIFICATION HUB
1902	DATA ANALYTICS
2321	MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM
2392	MFP/CCT SUPPLEMENTAL FUNDING
1768	T-MSIS
237	SSA COSTS FOR HEALTH COVERAGE INFO.
1441	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)
1675	FAMILY PACT PROGRAM ADMIN.
2362	RECOVERY INCENTIVES CONTINGENCY MANAGEMENT ADMIN
266	MMA - DSH ANNUAL INDEPENDENT AUDIT
2159	HEALTH INFORMATION EXCHANGE INTEROPERABILITY
1556	CCT OUTREACH - ADMINISTRATIVE COSTS
2438	HEALTH PLAN OF SAN MATEO DENTAL INTEGRATION EVAL
2123	CMS DEFERRED CLAIMS - OTHER ADMIN
2459	DESIGNATED STATE HEALTH PROGRAMS
2562	EPTP - STATEWIDE LEARNING COLLABORATIVE
2559	STATE ONLY CLAIMING ADJUSTMENTS - ADMIN.
2552	TRANSFORMING MATERNAL HEALTH PROVIDER INFR PYMT
2567	HR 1 - HEALTH ENROLLMENT NAVIGATORS
2592	RECONCILIATION - ADMIN
2593	PROPOSITION 35 FUNDING – CYBHI & BH-CONNECT
	DHCS-MEDICAL FI
2115	MEDICAL FI BO & IT COST REIMBURSEMENT
2117	MEDICAL FI BO & IT CHANGE ORDERS
2119	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES
2118	MEDICAL INFRASTRUCTURE & DATA MGT SVCS
2112	MEDICAL FI BO OTHER ESTIMATED COSTS
2116	MEDICAL FI BO TELEPHONE SERVICE CENTER

MEDI-CAL COUNTY AND OTHER LOCAL ASSISTANCE ADMINISTRATION POLICY CHANGE INDEX

FRN.	POLICY CHANGE TITLE
	DHCS-MEDICAL FI
2111	MEDICAL FI BUSINESS OPERATIONS
2113	MEDICAL FI BO HOURLY REIMBURSEMENT
2114	MEDICAL FI BO MISCELLANEOUS EXPENSES
2564	HR 1 - PROHIBITED ENTITIES SYSTEMS COSTS
2594	UIS MEMBER TRANSITION TO FFS SYSTEMS COSTS
	DHCS-HEALTH CARE OPT
2051	HCO OPERATIONS
2052	HCO COST REIMBURSEMENT
2053	HCO ESR HOURLY REIMBURSEMENT
	DHCS-DENTAL FI
2380	DENTAL FI-DBO ADMIN 2022 CONTRACT
2006	DENTAL FI ADMINISTRATION 2016 CONTRACT
	OTHER DEPARTMENTS
236	PERSONAL CARE SERVICES
233	HEALTH-RELATED ACTIVITIES - CDSS
1679	CALHEERS DEVELOPMENT
234	MATERNAL AND CHILD HEALTH
243	CDDS ADMINISTRATIVE COSTS
256	DEPARTMENT OF SOCIAL SERVICES ADMIN COST
246	HCPCFC CASE MANAGEMENT
2455	HCPCFC ADMIN COSTS
1192	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS
253	DEPARTMENT OF AGING ADMINISTRATIVE COSTS
2244	FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG
239	CLPP CASE MANAGEMENT SERVICES
1680	CALIFORNIA SMOKERS' HELPLINE
257	CALHHS AGENCY HIPAA FUNDING
1665	MEDI-CAL INPATIENT SERVICES FOR INMATES
232	VETERANS BENEFITS
1774	VITAL RECORDS
249	KIT FOR NEW PARENTS
263	MERIT SYSTEM SERVICES FOR COUNTIES
1114	PIA EYEWEAR COURIER SERVICE

COUNTY ADMINISTRATION ALLOCATION

FISCAL REFERENCE NUMBER:1704

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$2,377,805,000**	**$2,377,805,000**
FEDERAL FUNDS	$1,188,902,500	$1,188,902,500
GENERAL FUND	$1,188,902,500	$1,188,902,500
OTHER FUNDS	$0	$0

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.

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:
There is no change from the prior estimate for FY 2025-26 and FY 2026-27, or in the current estimate from FY 2025-26 to FY 2026-27.

COUNTY ADMINISTRATION ALLOCATION

Methodology:

1. The total rounded estimated FY 2025-26 and FY 2026-27 county administration costs are:

(Dollars in Thousands)

Total Allocation	TF	GF	FF
FY 2025-26	$2,377,805	$1,188,903	$1,188,903
FY 2026-27	$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

FISCAL REFERENCE NUMBER:214

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$200,841,000**	**$196,915,000**
FEDERAL FUNDS	$200,435,500	$196,846,000
GENERAL FUND	$405,500	$69,000
OTHER FUNDS	$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.

Reason for Change:
There is a decrease for FY 2025-26 and FY 2026-27, from the prior estimate, due to projects being removed, shifted, as well as projections being revised for various line items.

There is a decrease from FY 2025-26 to FY 2026-27, in the current estimate, due to one-time projects ending in FY 2025-26.

Methodology:
1. The following estimate was provided by CDSS on a cash basis:

SAWS

Line Item	FY 2025-26	FY 2026-27
AB 91 Inclusion Act	$0	$736,000
Accelerated Enrollment Enhancement	$592,000	$0
Alternate Formats	$12,070,000	$0
Appeals Case Management System	$135,000	$274,000
Auditor Access Profile	$113,000	$0
BenefitsCal Release of Information	$0	$1,497,000
Call Center Data	$94,000	$0
CalSAWS Project	$157,429,000	$189,339,000
Changes to 90 Day Cure	$0	$169,000
Child Health and Disability Prevention Program	$987,000	$0
Full-Scope Medi-Cal Expansion Enrollment Freeze	$1,158,000	$0
HR 1 - CalSAWS System Costs	$11,291,000	$1,324,000
Incarceration Automated Reporting to Counties	$884,000	$0
Medi-Cal Renewal Packet Printing	$412,000	$0
Post-Eligibility Treatment of Income	$0	$370,000
Premiums for Full-Scope Population	$1,836,000	$0
Reinstatement Of Asset Limit	$992,000	$0
Reinstatement Of Asset Limit - Mailing	$87,000	$0
Reinstatement Of Asset Limit: Pickle, Disabled Adult Child, and Disabled Widow/er	$0	$276,000
Report Support	$152,000	$0
Return Mail Automation	$1,182,000	$0
SB 1254 CalFresh Incarcerated Enrollment	$1,622,000	$0
SB 1341 Medi-Cal/SAWS	$4,185,000	$0
SB 242 HOPE Trust Accounts	$57,000	$0
SB 311 Medicare Part A Buy-In	$629,000	$0
Shared Application Forms Revisions	$1,348,000	$0
Single Streamline Portal Updates	$1,469,000	$0
Statewide Project Management	$2,117,000	$2,930,000
Total	**$200,841,000**	**$196,915,000**

*Totals may differ due to rounding.

2. Total estimated GF expenditures for FY 2025-26 and FY 2026-27 are:

GF Expenditure Items	FY 2025-26	FY 2026-27
Reinstatement Of Asset Limit: Pickle, Disabled Adult Child, and Disabled Widow/er	$0	$69,000
SB 1254 CalFresh Incarcerated Enrollment	$405,000	$0
Total	**$405,000**	**$69,000**

*Totals may differ due to rounding.

SAWS

3. Assume an estimated cost of **$200,841,000 TF ($405,000 GF)** in **FY 2025-26** and **$196,915,000 TF ($69,000 GF)** in **FY 2026-27**.

Funding:
100% Title XIX FF (4260-101-0890)
Enhanced CA 75/25 (4260-101-0890/0001)

CALWORKS APPLICATIONS

FISCAL REFERENCE NUMBER:217

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$99,964,000**	**$99,964,000**
FEDERAL FUNDS	$49,982,000	$49,982,000
GENERAL FUND	$49,982,000	$49,982,000
OTHER FUNDS	$0	$0

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:
There is a slight increase for FY 2025-26 and FY 2026-27, from the prior estimate, due to the most recent quarters of available data provided by CDSS. There is no change from FY 2025-26 to FY 2026-27 in the current estimate.

Methodology:
1. The estimated costs for FY 2025-26 and FY 2026-27 are provided on a cash basis by CDSS:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2025-26	$99,964	$49,982	$49,982
FY 2026-27	$99,964	$49,982	$49,982

*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

FISCAL REFERENCE NUMBER:1598

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$44,763,000**	**$46,391,000**
FEDERAL FUNDS	$22,381,500	$23,195,500
GENERAL FUND	$22,381,500	$23,195,500
OTHER FUNDS	$0	$0

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 a slight increase from the prior estimate, for FY 2025-26, due to updated actuals being higher than initially projected. There is an increase from the prior estimate, for FY 2026-27, due to updated actuals and revised projections. There is an increase from FY 2025-26 to FY 2026-27, in the current estimate, due to projecting caseload being higher in FY 2026-27.

Methodology:
1. The Department currently estimates the case management and redetermination for the former OTLICP members at $4.00 Per Member Per Month.

2. The estimated average monthly OTLICP members for FY 2025-26 are 932,564 and 966,482 for FY 2026-27.

3. The estimated costs are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2025-26	$44,763	$22,382	$22,382
FY 2026-27	$46,391	$23,196	$23,196

*Totals differ due to rounding.

CASE MANAGEMENT FOR OTLICP

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

FISCAL REFERENCE NUMBER:213

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$20,166,000**	**$20,166,000**
FEDERAL FUNDS	$17,430,000	$17,430,000
GENERAL FUND	$2,736,000	$2,736,000
OTHER FUNDS	$0	$0

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:
There is a decrease for FY 2025-26 or FY 2026-27, from the prior estimate, due to updating the estimate to align better with actual invoicing processes. There is no change from FY 2025-26 to FY 2026-27 in the current estimate.

Methodology:
1. The reimbursement rate is $268 for both current year and budget year. Assume in FY 2025-26 and FY 2026-27, PFSWs will continue processing a base caseload of 2,215 per month.

   FY 2025-26: 2,215 x $268 x 12 = $7,123,000 TF ($3,562,000 GF)
   FY 2026-27: 2,215 x $268 x 12 = $7,123,000 TF ($3,562,000 GF)

2. The Department completed the FY 2023-24 reconciliation in FY 2024-25. The FY 2023-24 reconciliation amounts are final, and the FY 2024-25 reconciliation amounts are placeholders.

LOS ANGELES COUNTY HOSPITAL INTAKES

(Dollars in Thousands)

Line Item	FY 2025-26			
	TF	GF	FF	CF
PFSW Base	$7,123	$3,562	$3,562	$0
2023-24 Recon.	$13,042	($826)	$13,868	$13,042
Total	**$20,166**	**$2,736**	**$17,430**	$13,042
Line Item	**FY 2026-27**			
	TF	**GF**	**FF**	**CF**
PFSW Base	$7,123	$3,562	$3,562	$0
2024-25 Recon.	$13,042	($826)	$13,868	$13,042
Total	**$20,166**	**$2,736**	**$17,430**	$13,042

* Totals may differ due to rounding.
** County Funds are not included in the Total Fund.

Funding:

(Dollars in Thousands)

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	$13,868	$0	$13,868
100% GF	4260-101-0001	($826)	($826)	$0
Total		**$20,166**	**$2,736**	**$17,430**
FY 2026-27	**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	$13,868	$0	$13,868
100% GF	4260-101-0001	($826)	($826)	$0
Total		**$20,166**	**$2,736**	**$17,430**

* Totals may differ due to rounding.

SAVE

FISCAL REFERENCE NUMBER:215

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$4,000,000	$4,000,000
GENERAL FUND	-$4,000,000	-$4,000,000
OTHER FUNDS	$0	$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 2025-26 or FY 2026-27, or in the current estimate from FY 2025-26 to FY 2026-27.

Methodology:
1. A reconciliation is completed 18 months after the end of each fiscal year to adjust funding received by counties from 50% FFP to 100% FFP.

2. The Medi-Cal accrual costs for SAVE reported over the last three years by the counties were:

Fiscal Year	Actual	Fiscal Year	Estimated
FY 2021-22	$8,890,711	FY 2024-25	$8,000,000
FY 2022-23	$8,302,183	FY 2025-26	$8,000,000
FY 2023-24	$8,400,365	FY 2026-27	$8,000,000

SAVE

3. Based on claims through June 2025, federal funds will be:

(Dollars in Thousands)

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**

FY 2026-27	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)

ENHANCED FEDERAL FUNDING

FISCAL REFERENCE NUMBER:1835

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$608,380,250	$633,390,000
GENERAL FUND	-$608,380,250	-$633,390,000
OTHER FUNDS	$0	$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.

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) 2026 on September 25, 2025.

Reason for Change:
The change from the prior estimate, for FY 2025-26 and FY 2026-27, 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 2025-26 to FY 2026-27, in the current estimate, is an increase in GF savings due to updated estimated claim funding projections that utilized expenditure trends from FY 2024-25.

ENHANCED FEDERAL FUNDING

Methodology:

1. The effective date for the Department's APD was October 1, 2025.

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 2025-26, the Department will claim payments for FY 2024-25 Quarters 2 through 4 and FY 2025-26 Quarter 1. In FY 2026-27, the Department will claim payments for FY 2025-26 Quarters 2 through 4 and FY 2026-27 Quarter 1.

5. The savings are estimated to be:

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
Title XIX at 50% FFP	($2,433,521)	($1,216,761)	($1,216,761)
Title XIX at 75% FFP	$2,433,521	$608,380	$1,825,141
Total	**$0**	**($608,380)**	**$608,380**

FY 2026-27	TF	GF	FF
Title XIX at 50% FFP	($2,533,560)	($1,266,780)	($1,266,780)
Title XIX at 75% FFP	$2,533,560	$633,390	$1,900,170
Total	**$0**	**($633,390)**	**$633,390**

*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)

CALAIM - PATH

FISCAL REFERENCE NUMBER:2389

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$473,522,000**	**$515,456,000**
FEDERAL FUNDS	$236,761,000	$257,728,000
GENERAL FUND	$214,535,000	$181,355,000
OTHER FUNDS	$22,226,000	$76,373,000

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, 14184.700, 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.

<u>ECM and Community Supports Capacity and Infrastructure Building</u>
PATH provides funding to transition, build, expand, and maintain infrastructure/capacity to support the implementation of ECM and Community Supports through four initiatives:

- Technical Assistance (TA) Initiative: Virtual “marketplace" was developed to provide technical support and off-the-shelf resources from vendors to establish the infrastructure development.
- Collaborative Planning and Implementation Initiative: Provides funding to regional facilitators approved by the Department. Support for regional collaborative planning and implementation efforts includes among managed care plans, providers, Community-Based Organizations (CBOs), county agencies, hospitals, tribes, and others to assess gaps and promote readiness.

CALAIM - PATH

- 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 others, 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 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. The TPA supports implementation of the PATH CITED IGT and PATH JI IGT awards while the Department serves as the fiscal administrator to process all IGT payments.

Reason for Change:
The change from the prior estimate, for FY 2025-26, is a decrease due to aligning payments with milestone achievements, completion of reporting deliverables, and ongoing project approvals. Additionally, some funding has shifted from FY 2025-26 into FY 2026-27. The change from the prior estimate, for FY 2026-27, is an increase due to shifting some funds from FY 2025-26. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to anticipating more payments in FY 2026-27.

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. As part of the JI Capacity Building Program, in FY 2025-26, the Department is awarding Los Angeles County an additional $59 million Total Fund via an intergovernmental transfer (IGT).

3. Assume all payments that do not require a State Share IGT 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 processes the passthrough invoice and makes payment to PCG. PCG then has up to three business days to make that payment to the PATH grantee once funds are received from the Department.

CALAIM - PATH

a. State Share IGT payments for the PATH CITED IGT and JI IGT awards will be processed in alignment with standard IGT procedure. Funding is federally matched at the 50% regular matching rate.

4. Assume TA Marketplace Vendors are paid based on completion of deliverables in their approved budgets and scope of work.

5. Assume the Collaborative Planning and Implementation Initiative facilitators are paid quarterly based on payment terms outline in their contract.

6. Assume approved applicants for the non-IGT CITED Initiative are paid based on completing milestones and quarterly reporting.

    a. Assume approved CITED IGT applicants are paid based on completing milestones

7. Assume approved non-IGT JI applicants are paid based on completing milestones and required reporting.
    a. Assume approved JI IGT applicants are paid based on completing milestones.

8. On a cash basis, all PATH Program costs are estimated to be:

(Dollars in Thousands)

Fiscal Years	TF	GF	GF Reimb.	FF
FY 2025-26	**$473,522**	**$214,535**	**$22,226**	**$236,761**
FY 2026-27	**$515,456**	**$181,355**	**$76,373**	**$257,728**

*Totals may differ due to rounding.

Funding:

(Dollars in Thousands)

FY 2025-26	TF	GF	GF Reimb.	FF
100% Title XIX FF (4260-101-0890)	$22,226	$0	$0	$22,226
50% Title XIX / 50% GF (4260-101-0890/0001)	$429,070	$214,535	$0	$214,535
Reimbursement GF (4260-601-0995)	$22,226	$0	$22,226	$0
Total	**$473,522**	**$214,535**	**$22,226**	**$236,761**
FY 2026-27	**TF**	**GF**	**GF Reimb.**	**FF**
100% Title XIX FF (4260-101-0890)	$76,373	$0	$0	$76,373
50% Title XIX / 50% GF (4260-101-0890/0001)	$362,710	$181,355	$0	$181,355
Reimbursement GF (4260-601-0995)	$76,373	$0	$76,373	$0
Total	**$515,456**	**$181,355**	**$76,373**	**$257,728**

*Totals may differ due to rounding.

COUNTY SPECIALTY MENTAL HEALTH ADMIN

FISCAL REFERENCE NUMBER:1721

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$284,592,000**	**$304,523,000**
FEDERAL FUNDS	$273,949,000	$290,611,000
GENERAL FUND	$10,643,000	$13,912,000
OTHER FUNDS	$0	$0

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 Medi-Cal Specialty Mental Health program. Counties must report their administration costs and direct facility expenditures quarterly. Along with administration costs, counties may claim reimbursement for costs incurred for county Quality Assurance and Utilization Review (QAUR). Finally, counties may obtain State General Fund reimbursement for the non-federal share of administration and QUAR cost subject to Proposition 30. Costs incurred to implement the following requirements are subject to Proposition 30: Performance Outcomes System (POS), the Behavioral Health Quality and Equity Framework, Managed Care Regulations – Mental Health (MH), MH Parity Final Rule, and the Interoperability Final Rule.

The QAUR and administration 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 changed 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, an increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased

COUNTY SPECIALTY MENTAL HEALTH ADMIN

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.

The Department implemented, in FY 2025-26, the Behavioral Health Quality and Equity Framework to assist Behavioral Health Plans with improving on a set of Behavioral Health Performance Measures. Mental Health Plans will be able to claim reimbursement for these costs pursuant to Proposition 30.

Beginning in FY 2026-27, new costs to support Child and Adolescent Needs and Strengths (CANS) reporting, under the Performance Outcome System, are being added. This new reporting solution will integrate data collected into a single statewide database for both Department of Health Care Services (DHCS) and California Department of Social Services (CDSS) reporting.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is a decrease due to a change in the Medicaid Children's Health Insurance Program (MCHIP) split for claims types of MH parity and managed care.

The change in FY 2026-27, from the prior estimate, is an increase due to adjusted MCHIP claims amounts and the updated percentage of MCHIP type claims for MH parity rule.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to the standard projected growth rate in claims of 5.1% and the addition of CANS Assessment costs beginning in FY 2026-27.

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. For the CANS Assessment costs, however, no lags are assumed and costs are estimated to occur annually on a cash basis. The estimated costs are as follows:

COUNTY SPECIALTY MENTAL HEALTH ADMIN

Fiscal Year	Type	Accrual	FY 2025-26	FY 2026-27
FY 2023-24	Other Admin	$353,437,000	$26,509,000	$0
	MCHIP	$19,754,000	$1,482,000	$0
	QAUR	$66,996,000	$5,025,000	$0
	POS	$3,753,000	$282,000	$0
	Parity	$27,312,000	$2,049,000	$0
	Managed Care	$12,551,000	$941,000	$0
Subtotal		$483,804,000	$36,288,000	$0
FY 2024-25	Other Admin	$371,456,000	$275,503,000	$27,861,000
	MCHIP	$20,761,000	$15,398,000	$1,557,000
	QAUR	$70,413,000	$52,224,000	$5,281,000
	POS	$3,945,000	$2,926,000	$296,000
	Parity	$28,705,000	$21,290,000	$2,153,000
	Managed Care	$13,191,000	$9,784,000	$989,000
Subtotal		$508,471,000	$377,125,000	$38,138,000

FY 2025-26	Other Admin	$390,393,000	$71,563,000	$289,548,000
	MCHIP	$21,820,000	$4,000,000	$16,183,000
	QAUR	$74,004,000	$13,566,000	$54,888,000
	POS	$4,146,000	$760,000	$3,075,000
	Parity	$30,169,000	$5,530,000	$22,376,000
	Managed Care	$13,864,000	$2,541,000	$10,283,000
	BH Quality & Equity	$600,000	$110,000	$445,000
Subtotal		$534,995,000	$98,070,000	$396,798,000
FY 2026-27	Other Admin	$410,295,000	$0	$75,211,000
	MCHIP	$22,932,000	$0	$4,204,000
	QAUR	$77,779,000	$0	$14,258,000
	POS	$4,357,000	$0	$799,000
	Parity	$31,708,000	$0	$5,812,000
	Managed Care	$14,571,000	$0	$2,671,000
	BH Quality & Equity	$600,000	$0	$110,000
	CANS Assessment	$5,000,000	$0	$5,000,000
Subtotal		$567,242,000	$0	$108,065,000
Total			$511,483,000	$543,001,000

COUNTY SPECIALTY MENTAL HEALTH ADMIN

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, General Fund (GF) 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 are 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% 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).

7. BH Quality and Equity Framework funding is available for FY 2025-26 and FY 2026-27 in the amount of $600,000 for SMHS and is assumed to be funded with 50% FF and 50% GF split.

8. Starting in FY 2026-27, DHCS will incur annual CANS Assessment costs of $5 million, which include licensing and subscription feeds, to implement a statewide database.

9. On a cash basis, the amounts for FY 2025-26 and FY 2026-27 are:

Claim Type	**FY 2025-26**				
	TF	**FF**	**GF**	**CF**	**COVID-19 FF**
Other Admin	$373,576,000	$186,788,000	$0	$186,788,000	$0
MCHIP	$20,880,000	$13,572,000	$0	$7,298,000	$10,000
QAUR Reg	$24,514,000	$12,257,000	$0	$12,257,000	$0
QAUR SPMP	$46,301,000	$34,726,000	$0	$11,575,000	$0
POS	$3,967,000	$2,353,000	$1,614,000	$0	$0
Parity	$28,869,000	$16,563,000	$6,146,000	$6,146,000	$14,000
Managed Care Regulations	$13,266,000	$7,604,000	$2,828,000	$2,827,000	$7,000
BH Quality & Equity	$110,000	$55,000	$55,000	$0	$0
Total	$511,483,000	**$273,918,000**	**$10,643,000**	$226,891,000	**$31,000**

COUNTY SPECIALTY MENTAL HEALTH ADMIN

Claim Type	FY 2026-27			
	TF	**FF**	**GF**	**CF**
Other Admin	$392,620,000	$196,310,000	$0	$196,310,000
MCHIP	$21,944,000	$14,264,000	$0	$7,680,000
QAUR Reg	$25,765,000	$12,882,000	$0	$12,883,000
QAUR SPMP	$48,663,000	$36,497,000	$0	$12,166,000
POS	$4,170,000	$2,473,000	$1,697,000	$0
Parity	$30,341,000	$17,407,000	$6,467,000	$6,467,000
Managed Care Regulations	$13,943,000	$7,999,000	$2,972,000	$2,972,000
BH Quality & Equity	$555,000	$278,000	$277,000	$0
CANS Assessment	$5,000,000	$2,500,000	$2,500,000	$0
Total	$543,001,000	**$290,610,000**	**$13,913,000**	$238,478,000

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)

INTERIM AND FINAL COST SETTLEMENTS-SMHS

FISCAL REFERENCE NUMBER:1757

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$186,894,000**	**$182,450,000**
FEDERAL FUNDS	$186,894,000	$182,450,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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 2025-26 and FY 2026-27, from the prior estimate, is due to:

- A large portion of interim and final cost settlements, which were previously estimated in FY 2025-26, shifting to FY 2026-27.
- A portion of FY 2020-21 interim settlements, all the FY 2022-23 interim settlements, and FY 2019-20 audit settlements shifting to FY 2026-27.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease due to a larger amount of interim and final audit settlements being processed in FY 2025-26, with the remaining settlements projected to occur in FY 2026-27 as the settlement process ends.

Methodology:

1. Interim cost settlements are based on the difference between each county MHP’s filed cost report and the payments they received from the Department.

INTERIM AND FINAL COST SETTLEMENTS-SMHS

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 2025-26 and FY 2026-27 for interim and final audit settlements not yet received, the following procedures are used:

   - The average expenditure of $1,351,931 per interim settlement is determined by dividing the actual net outflow of $102,746,744 from FY 2024-25 by 76, the number of interim settlement packages processed in FY 2024-25. The average recoupment of $352,871 per final audit settlement is determined by dividing the net inflow, $15,526,321, by 44, the number of final audit settlements processed in FY 2024-25.

   - 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 2025-26 and FY 2026-27.

6. The net FF to be reimbursed and/or recouped in FY 2025-26 for interim settlements and final audit settlements are shown below:

Interim Settlements	TF	FF
FY 2015-16	$1,352,000	$1,352,000
FY 2016-17	$2,785,000	$2,785,000
FY 2017-18	$50,199,000	$50,199,000
FY 2018-19	$78,296,000	$78,296,000
FY 2019-20	$86,732,000	$86,732,000
FY 2020-21	$17,240,000	$17,240,000
Subtotal	$236,604,000	$236,604,000

INTERIM AND FINAL COST SETTLEMENTS-SMHS

Final Audit Settlements	TF	FF
FY 2014-15	($342,000)	($342,000)
FY 2015-16	($3,529,000)	($3,529,000)
FY 2016-17	($11,267,000)	($11,267,000)
FY 2017-18	($17,220,000)	($17,220,000)
FY 2018-19	($17,352,000)	($17,352,000)
Subtotal	($49,710,000)	($49,710,000)
Total FY 2025-26	$186,894,000	$186,894,000

7. The net FF to be reimbursed and/or recouped in FY 2026-27 for interim settlements and final audit settlements are shown below:

Interim Settlements	TF	FF
FY 2020-21	$72,094,000	$72,094,000
FY 2021-22	$92,014,000	$92,014,000
FY 2022-23	$94,774,000	$94,774,000
Subtotal	$258,882,000	$258,882,000

Final Audit Settlements	TF	FF
FY 2019-20	($18,269,000)	($18,269,000)
FY 2020-21	($18,818,000)	($18,818,000)
FY 2021-22	($19,382,000)	($19,382,000)
FY 2022-23	($19,963,000)	($19,963,000)
Subtotal	($76,432,000)	($76,432,000)
Total FY 2026-27	$182,450,000	$182,450,000

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

CCS PROGRAM COUNTY ADMINISTRATIVE BUDGET

FISCAL REFERENCE NUMBER:230

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$204,223,000**	**$206,028,000**
FEDERAL FUNDS	$131,628,950	$131,578,400
GENERAL FUND	$72,594,050	$74,449,600
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the California Children's Services (CCS) program county administrative cost.

Authority:
Health & Safety Code, sections 123800-123995
AB 2724 (Chapter 73, Statutes of 2022)
AB 133 (Chapter 143, Statutes of 2022)
SB 184 (Chapter 47, Statues of 2022)
AB 118 (Chapter 42, Statutes of 2023)
SB 108 (Chapter 35, Statues of 2024)

Interdependent Policy Changes:
Not Applicable

Background:
The CCS program provides medical case management to all CCS clients.

In 33 counties, that are considered Whole Child Model (WCM) counties, the Medi-Cal managed care plans are responsible for administering the CCS program and coordinating with the County. The County is responsible for medical, residential, and financial eligibility determinations. Specifically, the managed care plan is responsible for case management, authorization of services/treatment, and other program administrative functions.

Medi-Cal Managed Care Plan	County
CenCal Health	San Benito[1], San Luis Obispo, Santa Barbara, Mariposa[1]
Central California Alliance for Health	Merced, Monterey, Santa Cruz
Health Plan of San Mateo	San Mateo
CalOptima	Orange
Partnership HealthPlan of California	Butte[1], Colusa[1], Del Norte, Glenn[1], Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Nevada[1], Placer[1], Plumas[1], Sierra[1], Siskiyou, Shasta, Solano, Sonoma, Sutter[1], Tehama[1], Trinity, Yolo, Yuba[1]

[1] Effective January 1, 2025, WCM went live in these counties under AB 118.

For the remaining 25 Classic CCS counties, in independent counties (counties with a population greater than 200,000), county staff are primarily responsible for administering the CCS program locally, including determining financial, residential, and medical eligibility including the evaluation and adjudication of service authorization requests (SARs). For dependent counties (counties

CCS PROGRAM COUNTY ADMINISTRATIVE BUDGET

with a population under 200,000), the state shares case management activities. Dependent counties are responsible for financial and residential verifications and the Department's CCS clinical staff are responsible for medical eligibility determinations and SAR adjudications.

The Children's Medical Services Network (CMS Net) case management database is utilized by CCS counties and the Department.

SB 184 sunset 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 support implementation of the CCS Compliance, Monitoring, and Oversight program, effective July 1, 2025. The CCS Monitoring and Oversight Memorandum of Understanding was deferred to an undetermined date. In the interim, counties may voluntarily participate in CCS Monitoring and Oversight activities. Counties received the funds in FY 2024-25 to assist with implementation activities. Counties continue to receive funds in FY 2025-26 to support CCS Program administrative functions.

SB 108 extended flexibility to the counties to support the HCPCFC.

Reason for Change:
There is no substantial change for FY 2025-26 from the prior estimate. The Total Fund increase is due to rounding. The General Fund decrease is due to revised enhanced Federal Medical Assistance Percentage splits that are based on more recent actuals that reduced the General Fund and County Fund match.

There is an increase for FY 2026-27 from the prior estimate, and from FY 2025-26 to FY 2026-27 in the current estimate, due to CCS clients with Unsatisfactory Immigration Status (UIS) shifting out of the WCM and into Fee-For-Service (FFS).

Methodology:

1. Starting in November 2024, the county administrative estimate is updated to reflect recent caseload and per member, per month cost data.

2. The CCS program county administrative costs for FY 2025-26 are $187,255,000 and $187,255,000 for FY 2026-27.

3. Assume administrative costs of $1,057,000 in both FY 2025-26 and FY 2026-27 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 $3,852,000 in FY 2025-26 and $4,150,000 in FY 2026-27.

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:

CCS PROGRAM COUNTY ADMINISTRATIVE BUDGET

	FY 2025-26	FY 2026-27
County Administration:	$32,416,000	$32,416,000
County share of cost:	($2,626,000)	($2,626,000)
Total Medi-Cal OTLICP:	$29,790,000	$29,790,000

6. County data processing costs associated with CMS Net for OTLICP are estimated to be $559,000 in FY 2025-26 and $602,000 in FY 2026-27.

7. Payments to the COHS health plans under the WCM are applied against the CCS program county administrative budget. On a cash basis the expenditures are estimated to be $25,802,000 in FY 2025-26 and $24,338,000 in FY 2026-27. Beginning January 1, 2027, CCS clients with UIS will transition to the FFS delivery system.

8. Enhanced, Title XIX (75% FFP), funding is available for Skilled Professional Medical Personnel for the Medi-Cal and OTLICP populations in FY 2025-26 and FY 2026-27.

9. To support the 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 member caseload. The CCS Compliance M&O cost is estimated at $10,138,000.

10. The estimated CCS program county administrative budget is below.

FY 2025-26				
CCS Medi-Cal/OTLICP	**TF***	**GF**	**FF**	**CF****
CCS Admin. Budget	$27,164,000	$6,322,000	$20,842,000	$2,626,000
CMS Net	$559,000	$196,000	$363,000	$0
Subtotal	$27,723,000	$6,518,000	$21,205,000	$2,626,000
CCS Medi-Cal				
CCS Admin. Budget	$187,255,000	$70,394,000	$116,861,000	$0
Medi-Cal Expansion	$1,057,000	$1,057,000	$0	$0
CMS Net	$3,852,000	$1,926,000	$1,926,000	$0
Subtotal	$192,164,000	$73,377,000	$118,787,000	$0
WCM Implementation	($25,802,000)	($12,370,000)	($13,432,000)	$0
CCS Compliance M&O	$10,138,000	$5,069,000	$5,069,000	$0
Total	**$204,223,000**	**$72,594,000**	**$131,629,000**	$2,626,000

CCS PROGRAM COUNTY ADMINISTRATIVE BUDGET

FY 2026-27				
CCS Medi-Cal/OTLICP	**TF***	**GF**	**FF**	**CF****
CCS Admin. Budget	$27,164,000	$6,322,000	$20,842,000	$2,626,000
CMS Net	$602,000	$211,000	$391,000	$0
Subtotal	$27,766,000	$6,533,000	$21,233,000	$2,626,000
CCS Medi-Cal				
CCS Admin. Budget	$187,255,000	$70,394,000	$116,861,000	$0
Medi-Cal Expansion	$1,057,000	$1,057,000	$0	$0
CMS Net	$4,150,000	$2,075,000	$2,075,000	$0
Subtotal	$192,462,000	$73,526,000	$118,936,000	$0
WCM Implementation	($24,338,000)	($10,678,000)	($13,660,000)	$0
CCS Compliance M&O	$10,138,000	$5,069,000	$5,069,000	$0
Total	**$206,028,000**	**$74,450,000**	**$131,578,000**	$2,626,000

* Totals may differ due to rounding
** County Funds are not included in the Total Fund

Funding:

FY 2025-26	**TF***	**GF**	**FF**	**CF****
50% FF Title XIX/50% GF (4260-101-0890/0001)	$86,050,000	$43,025,000	$43,025,000	$0
100% FF Title XXI (4260-101-0890)	$9,753,000	$0	$9,753,000	$0
100% GF Title XXI (4260-101-0001)	$2,626,000	$2,626,000	$0	$2,626,000
75% FF Title XIX/25% GF (4260-101-0890/0001)	$107,719,000	$26,930,000	$80,789,000	$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)	($2,982,000)	($1,044,000)	($1,938,000)	$0
Total	**$204,223,000**	**$72,594,000**	**$131,629,000**	$2,626,000

CCS PROGRAM COUNTY ADMINISTRATIVE BUDGET

FY 2026-27	TF*	GF	FF	CF**
50% FF Title XIX/50% GF (4260-101-0890/0001)	$85,971,000	$42,986,000	$42,985,000	$0
100% FF Title XXI (4260-101-0890)	$9,753,000	$0	$9,753,000	$0
100% GF Title XXI (4260-101-0001)	$2,626,000	$2,626,000	$0	$2,626,000
75% FF Title XIX/25% GF (4260-101-0890/0001)	$107,719,000	$26,930,000	$80,789,000	$0
100% GF Title XIX (4260-101-0001)	$2,958,000	$2,958,000	$0	$0
65% FF Title XXI/35% GF (4260-101-0890/0001)	($2,999,000)	($1,050,000)	($1,949,000)	$0
Total	**$206,028,000**	**$74,450,000**	**$131,578,000**	$2,626,000

* Totals differ due to rounding.
** County Funds are not included in the Total Fund

CYBHI - BH SERVICES AND SUPPORTS PLATFORM

FISCAL REFERENCE NUMBER:2289

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$175,900,000**	**$109,900,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$175,900,000	$53,400,000
OTHER FUNDS	$0	$56,500,000

Purpose:
This policy change estimates costs for the behavioral health (BH) virtual services platforms, including digital Soluna and BrightLife Kids, which serves California children and youth ages 0-25, and their families and parents/caregivers. Additionally, the policy change estimates costs for California Child and Adolescent Mental Health Access Portal (Cal-MAP), a statewide education and technical assistance campaign for primary care providers, and costs for promotion of various digital health tools.

Authority:
AB 133 (Chapter 143, Statutes of 2021)
W&I Code 5961.1
Kooth, Inc. Contract #22-20555
Brightline Contract #23-30175
Carelon Behavioral Health, Inc. Contract #23-30348
M&M Media Solutions Inc Contract #22-20340
University of California San Francisco Child and Adolescent Psychiatry Portal Contract #23-30405
California Coalition for Youth (CCY) Contract #23-30186
McKinsey Contract #22-20417

Interdependent Policy Changes:
Proposition 35 – CYBHI and BH-CONNECT (FRN #2593)

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.

In January 2024, the Department launched two new digital behavioral health apps for all children, youth, families, and caregivers in California. Designed to meet the diverse needs of youth and families across the state, the new mental health apps are BrightLife Kids for children and youth (aged 0-12) and their parents and caregivers, and Soluna for teens and young adults (aged 13-25). These apps provide free digital tools, resources, and virtual services to support behavioral health and emotional well-being. The Department is partnering with two well-established digital health companies, Brightline and Kooth US, respectively, to operate the apps. They offer access to highly qualified professional behavioral health coaches with appointments available in English and Spanish through video and chat, as well as all translation services for all Medi-Cal threshold languages via telephone. The programs also offer digital education and

CYBHI - BH SERVICES AND SUPPORTS PLATFORM

behavioral wellness support resources and exercises, a directory of resources to connect youth to local health resources in their areas, including live care navigation support, and moderated forums to connect users with other youth or caregivers. These resources are free to every California family, regardless of income, insurance coverage, or immigration status.

Through a partnership with the University of California, San Francisco Child and Adolescent Psychiatry Program (USCF CAPP), the Department also launched a statewide behavioral health eConsult service, the California Child and Adolescent Mental Health Access Portal (Cal-MAP), to provide pediatricians, primary care physicians and other practitioners (e.g., school-based service providers) access to consultation support from licensed behavioral health professionals, including psychiatrists. In addition to providing remote and real-time consultation support with behavioral health clinical experts, it offers access to behavioral health resources, tools and supports, including trainings to strengthen the workforce and improve the capacity of primary care providers and pediatricians to provide behavioral health treatment to children, youth and young adults.

The provider education and technical assistance campaign and the promotional campaigns are designed to drive adoption of these digital health strategies in coordination with community-based care to seamlessly integrate the BH virtual services platforms into the larger behavioral health delivery systems.

Reason for Change:
There is no change from the prior estimate for FY 2025-26. The change in FY 2026-27 from the prior estimate is due to the Department's receipt of funding from the California Department of Public Health (CDPH) and the Department of Health Care Access and Information (HCAI) through an interagency agreement (IA). The change from FY 2025-26 to FY 2026-27 is a decrease due to lower projected expenditures.

Methodology:
1. The Budget Act for FY 2022-23 provided $230 million GF, available for expenditure through June 30, 2025. The Budget Act for FY 2023-24 provided an additional $124,900,000. The Budget Act for FY 2025-26 provided an additional $175,900,000. The proposed Budget Act for FY 2026-27 would add $109,900,000.

2. For FY 2026-27, the Department will contract with CDPH and HCAI through an IA to support the BH services virtual platforms and Cal-MAP. The table below displays the estimated spending and remaining funds by Appropriation Year:

CYBHI - BH SERVICES AND SUPPORTS PLATFORM

	TF	GF	FF
Appropriation Year 2021-22	$10,000,000	$10,000,000	$0
Prior Years	$10,000,000	$10,000,000	$0
Total Estimated Remaining	$0	$0	$0
Appropriation Year 2022-23	$230,000,000	$230,000,000	$0
Prior Years	$230,000,000	$230,000,000	$0
Total Estimated Remaining	$0	$0	$0
Appropriation Year 2023-24	$124,900,000	$124,900,000	$0
Prior Years	$90,400,000	$90,400,000	$0
Total Estimated Remaining	$34,500,000	$34,500,000	$0
Appropriation Year 2025-26	$175,900,000	$175,900,000	$0
Prior Years	$0	$0	$0
Estimated in FY 2025-26	$175,900,000	$175,900,000	$0
Total Estimated Remaining	$0	$0	$0
Appropriation Year 2026-27	$109,900,000	$109,900,000	$0
Prior Years	$0	$0	$0
Estimated in FY 2026-27	$109,900,000	$109,900,000	$0
Total Estimated Remaining	$0	$0	$0

Fiscal Year	TF	GF	FF	GF Reimb
FY 2025-26	**$175,900,000**	**$175,900,000**	**$0**	**$0**
FY 2026-27	**$109,900,000**	**$53,400,000**	**$0**	**$56,500,000**

Funding:
100% General Fund (4260-101-0001)
Reimbursement GF (4260-601-0995)

MEDI-CAL RX - ADMINISTRATIVE COSTS

FISCAL REFERENCE NUMBER:2167

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$158,298,000**	**$127,329,000**
FEDERAL FUNDS	$116,796,750	$93,946,700
GENERAL FUND	$41,501,250	$33,382,300
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the cost of the Medi-Cal Rx administrative services contracts.

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., now Prime Therapeutics State Government Solutions, LLC, 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. Moving forward, upon pending CMS Advanced Planning Document (APD) approval, the Department will exercise the contract option to change 4 one-year extensions to one 4-year extension through December 31, 2029.

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 2026-27. 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

Reason for Change:
There is no change in FY 2025-26 and FY 2026-27, from the prior estimate.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to a decrease in estimated contractor costs.

Methodology:

1. Contractor costs are included in FY 2025-26 and FY 2026-27.

2. A portion of the Contractor costs estimated to occur in FY 2024-25 have been shifted to FY 2025-26.

3. The estimated cost for FY 2025-26 and FY 2026-27 is:

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
New Pharmacy Related Administrative Costs	$158,298	$41,501	$116,797
Total	**$158,298**	**$41,501**	**$116,797**

(Dollars in Thousands)

FY 2026-27	TF	GF	FF
New Pharmacy Related Administrative Costs	$127,329	$33,382	$93,947
Total	**$127,329**	**$33,382**	**$93,947**

Funding:
(Dollars in Thousands)

FY 2025-26	TF	GF	FF
FI 75% Title XIX / 25% GF	$140,437	$35,109	$105,328
FI T21 65/35	$13,734	$4,807	$8,927
FI 100% GF	$682	$682	$0
75% Title XIX / 25% GF	$3,124	$781	$2,343
65% Title XXI / 35% GF	$306	$107	$199
100% GF	$15	$15	$0
Total	**$158,298**	**$41,501**	**$116,797**

MEDI-CAL RX - ADMINISTRATIVE COSTS

(Dollars in Thousands)

FY 2026-27	TF	GF	FF
FI 75% Title XIX / 25% GF	$112,351	$28,088	$84,263
FI T21 65/35	$10,987	$3,845	$7,142
FI 100% GF	$546	$546	$0
75% Title XIX / 25% GF	$3,124	$781	$2,343
65% Title XXI / 35% GF	$306	$107	$199
100% GF	$15	$15	$0
Total	**$127,329**	**$33,382**	**$93,947**

COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES

FISCAL REFERENCE NUMBER:1963

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$167,907,000**	**$148,013,000**
FEDERAL FUNDS	$167,907,000	$148,013,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

Purpose:
This policy change budgets the federal financial participation (FFP) for claims submitted on behalf of local governmental agencies (LGAs) as well as American Indian/Alaskan Native Tribes and Tribal Organizations for Medicaid administrative activities (MAA).

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 2025-26, from the prior estimate, is due to:

- Total Fund and Federal Fund are increasing due to higher overall actual claims received for FY 2023-24 to be paid in FY 2025-26, as well as the resulting increase in the growth factor used to estimate FY 2024-25 Q1 claims payable in SFY 2025-26.
- There is no impact to General Fund, or Other State Fund, as this program only reimburses the federal share.

The change in FY 2026-27, from the prior estimate, is due to:

- Total Fund and Federal Fund are increasing due to higher overall actual claims for FY 2023-24, which in turn increased the growth factor used to estimate FY 2024-25 and FY 2025-26 claims to be paid in SFY 2026-27.
- There is no impact to General Fund, or Other State Fund, as this program only reimburses the federal share.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to:

- Total Fund and Federal Fund are decreasing due to the rollover of SFY 2023-24 Q1 invoice payments, which were paid in SFY 2025-26 instead of SFY 2024-25 as

COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES

previously projected. This rollover increased total payments in SFY 2025-26. The estimate for SFY 2026-27 assumes payment of only one fiscal year's invoices, with no invoices carried over from SFY 2025-26.
- There is no impact to General Fund, or Other State Fund, as this program only reimburses the federal share.

Methodology:
County Medi-Cal Administrative Activities

1. The CMAA FY 2025-26 estimate includes the remaining actuals from FY 2023-24 Q1 to Q4 claims and estimated FY 2024-25 Q1 claims. The FY 2023-24 Q1 to Q4 claims are based on actual claims received. The estimated base payments for FY 2024-25 claims assume a 6% growth factor from FY 2023-24, based on growth in CMAA and TMAA claims from FY 2019-20 through FY 2023-24.

CMAA FY 2025-26 Estimated Payments	
FY 2023-24 Q1 to Q4	$130,934,000
FY 2024-25 Q1	$36,272,000
Total	$167,206,000

2. The CMAA FY 2026-27 estimate includes estimated claims for FY 2024-25 Q2 to Q4 and FY 2025-26 Q1. The estimated base payments for FY 2024-25 and FY 2025-26 claims assume a 6% growth factor from FY 2023-24, based on growth in CMAA and TMAA claims from FY 2019-20 through FY 2023-24.

CMAA FY 2026-27 Estimated Payments	
FY 2024-25 Q2 to Q4	$108,817,000
FY 2025-26 Q1	$38,449,000
Total	$147,266,000

Tribal Medi-Cal Administrative Activities

1. The TMAA FY 2025-26 estimate includes the remaining actuals from FY 2023-24 Q2 to Q4 invoices and estimated claims for FY 2024-25 Q1 invoices. The estimated base payments for FY 2024-25 invoices assume a 6% growth factor from FY 2023-24, based on growth in TMAA and CMAA claims from FY 2019-20 through FY 2023-24.

TMAA FY 2025-26 Estimated Payments	
FY 2023-24 Q2 to Q4	$517,000
FY 2024-25 Q1	$184,000
Total	$701,000

2. The TMAA FY 2026-27 estimate includes estimated claims for FY 2024-25 Q2 to Q4 claims, and FY 2025-26 Q1 claims. The estimated base payments for FY 2024-25 and FY 2025-26

COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES

claims assume a 4% growth factor from FY 2023-24, based on growth in TMAA and CMAA claims from FY 2019-20 through FY 2023-24.

TMAA FY 2026-27 Estimated Payments	
FY 2024-25 Q2 to Q4	$552,000
FY 2025-26 Q1	$195,000
Total	$747,000

3. Total CMAA and TMAA reimbursements for FY 2025-26 and FY 2026-27 on a cash basis are:

FY 2025-26	**TF**	**FF**
County MAA	$167,206,000	$167,206,000
Tribal MAA	$701,000	$701,000
Total	**$167,907,000**	**$167,907,000**

FY 2026-27	**TF**	**FF**
County MAA	$147,266,000	$147,266,000
Tribal MAA	$747,000	$747,000
Total	**$148,013,000**	**$148,013,000**

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

SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES

FISCAL REFERENCE NUMBER:235

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$153,579,000**	**$148,168,000**
FEDERAL FUNDS	$153,579,000	$148,168,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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 2025-26, from the prior estimate, is due to:

- Actual invoices received for the remaining FY 2023-24 Q1 invoices and Q2-Q4 invoices, as well as the estimated amount for FY 2024-25 Q1 invoices.
- FY 2024-25 Q1 estimate is calculated based on the actual FY 2023-24 Q1 invoice amounts, adjusted by the 4.47% Employee Cost Index (ECI) factor.

The change in FY 2026-27, from the prior estimate, is due to:

- Updated actuals received for FY 2023-24 Q2-Q4. Actual amounts were increased by the 4.47% ECI adjustment factor, which raised the estimated invoice amounts for FY 2024-25 Q2-Q4 and FY 2025-26 Q1.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to:

- Four FY 2023-24 Q1 invoices that could not be paid during SFY 2024-25 and were instead carried over into SFY 2025-26, which increased the amount of total invoice claims the program pays in a given year.

SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES

Methodology:
The FY 2025-26 estimate includes:

1. The FY 2023-24 Q1 Los Angeles LEC, Orange LEC, Sonoma LEC, and Stanislaus LEC actual invoices received. The invoices were projected to be paid in FY 2024-25 but will now be paid in FY 2025-26. (The ECI factor is not added to actual claim amounts.)
2. The actual invoice amounts received for FY 2023-24 Q2-Q4 and the estimated invoice amount for FY 2024-25 Q1, which is to be paid in FY 2025-26. The estimated amount for FY 2024-25 invoices is based on the actual amounts received from FY 2023-24 Q1, plus a 4.47% ECI adjustment factor.

The FY 2026-27 estimate includes:

1. The FY 2024-25 Q2-Q4 and FY 2025-26 Q1 estimate amounts are based on the actual invoices received from FY 2023-24 Q2-Q4. The estimated amount for FY 2025-26 Q1 is based on the invoice estimate for FY 2024-25 Q1, plus an ECI adjustment factor of 4.47%.

FY 2025-26	**TF**	**FF**
FY 2023-24 Q1 Los Angeles LEC, Orange LEC, Sonoma LEC, and Stanislaus LEC	$11,576,000	$11,576,000
FY 2023-24 Q2-Q4	$113,901,000	$113,901,000
FY 2024-25 Q1	$27,932,000	$27,932,000
Total	**$153,579,000**	**$153,579,000**

FY 2026-27	**TF**	**FF**
FY 2024-25 Q2-Q4	$118,988,000	$118,988,000
FY 2025-26 Q1	$29,180,000	$29,180,000
Total	**$148,168,000**	**$148,168,000**

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

DRUG MEDI-CAL COUNTY ADMINISTRATION

FISCAL REFERENCE NUMBER:1813

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$119,212,000**	**$123,527,000**
FEDERAL FUNDS	$118,580,000	$122,956,000
GENERAL FUND	$632,000	$571,000
OTHER FUNDS	$0	$0

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.

<u>DMC County Administrative Costs</u>
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 invoices no later than 60 days after the end of the quarter and are 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.
- 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.

DRUG MEDI-CAL COUNTY ADMINISTRATION

- 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.

Effective FY 2025-26, the Department plans to implement the Behavioral Health Quality and Equity (BH QI/HE Framework to assist Behavioral Health Plans (BHPs) improve a set of Behavioral Health Performance Measures. DMC-ODS Counties will be eligible to claim reimbursement for these costs under Proposition 30.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is an increase due to more General Fund (GF) estimated for annual settlements.

There is no change in FY 2026-27 from the prior estimate.

The change in the current estimate, from FY 2025-26 to FY 2026-27, is a net increase due to the expectation that claiming trends will continue to rise, resulting in higher estimated county administration, UR and QA, and QI/HE funding claims for FY 2026-27, partially offset by a projected decrease in annual settlement costs.

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.

4. Assume the BH QI/HE (UR and QA Administration QI/HE Funding) framework funding will be available for county claims in FY 2025-26 and FY 2026-27 for the DMC-ODS Waiver.

DRUG MEDI-CAL COUNTY ADMINISTRATION

5. The estimated DMC county administration, annual settlement, UR and QA administration, and UR and QA administration QI/HE costs for FY 2025-26 and FY 2026-27 are:

FY 2025-26	**TF**	**GF**	**FF**	**CF**
County Administration	$71,474,000	$0	$35,737,000	$35,737,000
UR and QA Administration	$82,182,000	$0	$56,677,000	$25,505,000
UR and QA Administration QI/HE Funding	$178,000	$89,000	$89,000	$0
Annual Settlements	$52,154,000	$543,000	$26,077,000	$25,534,000
Total	$205,988,000	**$632,000**	**$118,580,000**	$86,776,000

FY 2026-27	**TF**	**GF**	**FF**	**CF**
County Administration	$73,118,000	$0	$36,559,000	$36,559,000
UR and QA Administration	$92,277,000	$0	$63,639,000	$28,638,000
UR and QA Administration QI/HE Funding	$500,000	$250,000	$250,000	$0
Annual Settlements	$45,016,000	$321,000	$22,508,000	$22,187,000
Total	$210,911,000	**$571,000**	**$122,956,000**	$87,384,000

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

CALAIM-BH-CONNECT WORKFORCE INITIATIVE

FISCAL REFERENCE NUMBER:2517

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$95,095,000**	**$213,750,000**
FEDERAL FUNDS	$95,095,000	$213,750,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the federal share of costs 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 received approval on December 16, 2024, from the Centers for Medicare and Medicaid Services (CMS) for the BH-CONNECT Demonstration, which aims to expand access to and strengthen the continuum of mental health services for Medi-Cal members living with significant behavioral health needs.

The BH-CONNECT Section 1115 Demonstration includes $1.9 billion in total funds over the life of the demonstration for a workforce initiative. Of this amount, half will be funded with Medicaid matching funds, and 85 percent of the remaining state share will be covered by the Designated State Health Programs (DSHP) funding stream.

Proposition 1, from the recast Behavioral Health Services Act (BHSA), provides state-directed resources for the Department of Health Care Access and Information (HCAI) for the workforce initiative, accounting for the remaining 15 percent of the non-federal share of costs.

The BHSA state-directed funds and state General Fund equivalent to the amounts ultimately covered by DSHP funding are assumed to be included in the HCAI budget.

Reason for Change:
There is no change from the prior estimate for FY 2025-26 and FY 2026-27.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to FY 2026-27 reflecting a full year’s cost.

CALAIM-BH-CONNECT WORKFORCE INITIATIVE

Methodology:

1. Payments for the BH-CONNECT Workforce Initiative began in December 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 and FY 2026-27, on a cash basis, is:

(Dollars in Thousands)

BH-CONNECT Workforce Initiative	TF	FF
FY 2025-26	$95,095	$95,095
FY 2026-27	$213,750	$213,750

Funding:

100% Title XIX FF (4260-101-0890)

BH TRANSFORMATION FUNDING FOR COUNTY BH DEPTS.

FISCAL REFERENCE NUMBER:2491

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$93,508,000**	**$17,001,000**
FEDERAL FUNDS	$38,508,000	$7,001,000
GENERAL FUND	$0	$0
OTHER FUNDS	$55,000,000	$10,000,000

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)]
Budget Act of 2025 [AB 102 (Chapter 5, Statutes of 2025)]

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 in FY 2025-26 and FY 2026-27, from the prior estimate.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease due to a lower allocation of $10 million to the Behavioral Health Services Fund (BHSF) for FY 2026-27, alongside a decrease in Federal Funds. This decreased allocation is associated with a lower than estimated receipt of reimbursement claims, compared to prior estimates.

Methodology:
1. The 2025 Budget Act includes $55 million BHSF in FY 2025-26. It is assumed that $10 million BHSF funding will be available in FY 2026-27.

2. The following are the estimated costs in FY 2025-26 and FY 2026-27, on a cash basis:

BH TRANSFORMATION FUNDING FOR COUNTY BH DEPTS.

(Dollars in Thousands)

Fiscal Year	TF	BHSF	FF
FY 2025-26	$93,508	$55,000	$38,508
FY 2026-27	$17,001	$10,000	$7,001

Funding:
100% Behavioral Health Services Fund (4260-101-3085)
100% Title XIX (4260-101-0890)

POSTAGE & PRINTING

FISCAL REFERENCE NUMBER:231

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$71,362,000**	**$71,362,000**
FEDERAL FUNDS	$35,552,500	$35,552,500
GENERAL FUND	$35,809,500	$35,809,500
OTHER FUNDS	$0	$0

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.

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 & PRINTING

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 2025-26 and FY 2026-27, is a slight increase due to an increase in base mass mailings. There is no change from FY 2025-26 to FY 2026-27 in the current estimate.

Methodology:
1. Based on actuals, the reported population receiving Form 1095-B mailings for FY 2025-26 and FY 2026-27 is assumed to be 15,810,000.

2. Assume that the cost per mailing is $0.77:

   15,810,000 mailings x $0.77 per mailing = $12,174,000 (rounded)

3. Based on FY 2024-25 actuals, assume that 2% 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 $0.77 per unit.

   2% x 15,810,000 mailings = 316,200 returned mailings

   316,200 returned mailings x $0.77 per unit = $243,000 (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 $0.77 per unit. Based on actuals, 124,400 NFRAs were mailed for FY 2024-25. Assume 124,400 mailers will be sent out to members for FY 2025-26 and FY 2026-27.

   124,400 mailings x $0.77 per mailing = $96,000 (rounded)

5. TAR postage costs for Medi-Cal are assumed to be $80,000 for FY 2025-26 and FY 2026-27.

6. Office of State Publishing costs for printing Family Planning, Access, Care, and Treatment program brochures are assumed to be $150,000 in FY 2025-26 and FY 2026-27.

7. Postage costs for the HR 1 - Fed Work & Community Engagement Requirement policy change are assumed to be $8,000,000 in FY 2025-26 and FY 2026-27.

8. The Department estimates the printing and postage costs for FY 2025-26 and FY 2026-27 are:

POSTAGE & PRINTING

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
Base Mass Mailing	$43,169	$21,714	$21,456
1095B			
1095 Mailings	$12,174	$6,087	$6,087
Reprinted/Corrected Form 1095-B	$243	$122	$121
Notice for Requested Action	$96	$48	$48
1095 B Subtotal	$12,513	$6,257	$6,256
Emergency Mailings	$7,600	$3,800	$3,800
TAR Postage	$80	$40	$40
HR 1 - Fed Work & Community Engagement Requirement	$8,000	$4,000	$4,000
Total	**$71,362**	**$35,811**	**$35,552**
FY 2026-27	**TF**	**GF**	**FF**
Base Mass Mailing	$43,169	$21,714	$21,456
1095B			
1095 Mailings	$12,174	$6,087	$6,087
Reprinted/Corrected Form 1095-B	$243	$122	$121
Notice for Requested Action	$96	$48	$48
1095 B Subtotal	$12,513	$6,257	$6,256
Emergency Mailings	$7,600	$3,800	$3,800
TAR Postage	$80	$40	$40
HR 1 - Fed Work & Community Engagement Requirement	$8,000	$4,000	$4,000
Total	**$71,362**	**$35,811**	**$35,552**

*Totals may differ due to rounding.

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

CALAIM - POPULATION HEALTH MANAGEMENT

FISCAL REFERENCE NUMBER:2288

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$71,365,000**	**$54,604,000**
FEDERAL FUNDS	$68,566,000	$50,994,200
GENERAL FUND	$2,799,000	$3,609,800
OTHER FUNDS	$0	$0

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)
SB 101 Act of 2025
Contract # 22-20426 A02
Contract # 24-40170
Contract # 25-50067

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 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 will allow the Department to have an elevated view of the care provided to Medi-Cal members.

CALAIM - POPULATION HEALTH MANAGEMENT

Reason for Change:
There is no change from the prior year to FY 2025-26 for GF. There is an increase from the prior year to FY 2025-26 for FF due to updated actuals and adjusted projections. The non-federal share was previously encumbered through multi-year appropriations. The change from the prior estimate, for FY 2026-27, is a decrease for GF due to adjusted projections. There is a decrease from the prior year to FY 2026-27 for FF due to adjusted projections based on actuals trend. A portion of the non-federal share was previously encumbered through multi-year appropriations. The change from FY 2025-26 to FY 2026-27 is a decrease due to projected contract deliverables.

Methodology:
1. The Budget Act for 2021-22 provided $30 million from the General Fund (GF) and $270 million in Federal Funds (FF) for this service, available to be spent through June 30, 2024. AB 107 reappropriated $19,773,000 for encumbrance or expenditure through June 30, 2025. SB 101 Act of 2025 further reappropriated $19,773,000 for encumbrance or expenditures through June 30, 2026.

2. Previously, this policy change was funded using only a FFP split of 90% FF and 10% GF. However, in accordance with the Centers for Medicare & Medicaid Services (CMS) approved Implementation Advanced Planning Document (IAPD), the Department has corrected the funding splits for FY 2025-26 and FY 2026-27. In addition, the Department reconciled FY 2023-24 and FY 2024-25 to return $2.8 million dollars to the federal government for previous billings that were based on the incorrect FFP split. The refund occurred in October 2025.

3. Total estimated multiyear and ongoing expenditures for the program are:

	TF	GF	FF
SB 101 Reappropriated Amount	$197,730,000	$19,773,000	$177,957,000
Federal Repayment	$0	$2,799,000	-$2,799,000
FY 2025-26 Anticipated Expenditures (From previously re-appropriated amount)	$81,748,000	$10,383,000	$71,365,000
FY 2026-27 Portion of Anticipated Expenditures (From previously re-appropriated amount)	$47,378,000	$6,591,000	$40,787,000
FY 2026-27 Portion of Anticipated Expenditures (In addition to previously re-appropriated amount)	$13,817,000	$3,610,000	$10,207,000

4. The total budgeted dollars for FY 2025-26 are **$71,365,000, and $54,604,000** for FY 2026-27.

CALAIM - POPULATION HEALTH MANAGEMENT

Funding:

FY 2025-26	TF	GF	FF
100% Title XIX FF (4260-101-0890)	$68,566,000	$0	$68,566,000
100% GF (4260-101-0001)	$2,799,000	$2,799,000	$0
Total	**$71,365,000**	**$2,799,000**	**$68,566,000**

FY 2026-27	TF	GF	FF
100% Title XIX FF (4260-101-0890)	$40,787,000	$0	$40,787,000
90% Title XIX/ 10% GF (4260-101-0001/0890)	$154,000	$15,000	$139,000
75% Title XIX / 25% GF (4260-101-0001/0890)	$12,364,000	$3,091,000	$9,273,000
65% Title XXI / 35% GF (4260-101-0001/0890)	$1,224,000	$428,000	$796,000
100% GF (4260-101-0001)	$75,000	$75,000	$0
Total	**$54,604,000**	**$3,609,000**	**$50,995,000**

SMH MAA

FISCAL REFERENCE NUMBER:1722

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$52,327,000**	**$55,641,000**
FEDERAL FUNDS	$52,327,000	$55,641,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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 Medi-Cal Specialty Mental Health program. Counties must report their administration costs and direct facility expenditures quarterly. Along with administration costs, counties may claim reimbursement for costs incurred for county Quality Assurance and Utilization Review (QAUR). Finally, counties may obtain State General Fund reimbursement for the non-federal share of administration and QUAR cost subject to Proposition 30. Costs incurred to implement the following requirements are subject to Proposition 30: Performance Outcomes System (POS), the Behavioral Health Quality and Equity Framework, Managed Care Regulations – Mental Health (MH), MH Parity Final Rule, and the Interoperability Final Rule.

The QAUR and administration 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 changed 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, an increased federal medical assistance percentage (FMAP) was made available to the Department. In general, the increased

SMH MAA

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.

The Department implemented, in FY 2025-26, the Behavioral Health Quality and Equity Framework to assist Behavioral Health Plans with improving on a set of Behavioral Health Performance Measures. Mental Health Plans will be able to claim reimbursement for these costs pursuant to Proposition 30.

Beginning in FY 2026-27, new costs to support Child and Adolescent Needs and Strengths (CANS) reporting, under the Performance Outcome System, are being added. This new reporting solution will integrate data collected into a single statewide database for both Department of Health Care Services (DHCS) and California Department of Social Services (CDSS) reporting.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is a decrease due to a change in the Medicaid Children's Health Insurance Program (MCHIP) split for claims types of MH parity and managed care.

The change in FY 2026-27, from the prior estimate, is an increase due to adjusted MCHIP claims amounts and the updated percentage of MCHIP type claims for MH parity rule.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to the standard projected growth rate in claims of 5.1% and the addition of CANS Assessment costs beginning in FY 2026-27.

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. For the CANS Assessment costs, however, no lags are assumed and costs are estimated to occur annually on a cash basis. The estimated costs are as follows:

SMH MAA

Fiscal Year	Type	Accrual	FY 2025-26	FY 2026-27
FY 2023-24	Other Admin	$353,437,000	$26,509,000	$0
	MCHIP	$19,754,000	$1,482,000	$0
	QAUR	$66,996,000	$5,025,000	$0
	POS	$3,753,000	$282,000	$0
	Parity	$27,312,000	$2,049,000	$0
	Managed Care	$12,551,000	$941,000	$0
Subtotal		$483,804,000	$36,288,000	$0
FY 2024-25	Other Admin	$371,456,000	$275,503,000	$27,861,000
	MCHIP	$20,761,000	$15,398,000	$1,557,000
	QAUR	$70,413,000	$52,224,000	$5,281,000
	POS	$3,945,000	$2,926,000	$296,000
	Parity	$28,705,000	$21,290,000	$2,153,000
	Managed Care	$13,191,000	$9,784,000	$989,000
Subtotal		$508,471,000	$377,125,000	$38,138,000
FY 2025-26	Other Admin	$390,393,000	$71,563,000	$289,548,000
	MCHIP	$21,820,000	$4,000,000	$16,183,000
	QAUR	$74,004,000	$13,566,000	$54,888,000
	POS	$4,146,000	$760,000	$3,075,000
	Parity	$30,169,000	$5,530,000	$22,376,000
	Managed Care	$13,864,000	$2,541,000	$10,283,000
	BH Quality & Equity	$600,000	$110,000	$445,000
Subtotal		$534,995,000	$98,070,000	$396,798,000
FY 2026-27	Other Admin	$410,295,000	$0	$75,211,000
	MCHIP	$22,932,000	$0	$4,204,000
	QAUR	$77,779,000	$0	$14,258,000
	POS	$4,357,000	$0	$799,000
	Parity	$31,708,000	$0	$5,812,000
	Managed Care	$14,571,000	$0	$2,671,000
	BH Quality & Equity	$600,000	$0	$110,000
	CANS Assessment	$5,000,000	$0	$5,000,000
Subtotal		$567,242,000	$0	$108,065,000
Total			$511,483,000	$543,001,000

SMH MAA

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, General Fund (GF) 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 are 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% 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).

7. BH Quality and Equity Framework funding is available for FY 2025-26 and FY 2026-27 in the amount of $600,000 for SMHS and is assumed to be funded with 50% FF and 50% GF split.

8. Starting in FY 2026-27, DHCS will incur annual CANS Assessment costs of $5 million, which include licensing and subscription feeds, to implement a statewide database.

9. On a cash basis, the amounts for FY 2025-26 and FY 2026-27 are:

Claim Type	**FY 2025-26**				
	TF	**FF**	**GF**	**CF**	**COVID-19 FF**
Other Admin	$373,576,000	$186,788,000	$0	$186,788,000	$0
MCHIP	$20,880,000	$13,572,000	$0	$7,298,000	$10,000
QAUR Reg	$24,514,000	$12,257,000	$0	$12,257,000	$0
QAUR SPMP	$46,301,000	$34,726,000	$0	$11,575,000	$0
POS	$3,967,000	$2,353,000	$1,614,000	$0	$0
Parity	$28,869,000	$16,563,000	$6,146,000	$6,146,000	$14,000
Managed Care Regulations	$13,266,000	$7,604,000	$2,828,000	$2,827,000	$7,000
BH Quality & Equity	$110,000	$55,000	$55,000	$0	$0
Total	$511,483,000	**$273,918,000**	**$10,643,000**	$226,891,000	**$31,000**

SMH MAA

Claim Type	FY 2026-27			
	TF	FF	GF	CF
Other Admin	$392,620,000	$196,310,000	$0	$196,310,000
MCHIP	$21,944,000	$14,264,000	$0	$7,680,000
QAUR Reg	$25,765,000	$12,882,000	$0	$12,883,000
QAUR SPMP	$48,663,000	$36,497,000	$0	$12,166,000
POS	$4,170,000	$2,473,000	$1,697,000	$0
Parity	$30,341,000	$17,407,000	$6,467,000	$6,467,000
Managed Care Regulations	$13,943,000	$7,999,000	$2,972,000	$2,972,000
BH Quality & Equity	$555,000	$278,000	$277,000	$0
CANS Assessment	$5,000,000	$2,500,000	$2,500,000	$0
Total	$543,001,000	**$290,610,000**	**$13,913,000**	$238,478,000

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)

CALAIM - BH - CONNECT DEMONSTRATION ADMIN

FISCAL REFERENCE NUMBER:2398

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$65,490,000**	**$176,866,000**
FEDERAL FUNDS	$32,745,000	$88,433,000
GENERAL FUND	$8,433,000	$8,433,000
OTHER FUNDS	$24,312,000	$80,000,000

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. Since the pandemic, California hospitals report significant increases in the number of adolescents seeking psychiatric treatment in emergency departments, as well as long waitlists for psychiatric inpatient beds for children and adolescents. For adults, the situation is similarly serious. More than one in 20 adult residents in California is living with significant behavioral health needs, and the evidence continues to mount that individuals who are experiencing or at risk of homelessness and those involved in the justice system experience high rates of untreated mental illness and/or substance use disorder. Even so, approximately one-third of individuals enrolled in Medi-Cal and who are living with significant behavioral health needs do not receive any Medi-Cal Specialty Mental Health Services. As a result, the Department has made strengthening California's behavioral health system a top priority and is 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.

On December 16, 2024, the Centers for Medicare & Medicaid Services (CMS) approved the BH-CONNECT demonstration that aims to expand access and strengthen the continuum of mental 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.

California's approved BH-CONNECT demonstration includes the following initiatives: (1) Access, Reform and Outcomes Incentive Program, (2) Workforce Initiative, (3) Activity Funds Initiative, (4) Serious Mental Illness Program (MH IMD FFP Program), (5) Community Transition In-Reach Services, and (6) Health-Related Social Needs (i.e., Transitional Rent). The overall goals of this demonstration include:

CALAIM - BH - CONNECT DEMONSTRATION ADMIN

- Expanding the continuum of community-based behavioral health services and evidence-based practices (EBPs) available through Medi-Cal.
- Strengthening family-based services and support for children and youth living with significant behavioral health needs, including children and youth involved in child welfare.
- Investing in statewide practice transformations to better enable county behavioral health delivery systems and providers to support Medicaid beneficiaries living with significant behavioral health needs.
- Strengthening the workforce needed to deliver community-based behavioral health services to Medicaid beneficiaries.
- Reducing use of institutional care by those individuals most significantly affected by significant behavioral health needs.
- Shortening lengths of stay in institutional settings and support successful transitions to community-based care settings and community reintegration.
- Promoting improved health outcomes, community integration, treatment and recovery for individuals who are homeless or at risk of homelessness and experiencing critical transitions.

Reason for Change:
The change in FY 2025-26 and FY 2026-27, from the prior estimate, is due to a projected increase in administrative costs for SMHS – Opt-in due to updated expenditure projections for the Access, Reform and Outcome Incentive Program, which continues to see higher-than-anticipated incentive payments aligned with program performance goals.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due higher SMHS – Opt-in costs estimated in FY 2026-27 due to continued program expansion, in addition to FY 2026-27 reflecting a full year’s cost.

Methodology:
1. The BH-CONNECT demonstration will be implemented through a staged approach over multiple years, by December 31, 2026. Payments for the administrative activities began in December 2025.

2. Total estimated administrative costs for the BH-CONNECT Demonstration, on a cash basis, is as follows:

(Dollars in Thousands)

FY 2025-26	TF	GF	FFP	IGT*
SMHS - Statewide	$16,866	$8,433	$8,433	$0
SMHS -Opt-in	$48,624	$0	$24,312	$24,312
Total	**$65,490**	**$8,433**	**$32,745**	**$24,312**

(Dollars in Thousands)

FY 2026-27	TF	GF	FFP	IGT*
SMHS - Statewide	$16,866	$8,433	$8,433	$0
SMHS -Opt-in	$160,000	$0	$80,000	$80,000
Total	**$176,866**	**$8,433**	**$88,433**	**$80,000**

CALAIM - BH - CONNECT DEMONSTRATION ADMIN

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

ACTUARIAL COSTS FOR RATE DEVELOPMENT

FISCAL REFERENCE NUMBER:1937

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$41,000,000**	**$45,000,000**
FEDERAL FUNDS	$20,500,000	$22,500,000
GENERAL FUND	$20,350,000	$22,500,000
OTHER FUNDS	$150,000	$0

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 2025-26. The change from the prior estimate, for FY 2026-27, is a slight decrease due to updated calculations. The change from FY 2025-26 to FY 2026-27 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

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. The FY 2025-26 and FY 2026-27 amounts on an accrual basis are estimated to be:

Policy	FY 2025-26	FY 2026-27
Ongoing Actuarial Services	$39,700,000	$44,000,000
HQAF Program	$300,000	$0
Consulting Actuaries	$2,100,000	$2,100,000
Total	**$42,100,000**	**$46,100,000**

The FY 2025-26 and FY 2026-27 amounts on a cash basis are estimated to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	HQAF	FF
FY 2025-26	**$41,000**	**$20,350**	**$150**	**$20,500**
FY 2026-27	**$45,000**	**$22,500**	**$0**	**$22,500**

Funding:
50% Title XIX FF / 50% GF (4260-101-0890/0001)
Hospital Quality Assurance Revenue Fund (4260-611-3158)

MEDI-CAL RECOVERY CONTRACTS

FISCAL REFERENCE NUMBER:1551

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$41,445,000**	**$35,100,000**
FEDERAL FUNDS	$31,083,750	$26,325,000
GENERAL FUND	$10,361,250	$8,775,000
OTHER FUNDS	$0	$0

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
Department of Social Services (CDSS)	25-50018
Health Management Systems Inc. (HI)	18-95310 A03
Health Management Systems Inc. (HI)	25-50331
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.

MEDI-CAL RECOVERY CONTRACTS

The Department awarded the Health Insurance contract (25-50331) to Health Management Systems, Inc. (HMS) with an effective date of December 1, 2025 and an expiration date of November 30, 2030. The contingency fee is 8.25%.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is due to:
- No change in the online database contracts for FY 2025-26 from the prior estimate.
- For the HMS – Health Insurance Contract, the recovery amounts for FY 2025-26 Direct Billing continue to increase due to the implementation of prompt payment standards for insurance carriers and the restriction of denials. This includes growth in pharmacy and medical fee-for-service billings, which fall under Direct Billing and have increased following the January 1, 2025 policy changes. FY 2025-26 also reflects approximately five months of overlapping recoveries and invoicing for both Contract 18-95310 A03 and Contract 25-50331. Final invoicing for Contract 18-95310 A03 will conclude in May 2026.

The change in FY 2026-27, from the prior estimate, is due to:
- No change in the online database contracts for FY 2026-27 from the prior estimate.
- For the HMS – a net increase is expected for the Health Insurance Contract. The recovery amounts for FY 2026-27 are expected to increase for pharmacy and medical fee-for-service direct billing due to implementation of the prompt payment standards.
- CI Disallowance, MCA Disallowance, Newborn Initiatives, MCP Come Behind, MCP Dental, and Provider Type 14 decrease in FY 2026-27 because FY 2025-26 includes invoicing and recoveries for two contracts (18-95310 A03 and 25-50331), while FY 2026-27 returns to normal operations with activity under only one contract (25-50331). For the Newborn Initiative, preliminary results also indicate lower-than-anticipated recoveries.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to:
- No change in the online database contracts from FY 2025-26 to FY 2026-27 in the current estimate.
- For the HMS – Health Insurance Contract, recoveries for FY 2026-27 are lowered due to close out of contract 18-95310 A03 in FY 2025-26. All recovery activities and invoices for FY 2026-27 will fall under a singular contract, 25-50331.

Methodology:
1. The amounts paid to the HMS contractor for HI are contingent upon recoveries. Assume the following recoveries for each fiscal year at the contracted contingency fee percentage. Fiscal Year 2025-26 includes both contract 18-95310 A03, which concluded on 11/30/2025, and contract 25-50331, which began on 12/1/2025. The contingency fee for contract 18-95310 A03 was 8.5%. The term of contract 25-50331 is December 1, 2025 through November 30, 2030, and the contingency fee is 8.25%.

   Recoveries x Contingency Fee % = Total Contingency Fee

MEDI-CAL RECOVERY CONTRACTS

Contractor	FY 2025-26 Recoveries	FY 2026-27 Recoveries	Contingency Fee %	FY 2025-26 Contingency Fee	FY 2026-27 Contingency Fee
HMS 18A03	$295,770,000	$0	8.50%	$25,141,000	$0
HMS 25-50331	$197,180,000	$425,000,000	8.25%	$16,267,000	$35,063,000
Total:	**$492,950,000**	**$425,000,000**		**$41,408,000**	**$35,063,000**

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 2025-26	FY 2026-27
Department of Industrial Relations - EAMS	$5,000	$5,000
Department of Social Services	$4,000	$4,000
RELX Inc.	$28,000	$28,000
Total	$37,000	$37,000

3. The payments shown below include recent recovery activity.

FY 2025-26	TF	GF	FF
Health Insurance	$41,408,000	$10,352,000	$31,056,000
Online Database Contracts	$37,000	$9,000	$28,000
Total	**$41,445,000**	**$10,361,000**	**$31,084,000**

FY 2026-27	TF	GF	FF
Health Insurance	$35,063,000	$8,766,000	$26,297,000
Online Database Contracts	$37,000	$9,000	$28,000
Total	**$35,100,000**	**$8,775,000**	**$26,325,000**

Funding:
75% Title XIX / 25% GF (4260-101-0001/0890)

ENTERPRISE DATA ENVIRONMENT

FISCAL REFERENCE NUMBER:252

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$29,978,000**	**$52,166,000**
FEDERAL FUNDS	$21,924,400	$38,264,300
GENERAL FUND	$8,053,600	$13,901,700
OTHER FUNDS	$0	$0

Purpose:
The policy change estimates the costs associated with the Enterprise Data Environment (EDE), which encompasses:

- Infrastructure and Tools: Management Information System/Decision Support System (MIS/DSS) Data Warehouse, Management Administration Reporting Subsystem (MARS), Surveillance Utilization Reporting System (SURS), cloud platforms, data lakes, ETL/ELT tools, and BI software.
- Data Governance: Policies and standards for data quality, security (access controls, encryption), compliance, and lineage.
- Data Management Practices: Processes for data integration, cleansing, transformation, master data management, and data lifecycle management.
- Architecture: Defines how data flows, where it resides, and how different systems connect.

Authority:
Contract #14-90129 A06
Contract # 21-10284
Contract # 24-060C
Contract # 25-50426
Contract # 25-50403
Contract # 23-30372 A03
Centers for Medicare & Medicaid Services (CMS) Transformed Medicaid Statistical Information System (T-MSIS) Requirements

Interdependent Policy Changes:
Not Applicable

Background:
The EDE supports multiple areas within the Department, including, but not limited to, Audits & Investigations, Managed Care Operations, Pharmacy Benefits, Provider Enrollment, Integrated Systems of Care, Third Party Liability and Recovery, and Accounting, as well as several State departments and other approved entities. It equips the Department staff and partner agencies with essential information and tools to oversee and administer Medi-Cal and other health and human services, including access to quality health care services, preventive care, Managed Care Plan performance, and utilization trends across managed care and Fee-for-Service (FFS) models. The information available within EDE also helps detect service gaps and fraud, waste, and abuse.

ENTERPRISE DATA ENVIRONMENT

Ongoing maintenance and operations (M&O) and enhancements to the EDE are supported by several multi-year contracts. These contracts include M&O of the data warehouse, specialized subject-matter expertise for delivery of the critical enterprise data architecture, infrastructure, platforms, services, and supporting technologies required to enable data integration, data exchange, business intelligence, analytics, data storage, data feeds, Application Programming Interfaces (APIs), help desk support, training, and hardware and software refreshes.

Reason for Change:
The change from the prior estimate, for FY 2025-26, is a decrease due to updated actuals, adjusted projections, and delayed contract start and payment dates. The change from the prior estimate, for FY 2026-27, and from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to adjusted projections, the addition of several new software products, a new Enterprise Data Mesh contract, execution of Non-Competitively Bid (NCB) Amendment 6 for Optum's contract, and costs related to turnover and takeover activities.

Methodology:
1. Optum contract #14-90129 A05 (MIS/DSS, MARS, and SURS) extends the current Optum contract to June 30, 2026, with one optional twelve-month extension. The Department is currently procuring a NCB Amendment 6 of the current Data Warehouse contract to extend it until June 30, 2027, to allow sufficient time to develop and implement successful turnover and takeover from Optum.

2. The Department is currently 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 twelve-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. This contract includes 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 from Optum to the Department by July 2027.

5. SURS and MARS subsystems received CMS certification on August 31, 2020. The systems receive enhanced funding of 75%/25%.

6. The estimated breakdown of the SURS, MARS, MIS/DSS, Data Warehouse M&O, and Data Warehouse DSS costs are:

ENTERPRISE DATA ENVIRONMENT

Subsystem	FY 2025-26	FY 2026-27
SURS Operational Costs (75%/25%)	$7,983,000	$8,726,000
MARS Operational Costs (75%/25%)	$2,505,000	$2,856,000
MIS/DSS Operational Costs (75%/25%)	$16,947,000	$28,139,000
MIS/DSS Operational Costs (50%/50%)	$759,000	$823,000
Data Warehouse Operational Costs (75%/25%)	$1,244,000	$8,385,000
Data Warehouse DSS Operational Costs (75%/25%)	$540,000	$3,237,000
Total	**$29,978,000**	**$52,166,000**

7. 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%)	$26,472,000	$6,618,000	$19,854,000
Operational Costs (65%/35%)	$2,656,000	$930,000	$1,726,000
Operational Costs (50%/50%)	$688,000	$344,000	$344,000
100% State Fund	$162,000	$162,000	$0
Total FY 2025-26	**$29,978,000**	**$8,054,000**	**$21,924,000**

SURS, MARS, MIS/DSS, Data Warehouse M&O, and Data Warehouse DSS	TF	GF	FF
Operational Costs (75%/25%)	$46,516,000	$11,628,000	$34,888,000
Operational Costs (65%/35%)	$4,622,000	$1,618,000	$3,004,000
Operational Costs (50%/50%)	$746,000	$373,000	$373,000
100% State Fund	$282,000	$282,000	$0
Total FY 2026-27	**$52,166,000**	**$13,901,000**	**$38,265,000**

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)

OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS

FISCAL REFERENCE NUMBER:1748

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$29,494,000**	**$28,424,000**
FEDERAL FUNDS	$14,475,700	$13,990,550
GENERAL FUND	$15,018,300	$14,433,450
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the contract costs and other administrative vendor services for the County Children's Health Initiative Program (CCHIP), 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)
SB 1019 (Chapter 879, Statues of 2022)
Americans with Disabilities Act (ADA), Section 508
Title 2, California Code of Regulations, Section 14101(a)(4)
Title 42, California Code of Regulations, Section 11135, 7405, & 11546.7
Health Services Advisory Group, Inc. Contract 20-10359
Maximus Contract 20-10025 A1 & A2
Maximus Contract 25-50012
Maximus Contract 25-50017
Public Assistance Reporting Information System (PARIS) Contract 25-50052

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2013, the Managed Risk Medical Insurance Board (MRMIB) contracted with Maximus to provide Single Point of Entry (SPE) and administrative vendor services for the Healthy Families Program (HFP), Access for Infants and Mothers (AIM), and the Child Health and Disability Prevention (CHDP) Program Gateway. The Department transitioned the HFP and County Children's Health Initiative Program (CCHIP) into the Medi-Cal program in September 2013. The AIM Program was transitioned from MRMIB to the Department as of July 1, 2014, and renamed Medi-Cal Access Program (MCAP). As HFP and AIM transitioned into Medi-Cal programs, including the MCAP and Optional Targeted Low-Income Children's Program (OTLICP), Maximus' role evolved, including closing SPE for HFP and CHDP Gateway by January 1, 2014, forwarding applications to county welfare departments (CWDs), and supporting Covered California referrals. 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.

All MRMIB programs and the Maximus contract transitioned to the Department on July 1, 2014, with Maximus continuing administrative services for MCAP, OTLICP. Effective October 1, 2019, CCHIP also transitioned to Maximus. Maximus' services have included application processing,

OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS

case management, premium collection (discontinued under SB 184), publication development, and other administrative functions, with contract updates to support expanded responsibilities, including External Quality Review Organization (EQRO) activities required by CCHIP. 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.

Effective September 3, 2025, the Department has determined that the Optional Targeted Low Income Children Program Maximus contract is no longer required and has elected to terminate the agreement (Contract 20-10024).

Administrative Vendor Services:
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.

Contract Costs:
Effective July 1, 2025, the Maximus contract (Contract No. 25-50012) was renewed through July 31, 2030. Through this contract, Maximus oversees operational expenditures incurred for delivering services such as postage, telephone minutes, printing, and payment processing. These items are reimbursed based on actual usage and are not considered part of the core ongoing administrative vendor services.

The PARIS contract (Contract No. 25-50052) was implemented on July 1, 2025, to prevent fraud, abuse, and improper payments by identifying Medi-Cal members who are receiving benefits in another state, Maximus will provide the Department with document design, printing, mailing, response scanning, response reporting, call center and response portal website administration services.

EQRO is required 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 (Contract No. 20-10359). 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. During this time, 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.

Hearing Aid Coverage for Children Program:
Effective July 1, 2021, AB 89 (Chapter 7, Statutes of 2020) authorized 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 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.

OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS

Effective July 1, 2025, the Hearing Aid Coverage for Children Program (HACCP) transitioned to its own Maximus contract (Contract No. 25-50017).

Medi-Cal Publications:
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 formatting materials for uploading into the California Statewide Automated Welfare System.

Effective July 1, 2025, the Maximus contract for Medi-Cal Printing Maximus (Contract No. 20-10025 A1 & A2) has been renewed through July 1, 2026, to comply with the ADA, Section 205 amendment to the 1973 Rehabilitation Act, Title 42, California Code of Regulations, Section 11135, 7405, & 11546.7. The Department is required to ensure equal access to all information, resources, and opportunities afforded by technology. The Department must also make sure all communications are accessible, including appropriate readability, to members requiring "Alternate Formats" including braille, large font, digital data discs, etc., and translations into threshold languages in compliance with Title 2, California Code of Regulations, Section 14101(a)(4).

Effective January 1, 2027, the Breast and Cervical Cancer Treatment Program will verify the contact information for its members against the National Change of Address database to ensure addresses are current and to identify undeliverable mail on a quarterly basis, to comply with House Resolution 1 on a go forward basis.

Reason for Change:
There is a decrease for FY 2025-26 and FY 2026-27, from the prior estimate, due to reduced administrative services costs and contract costs. There is a decrease from FY 2025-26 to FY 2026-27, in the current estimate, due to assuming administrative services and contract cost reductions will continue through FY 2026-27.

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 contract costs are eligible for 100% GF.

2. Administrative vendor services costs are eligible for Title XIX 50/50 FMAP. HACCP administrative vendor costs are eligible for 100% GF.

3. Contract costs and administrative vendor service costs by program are as follows:

Program	FY 2025-26	FY 2026-27
OTLICP	$12,679,000	$12,045,000
MCAP	$5,397,000	$5,138,000
CCHIP	$4,418,000	$4,241,000
HACCP	$3,407,000	$3,145,000

OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS

4. Contract costs and administrative vendor service costs by cost category are as follows:

FY 2025-26	TF	GF	FF
Administrative Vendor Services	$5,109,000	$2,554,000	$2,555,000
Contract Costs	$13,978,000	$5,557,000	$8,421,000
Hearing Aid Coverage for Children Program	$3,407,000	$3,407,000	$0
Medi-Cal Publications	$7,000,000	$3,500,000	$3,500,000
Total	**$29,494,000**	**$15,018,000**	**$14,476,000**
FY 2026-27	**TF**	**GF**	**FF**
Administrative Vendor Services	$4,842,000	$2,421,000	$2,421,000
Contract Costs	$13,437,000	$5,367,000	$8,070,000
Hearing Aid Coverage for Children Program	$3,145,000	$3,145,000	$0
Medi-Cal Publications	$7,000,000	$3,500,000	$3,500,000
Total	**$28,424,000**	**$14,433,000**	**$13,991,000**

* Totals may differ due to rounding.

Funding:

FY 2025-26	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890/0001)	$16,539,000	$8,269,000	$8,270,000
65% Title XXI / 35% GF (4260-101-0890/0001)	$9,548,000	$3,342,000	$6,206,000
100% GF (4260-101-0001)	$3,407,000	$3,407,000	$0
Total	**$29,494,000**	**$15,018,000**	**$14,476,000**
FY 2026-27	**TF**	**GF**	**FF**
50% Title XIX / 50% GF (4260-101-0890/0001)	$16,272,000	$8,136,000	$8,136,000
65% Title XXI / 35% GF (4260-101-0890/0001)	$9,007,000	$3,152,000	$5,855,000
100% GF (4260-101-0001)	$3,145,000	$3,145,000	$0
Total	**$28,424,000**	**$14,433,000**	**$13,991,000**

* Totals may differ due to rounding.

MITA

FISCAL REFERENCE NUMBER:1137

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$33,594,000**	**$45,858,000**
FEDERAL FUNDS	$29,327,700	$40,033,250
GENERAL FUND	$4,266,300	$5,824,750
OTHER FUNDS	$0	$0

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 # 22-20038
Contract # 22-20441
Contract # 24-40166
Contract # 24-40213
Contract # 24-40218
Contract # 24-40228
Contract # 25-50172
Contract # 25-50178
Contract # 25-50193
Contract # 25-50327
Contract # 25-50330
Contract # 50050186

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

MITA

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 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 2025-26, is an increase due to updated actuals, adjusted projections, and a new Enterprise MITA Support Service contract. The change from the prior estimate, for FY 2026-27, is an increase due to adjusted projections and several new Enterprise MITA Support Service contracts, and one Provider Management contract. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to adjusted projections and a full year of expenditures for new Enterprise MITA Support Service and Provider Management contracts.

Methodology:
1. FY 2025-26 and FY 2026-27 contract amounts are associated with the MITA initiative throughout the Department in order to meet federal regulations and guidelines.

2. FY 2025-26 and FY 2026-27 include the cost of the MITA support services and UCSD IA estimates.

3. The projected costs are:

MITA

FY 2025-26	APD	TF	GF	FF
Enterprise MITA Support Services	MITA	$30,253,000	$3,842,000	$26,411,000
UCSD IA	MITA	$510,000	$65,000	$445,000
Enterprise Certification Support Services	MITA	$2,603,000	$331,000	$2,272,000
Provider Management	PROV.	$228,000	$29,000	$199,000
Total		**$33,594,000**	**$4,267,000**	**$29,327,000**

FY 2026-27	APD	TF	GF	FF
Enterprise MITA Support Services	MITA	$39,771,000	$5,051,000	$34,720,000
UCSD IA	MITA	$510,000	$65,000	$445,000
Enterprise Certification Support Services	MITA	$5,349,000	$679,000	$4,670,000
Provider Management	PROV.	$228,000	$29,000	$199,000
Total		**$45,858,000**	**$5,824,000**	**$40,034,000**

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

ELECTRONIC VISIT VERIFICATION M&O COSTS

FISCAL REFERENCE NUMBER:2505

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$37,762,000**	**$39,190,000**
FEDERAL FUNDS	$37,762,000	$39,190,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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 18-95714
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 in the M&O phase during the contract renewal process. The CDSS and CDA contract costs were previously budgeted in the Personal Care Services and Department of Aging Administrative Costs policy changes, respectively. The M&O costs for CDSS and CDA shifted into this policy change for FY 2025-26. This policy change also includes M&O costs for the CDDS and CDPH contracts.

ELECTRONIC VISIT VERIFICATION M&O COSTS

Reason for Change:
There is an increase for FY 2025-26 and a decrease for FY 2026-27, from the prior estimate, due to updated projections. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to updated projections.

Methodology:
1. Assume the total M&O costs for CDSS, CDA, CDPH, and CDDS are as follows:

FY 2025-26	TF	GF	FF
CDSS	$34,196,000	$0	$34,196,000
CDA	$180,000	$0	$180,000
CDPH	$79,000	$0	$79,000
CDDS	$3,307,000	$0	$3,307,000
Total	**$37,762,000**	**$0**	**$37,762,000**

FY 2026-27	TF	GF	FF
CDSS	$35,592,000	$0	$35,592,000
CDA	$202,000	$0	$202,000
CDPH	$89,000	$0	$89,000
CDDS	$3,307,000	$0	$3,307,000
Total	**$39,190,000**	**$0**	**$39,190,000**

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

EMSA - CALIFORNIA POISON CONTROL SYSTEM SVCS.

FISCAL REFERENCE NUMBER:2402

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$16,289,000**	**$18,291,000**
FEDERAL FUNDS	$16,289,000	$18,291,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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)
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 use constitute 21% and 20%, respectively, of the cases managed by CPCS. The Department and EMSA provide 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 by year. The current IA 24-40021 was executed in September 2024 and is effective from the start of 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.

Reason for Change:
The change in FY 2025-26 from the prior estimate is a decrease due to:

- Actual invoices for FY 2024-25 Q4 and FY 2025-26 Q1 were lower than previously assumed and
- Projected invoice amounts are assumed to be lower for FY 2025-26 Q1-Q2.

EMSA - CALIFORNIA POISON CONTROL SYSTEM SVCS.

There is no change in FY 2026-27 from the prior estimate.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a net increase due to:

- Projected decreases in FY 2025-26 Q4 invoices occurring in FY 2026-27 compared to fourth quarter invoices occurring in FY 2025-26.
- Projected increases in invoice amounts for FY 2026-27 Q1-Q3.

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 2025-26	TF	FF
FY 2024-25 Q4	$5,932	$5,932
FY 2025-26 Q1-Q3	$10,357	$10,357
Total	**$16,289**	**$16,289**

(Dollars in Thousands)

FY 2026-27	TF	FF
FY 2025-26 Q4	$4,524	$4,524
FY 2026-27 Q1-Q3	$13,767	$13,767
Total	**$18,291**	**$18,291**

Funding:
100% Title XXI FF (4260-101-0890)

HCBA WAIVER ADMINISTRATIVE COST

FISCAL REFERENCE NUMBER:2152

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$22,026,000**	**$23,380,000**
FEDERAL FUNDS	$10,918,000	$11,589,000
GENERAL FUND	$11,108,000	$11,791,000
OTHER FUNDS	$0	$0

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 (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 an 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 2025-26 and FY 2026-27, is a slight decrease due to updating projections using more recent expenditure data. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to the growth trend in administrative costs.

Methodology:
1. Assume there are 9,566 members in the HCBA Waiver in FY 2024-25.

2. Assume 486 new members will be enrolled in FY 2025-26 and 540 in FY 2026-27.

HCBA WAIVER ADMINISTRATIVE COST

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 2025-26	$22,026	$11,108	$10,918
FY 2026-27	$23,380	$11,791	$11,589

*Totals may differ due to rounding.

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

PAVE SYSTEM

FISCAL REFERENCE NUMBER:1932

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$16,316,000**	**$30,784,000**
FEDERAL FUNDS	$11,789,300	$22,152,650
GENERAL FUND	$4,526,700	$8,631,350
OTHER FUNDS	$0	$0

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 A05
Contract # 25-50199

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;
- Generates monthly alerts using mandatory compliance and risk data sources (at a minimum, based on Affordable Care Act (ACA) compliance) to indicate potential risk of fraud, program vulnerability or non-compliance issues for the provider and all parties associated with the provider; and
- Revalidation of all providers every five years.

Reason for Change:
The change from the prior estimate, FY 2025-26, is a decrease due to updated actuals, adjusted projections, and the removal of multiple change requests. The change from the prior estimate, FY 2026-27, from the prior estimate, and from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to adjusted projections for provider and help desk costs, which include additional and new pricing for analytics and chat interactions.

Methodology:
1. The Department continues to add programs and benefits to PAVE on a phase-in basis. M&O costs continue to increase due to rising inflationary costs, the inclusion of additional providers, new pricing for analytics and chat interactions, which increases system volume and associated support activities.

PAVE SYSTEM

2. 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.

3. The FY 2025-26 and FY 2026-27 costs are as follows:

FY 2025-26	TF	GF	FF
Provider Cost	$15,316,000	$4,026,000	$11,290,000
Help Desk Cost	$1,000,000	$500,000	$500,000
Total	**$16,316,000**	**$4,526,000**	**$11,790,000**

FY 2026-27	TF	GF	FF
Provider Cost	$28,514,000	$7,496,000	$21,018,000
Help Desk Cost	$2,270,000	$1,135,000	$1,135,000
Total	**$30,784,000**	**$8,631,000**	**$22,153,000**

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)

CAPMAN

FISCAL REFERENCE NUMBER:1318

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$19,788,000**	**$19,309,000**
FEDERAL FUNDS	$14,674,550	$14,240,750
GENERAL FUND	$5,113,450	$5,068,250
OTHER FUNDS	$0	$0

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 #24-40128

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:

<u>CAPMAN Prime Vendor Contracts</u>
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

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 June 2, 2025, through June 1, 2026.

Reason for Change:
The change from the prior estimate, for FY 2025-26, is an increase due to updated actuals and adjusted projection calculations. The change from the prior estimate, for FY 2026-27, is an increase due to adjusted projection calculations. The change from FY 2025-26 to FY 2026-27, in the current estimate, is a slight decrease due to adjusted projection calculations and the completion of the CAPMAN Discovery and Planning contract.

Methodology:
Total costs are estimated to be:

FY 2025-26	TF	GF	FF
CAPMAN Prime Vendor	$12,172,000	$3,200,000	$8,972,000
Support Services	$2,951,000	$776,000	$2,175,000
Hardware/Software	$4,010,000	$1,054,000	$2,956,000
Discovery & Planning	$655,000	$83,000	$572,000
Total	**$19,788,000**	**$5,113,000**	**$14,675,000**

FY 2026-27	TF	GF	FF
CAPMAN Prime Vendor	$12,171,000	$3,199,000	$8,972,000
Support Services	$2,951,000	$776,000	$2,175,000
Hardware/Software	$4,127,000	$1,085,000	$3,042,000
Discovery & Planning	$60,000	$8,000	$52,000
Total	**$19,309,000**	**$5,068,000**	**$14,241,000**

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)

PASRR

FISCAL REFERENCE NUMBER:1720

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$11,373,000**	**$9,637,000**
FEDERAL FUNDS	$8,529,750	$7,227,750
GENERAL FUND	$2,843,250	$2,409,250
OTHER FUNDS	$0	$0

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
Keystone Peer Review Organization, LLC (KEPRO) Interagency Agreement (IA) #23-30140, #25-50077

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. Under the 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.

The Department awarded the PASRR contract (#23-30140) to KEPRO, LLC, effective July 1, 2023, with an expiration date of June 30, 2026. Due to evaluations exceeding projections, contract #23-30140 was terminated on July 31, 2025. The funds initially allocated for this contract will be applied to the remaining invoices for FY 2024-25.

The Department awarded a PASRR contract (#25-50077) to KEPRO, LLC effective July 1, 2025, through June 30, 2027, with one optional extension through June 30, 2028.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is an increase due to actuals exceeding projections and an expected increase in cases.

The change in FY 2026-27, from the prior estimate, is an increase due to actuals exceeding projections and the projected growth of the skilled nursing facility population.

PASRR

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a net decrease due to increased prior year costs and delays in processing payments in FY 2026-27.

Methodology:

1. Expenditures for PASRR service contract #23-30140 expired on July 31, 2025. The PASRR service contract #25-50077 began on July 1, 2025.

2. The PASRR payments on a cash basis are estimated at:

(Dollars in Thousands)

FY 2025-26	**TF**	**GF**	**FF**
Evaluations	**$11,373**	**$2,843**	**$8,530**

(Dollars in Thousands)

FY 2026-27	**TF**	**GF**	**FF**
Evaluations	**$9,637**	**$2,409**	**$7,228**

Funding:
75% Title XIX / 25% GF (4260-101-0001/0890)

PUBLIC HEALTH REGISTRIES SUPPORT

FISCAL REFERENCE NUMBER:1370

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$13,480,000**
FEDERAL FUNDS	$0	$13,480,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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 the CAIR and CalREDIE 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 2024-25 and FY 2025-26. However, CDPH will be submitting an APD for FY 2026-27 to include the addition of the Vaccine Management System (VMS).

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.
- VMS supports vaccine ordering, clinic management, public scheduling, and public access to CAIR records. The VMS suite consists of three key modules. MyCAvax is the system that is used for providers to order vaccine and manage vaccine inventory. My Turn provides additional clinic management tools and connects to CAIR to send vaccine

PUBLIC HEALTH REGISTRIES SUPPORT

administration data. The third component, the Digital Vaccine Record (DVR) uses CAIR data to provide the public with an electronic copy of their vaccine administration data. While CAIR and VMS are two systems, they are closely tied together and provide the state with the tools for the full vaccine management lifecycle from vaccine ordering, inventory management, and administration.

Once the APD is submitted and approved, the programs will receive federal funding (50% Federal Fund (FF) / 50% General Fund). CDPH plans on submitting and receiving APD approval from CMS during FY 2026-27.

Reason for Change:
The change from the prior estimate, for FY 2025-26 and FY 2026-27, is a decrease due delayed submission of the APD. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due costs for CAIR, CalREDIE and VMS.

Methodology:

1. For the CAIR, CalREDIE, and VMS, 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 determined to not need certification by CMS and would qualify for 50% Title XIX funding with an approved APD.

FY 2026-27	**TF**	**CDPH GF**	**FF**
CalREDIE (50% FF/50% GF)	$1,343,000	$671,000	$671,000
CAIR (50% FF/50% GF)	$6,889,000	$3,445,000	$3,445,000
VMS (50% FF/50% GF)	$18,727,000	$9,364,000	$9,364,000
Total FY 2026-27	$26,959,000	$13,480,000	**$13,480,000**

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

SDMC SYSTEM M&O SUPPORT

FISCAL REFERENCE NUMBER:1732

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$2,689,000**	**$2,319,000**
FEDERAL FUNDS	$1,344,500	$1,159,500
GENERAL FUND	$1,344,500	$1,159,500
OTHER FUNDS	$0	$0

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.

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 is effective July 1, 2024, through June 30, 2027.

Reason for Change:
The change from the prior estimate, for FY 2025-26, is a decrease due to updated actuals, adjusted projections, and the absence of the Zero Dollar Claiming contract. The change from the prior estimate, for FY 2026-27, is a decrease due to adjusted projections and the absence of the

SDMC SYSTEM M&O SUPPORT

Zero Dollar Claiming contract. The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease due to adjusted projections.

Methodology:

FY 2025-26	TF	GF	FF
M&O	$2,689,000	$1,344,000	$1,345,000
Total	**$2,689,000**	**$1,344,000**	**$1,345,000**

*Totals may differ due to rounding

FY 2026-27	TF	GF	FF
M&O	$2,319,000	$1,159,000	$1,160,000
Total	**$2,319,000**	**$1,159,000**	**$1,160,000**

*Totals may differ due to rounding

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

ELECTRONIC ASSET VERIFICATION PROGRAM

FISCAL REFERENCE NUMBER:2002

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$8,632,000**	**$10,909,000**
FEDERAL FUNDS	$4,316,000	$5,454,500
GENERAL FUND	$4,316,000	$5,454,500
OTHER FUNDS	$0	$0

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

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 amendment 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 Department

ELECTRONIC ASSET VERIFICATION PROGRAM

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.

The Department anticipates a higher volume of AVP requests beginning in November 2025, due to the reinstatement of Asset Verification business processes. This is because the Department runs its annual renewal file two months prior to the beneficiary’s actual redetermination date (i.e., a November 2025 renewal file covers redeterminations due in January 2026). A sixth contract amendment to formalize these changes is in progress and is expected to be executed on or before November 1, 2025.

A sixth contract amendment was executed on October 17, 2025. This amendment increased the number of AVP inputs for the remainder of FY 2025-26, FY 2026-27, and FY 2027-28 to 125,000/month, due to Asset Limit Reinstatement as required by the 2025-2026 Health Omnibus Bill, Assembly Bill 116. This amendment also extended the term for an additional two years from December 31, 2028, through December 31, 2030.

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.

A first amendment for 23-30285 was executed on July 31, 2024. Due to vendor changes, LexisNexis will no longer offer Appriss and Accurint services after December 31, 2024. As a result, the Department contracts these services out through Equifax. This PC includes the cost of that contract.

*Includes the ten Accurint licenses provided by LNRS.

Reason for Change:
There is no change from the prior estimate for FY 2025-26 and FY 2026-27. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to yearly ramp-up costs.

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. The Department reinstated AVP in its entirety as of January 1, 2026, where AVP is used to determine or redetermine Medi-Cal eligibility for ABD applicants, members, and their responsible relatives.

ELECTRONIC ASSET VERIFICATION PROGRAM

3. 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 2025 through October 2025; 125,000 inputs x $4.85/input = $606,250 + $276,383 = $882,633/month from November through December 2025; and 125,000 inputs x $4.85/input = $606,250 + $284,675 = $890,925/month from January through June 2026.

4. The combined reimbursement rate for AVP and periodic data matching services, based on estimated query volumes, is estimated to be 125,000 inputs x $5.00/input = $624,437.50 + $284,675 = $909,112.50 from July 2026 through December 2026; and 125,000 inputs x $5.00/input = $624,437.50 + $284,675 = $909,112.50 from January 2027 – June 2027.

5. The Department is in the process of securing a contract amendment for the assumption of the reinstatement of asset verification. FY 2026-27 estimated costs are based on the revised price quote received from LexisNexis in August 2025 (prices per input are rounded).

6. Since contract 23-30285 is expected to term out on December 31, 2026, costs for the July through December 2026 period will be annualized to estimate budget year costs.

   The table below summarizes FY 2025-26 and FY 2026-27 costs:

Time Period	Monthly Rate	Months	Cost
July – October 2025	$380,263	4	$1,521,052
November – December 2025	$882,633	2	$1,765,266
January– June 2026	$890,925	6	$5,345,550
FY 2025-26		12	$8,631,868

Time Period	Monthly Rate	Months	Cost
July – December 2026	$909,112.50	6	$5,454,675
January – June 2027	$909,112.50	6	$5,454,675
FY 2026-27		12	$10,909,350

7. The estimated vendor costs are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2025-26	**$8,632**	**$4,316**	**$4,316**
FY 2026-27	**$10,909**	**$5,454**	**$5,455**

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

CALAIM - JUSTICE INVOLVED MAA

FISCAL REFERENCE NUMBER:2447

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$8,000,000**
FEDERAL FUNDS	$0	$4,000,000
GENERAL FUND	$0	$4,000,000
OTHER FUNDS	$0	$0

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:
In January 2023, California became the first state to secure federal approval to provide targeted Medicaid services to Medi-Cal-eligible individuals in state prisons, county jails, and youth correctional facilities during the 90 days prior to their release. Under a Medicaid 1115 demonstration waiver granted by the Centers for Medicare & Medicaid Services (CMS), California's Department of Health Care Services will work with state agencies, counties, providers, and community-based organizations to create a coordinated reentry process. This initiative aims to bridge critical gaps in care for justice-involved individuals by connecting them with physical and behavioral health services prior to release, ultimately improving health outcomes, reducing disparities, and advancing health equity across the state.

Inmates leaving correctional facilities are at increased 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 transportation. In California, average monthly Medicaid costs for justice-involved individuals following release are about twice the monthly costs for these members prior to incarceration. California Advancing & Innovating Medi-Cal (CalAIM) seeks to improve outcomes for this population by mandating county inmate pre-release application processes, allowing Medi-Cal reimbursement for services in the 90 days prior to release, and ensuring 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

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 aims to 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 October 1, 2026, pending CMS approval.

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:
The change from the prior estimate for FY 2025-26 and FY 2026-27 is a decrease due to shifting the implementation date from October 2025 to October 2026. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to the program implementing in FY 2026-27.

Methodology:

1. Assume the MAA program for the justice-involved population will be established no sooner than FY 2026-27 Quarter 2, subject to the necessary approvals being obtained from CMS.

2. Assume MAA claiming will begin no sooner than FY 2026-27 Quarter 2 by 75% of potential claiming units, with the first half of MAA payments anticipated for payment in Quarter 4 due to an estimated 6-month lag in claims submission and processing.

3. Assume the General Fund will be used for the non-federal share of the MAA claims.

4. Total estimated costs for FY 2025-26 and FY 2026-27 are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2025-26	$0	$0	$0
FY 2026-27	$8,000	$4,000	$4,000

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

PROTECTION OF PHI DATA

FISCAL REFERENCE NUMBER:1452

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$5,538,000**	**$14,980,000**
FEDERAL FUNDS	$2,769,000	$7,490,000
GENERAL FUND	$2,769,000	$7,490,000
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the upgrades to the infrastructure and ongoing costs of maintaining and securing electronic Protected Health Information (PHI).

Authority:
Contract # 24-40191
Contract # 24-40188
Contract # 22-20553 A04

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. Vulnerability management looks at known vulnerabilities in software and systems, reducing the risk of cyberattacks by patching and correcting known vulnerabilities that could lead to data breaches. In addition, it helps the Department comply with HIPAA regulatory requirements, by maintaining up-to-date security measures and ensuring the protection of sensitive data.

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.

PROTECTION OF PHI DATA

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.

Reason for Change:
The change from the prior estimate, for FY 2025-26, is a decrease due to updated actuals, delayed contract start and payment dates, and adjusted projection calculations. The change from the prior estimate, for FY 2026-27, and from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to adjusted projection calculations, the addition of several new software programs, and a full year of expenditures for new contracts for Database Administrator, Security Engineer, and Synercomm.

Methodology:

1. The costs include annual licensing, hardware, and software maintenance and support for:
    a. Backup and Recovery System is a solution that stores, protects data and prevents data loss by delivering data archival, monitoring, access control, encryption at rest, backup, and point-in-time recovery.
    b. 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.
    c. 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.
    d. Cloud Security Protection is a solution that ensures secure internet access for all users, and private applications without directly exposing the Department network to the internet. It protects internet access such as sandboxing, botnet protection, and advanced threat detection to prevent malware, ransomware, and phishing attacks.
    e. Automated security and compliance solutions are essential for managing security, privacy, and compliance throughout the software development lifecycle (SDLC). These solutions protect sensitive data by identifying and addressing security gaps, monitoring unauthorized access, and ensuring adherence to relevant regulations. By leveraging automation and data fusion, they enhance the maturity of Security Operations Centers (SOC), enabling quicker detection and response to security events, improving operational security, and reducing costs.

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 Enhancement 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,

PROTECTION OF PHI DATA

and resources. This includes establishing standardized and repeatable processes and procedures.

c. IAM operations functionality requires two or more resources to ensure that the organization's IAM framework is robust, versatile, and up to date with the latest industry standards and compliance requirements, intricate processes involving the management of digital identities, authentication methods, access controls, and regulatory compliance.

d. Vulnerability Management operations functionality requires two or more resources to review known vulnerabilities in software and systems, reducing cyberattack risk. This includes establishing standardized and repeatable processes and procedures to ensure sensitive data protection. Furthermore, these processes and procedures must be regularly evaluated and updated to ensure they remain effective.

3. The following amounts are based upon the latest projections of cost:

Fiscal Year	TF	GF	FF
FY 2025-26	$5,538,000	$2,769,000	$2,769,000
FY 2026-27	$14,980,000	$7,490,000	$7,490,000

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

BHSF - PROVIDER ACES TRAININGS

FISCAL REFERENCE NUMBER:2414

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$7,415,000**	**$0**
FEDERAL FUNDS	$3,707,000	$0
GENERAL FUND	$0	$0
OTHER FUNDS	$3,708,000	$0

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)]
Budget Act of 2025

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 million BHSF) in FY 2023-24, and $45.5 million TF ($22.75 million BHSF) in FY 2024-25.

An additional $2 million TF ($1 million BHSF) was approved to continue the program in FY 2025-26.

Reason for Change:
There are no changes in FY 2025-26 and FY 2026-27 from the prior estimate.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to all funds expended in FY 2025-26.

BHSF - PROVIDER ACES TRAININGS

Methodology:

1. The table below displays the estimated spending and remaining funds by Appropriation Year.

(Dollars in Thousands)

	TF	BHSF	FF*
Appropriation Year 2024-25	$45,500	$22,750	$22,750
Estimated in FY 2024-25	$40,085	$20,042	$20,043
Estimated in FY 2025-26	$5,415	$2,708	$2,707
Total Estimated Remaining	$0	$0	$0
Appropriation Year 2025-26	$2,000	$1,000	$1,000
Estimated in FY 2025-26	$2,000	$1,000	$1,000
Total Estimated Remaining	$0	$0	$0

2. The provider trainings costs, funded with BHSF, are estimated to be $7,415,000 TF ($3,708,000 SF) in FY 2025-26.

(Dollars in Thousands)

FY 2025-26	TF	BHSF	FF*
Appropriation Year 2024-25	$5,415	$2,708	$2,707
Appropriation Year 2025-26	$2,000	$1,000	$1,000
Total FY 2025-26	**$7,415**	**$3,708**	**$3,707**

*Federal funds authority is newly requested for the fiscal year in which funds are anticipated to be expended.

Funding:

Behavioral Health Services Fund (4260-101-3085)
100% Title XIX (4260-101-0890)

MOBILE VISION SERVICES

FISCAL REFERENCE NUMBER:2467

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$2,114,000**	**$2,208,000**
FEDERAL FUNDS	$1,374,000	$1,435,000
GENERAL FUND	$0	$0
OTHER FUNDS	$740,000	$773,000

Purpose:
This policy change estimates the costs of providing Mobile Vision Services.

Authority:
Welfare & Institutions Code section 14132.58 (c) (1)
SB 502 (Chapter 487, Statutes of 2023)
SB 776 (Chapter 788, Statutes of 2025)
SPA 24-0012
Contract 24-40114

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 contracted with a Third-Party Administrator to fund the program through private donations and federal funding.

Effective January 1, 2026, SB 776 removed the mobile optometric office restrictions placed on all owners and operators. The Third-Party Administrator will no longer have a subcontractor limitation and can increase their subcontractors and school engagements commensurate with the needs of the districts being served.

Reason for Change:
There is a decrease from the prior estimate, for FY 2025-26 and FY 2026-27, due to the Third-Party Administrator anticipating providing less services than initially projected. There is an increase from FY 2025-26 to FY 2026-27, in the current estimate, due to the Third-Party Administrator ramping up services over time.

Methodology:
1. For budgeting purposes, assume implementation 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:

MOBILE VISION SERVICES

(Dollars in Thousands)

FY 2025-26	TF	SF	FF
Federal Fund Match	$0	($1,374)	$1,374
Program Expenditures	$2,114	$2,114	$0
Total	**$2,114**	**$740**	**$1,374**
FY 2026-27	**TF**	**SF**	**FF**
Federal Fund Match	$0	($1,435)	$1,435
Program Expenditures	$2,208	$2,208	$0
Total	**$2,208**	**$773**	**$1,435**

Funding:
100%Title XXI FFP (4260-101-0890)
Vision Services CHIP HSI Special Fund (4260-101-8140)

MEDCOMPASS SOLUTION

FISCAL REFERENCE NUMBER:1982

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$7,036,000**	**$8,062,000**
FEDERAL FUNDS	$5,186,200	$5,942,100
GENERAL FUND	$1,849,800	$2,119,900
OTHER FUNDS	$0	$0

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 # 24-40001

Interdependent Policy Changes:
Not Applicable

Background:
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.

Reason for Change:
The change from the prior estimate, for FY 2025-26, is an increase due to updated actuals, higher Infrastructure-as-a-Service (IaaS) Managed Services M&O costs, and the addition of Waiver Personal Care Services (WPCS) M&O costs. The change from the prior estimate, for FY 2026-27, is an increase due to additional services and WPCS M&O costs. The change from FY2025-26 to FY 2026-27, in the current estimate, is an increase due to higher Licensing Fees, IaaS Managed Services M&O costs, additional services, and a full year of expenditure for WPCS M&O.

Methodology:
1. The NCB contract, 24-40001, with AssureCare, LLC began on August 1, 2024, to continue delivering M&O support services. The contract ends on January 31, 2029, and includes one optional two-year term.

2. The MedCompass system was certified in May 2021 and currently claims applicable costs at 75% FF/ 25% GF.

3. The FY 2025-26 and FY 2026-27 costs are as follows:

MEDCOMPASS SOLUTION

FY 2025-26	TF	GF	FF
Licensing Fees	$3,839,000	$1,009,000	$2,830,000
IaaS Managed Services M&O	$660,000	$174,000	$486,000
SaaS Ongoing Operation Support	$783,000	$206,000	$577,000
Additional Services	$1,465,000	$385,000	$1,080,000
WPCS M&O	$289,000	$76,000	$213,000
Total	**$7,036,000**	**$1,850,000**	**$5,186,000**

FY 2026-27	TF	GF	FF
Licensing Fees	$4,182,000	$1,100,000	$3,082,000
IaaS Managed Services M&O	$720,000	$189,000	$531,000
SaaS Ongoing Operation Support	$870,000	$229,000	$641,000
WPCS M&O	$1,560,000	$410,000	$1,150,000
Total	**$8,062,000**	**$2,120,000**	**$5,942,000**

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)

NEWBORN HEARING SCREENING PROGRAM

FISCAL REFERENCE NUMBER:1824

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$6,220,000**	**$6,313,000**
FEDERAL FUNDS	$3,110,000	$3,156,500
GENERAL FUND	$3,110,000	$3,156,500
OTHER FUNDS	$0	$0

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, based on their initial hearing screening, is referred for follow-up services. The HCCs provide a database that assists the NHSP in collection and reporting of infant hearing screening data. The information collected includes screening and diagnostic services provided to newborns and infants who are deaf or hard-of-hearing.

- HCC contract #24-40060 began July 1, 2024, and expires June 30, 2027.

Reason for Change:
There is no change from the prior estimate for FY 2025-26 and FY 2026-27. The increase from FY 2025-26 to FY 2026-27, in the current estimate, is due to terms of the awarded three-year contract.

Methodology:
1. The NHSP contract combines the HCC and Data Management services into one contract. Costs for FY 2025-26 and FY 2026-27 are $6,220,123 and $6,313,425, respectively.

2. The anticipated NHSP costs for FY 2025-26 and FY 2026-27 are as follows:

Fiscal Year	TF	GF	FF
FY 2025-26	$6,220,000	$3,110,000	$3,110,000
FY 2026-27	$6,313,000	$3,156,000	$3,157,000

NEWBORN HEARING SCREENING PROGRAM

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

COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE

FISCAL REFERENCE NUMBER:2334

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$13,267,000**
FEDERAL FUNDS	$0	$7,360,000
GENERAL FUND	$0	$5,907,000
OTHER FUNDS	$0	$0

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 Centers for Medicare and Medicaid Services (CMS) Interoperability regulations, including the CMS Interoperability and Patient Access Final Rule (CMS-9115-F) and the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F).

Authority:
CMS Interoperability Final Rules (CMS-9115-F and CMS-0057-F)
Behavioral Health Information Notice (BHIN) 26-008
BHIN 23-032

Interdependent Policy Changes:
Not Applicable

Background:
On May 1, 2020, 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. CMS-9115-F required that by January 1, 2021, impacted payers, including Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) counties, hereafter referred to as Behavioral Health Plans (BHPs), must implement and maintain a secure, standards-based Patient Access API in accordance with Title 42 Code of Federal Regulations (CFR) section 438.242(b)(5) and a publicly accessible standards-based Provider Directory API described at 42 CFR section 438.242(b)(6), including required policies, procedures, and publicly accessible documentation and resources. CMS-9115-F also requires impacted payers to comply with the public reporting and information blocking components of 45 CFR Part 171, where applicable.

Given the federal mandate, this proposal results in a Proposition 30 impact whereby 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.

COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE

In January 2024, CMS released the Interoperability and Prior Authorization final rule (CMS-0057-F), which advances interoperability and improves prior authorization processes. CMS-0057-F requires that by January 1, 2026, impacted payers, including BHPs to:

- Enhance API infrastructure to align with newly adopted technology standards and specifications under 45 CFR section 170.213 and 45 CFR section 170.215,
- Comply with mandatory prior authorization decision timeframes under 42 CFR section 438.210(d),
- Communicate a reason for denial when denying a prior authorization request in accordance with 42 CFR 438.242(b)(8) and 42 CFR section 431.80(a),
- Publicly report a list of all items and services that require prior authorization as well as key metrics required under 42 CFR section 438.210(f), and
- Report Patient Access API usage to CMS in accordance with 42 CFR section 438.242(b)(5)(iii).

CMS-0057-F further requires that by January 1, 2027, impacted payers, including BHPs, enhance the Patient Access API with information about prior authorizations for items and services in accordance with 42 CFR section 431.60(b)(5), excluding drugs, and implement and maintain a secure, standard-based: Provider Access API, Payer-to-Payer API, and Prior Authorization API, under 42 CFR section 438.242(b)(7). Additionally, CMS-0057-F requires impacted payers to publish member and provider education resources as required at 42 CFR 438.242, 42 CFR section 431.61(a)(4)(ii), 42 CFR section 431.61(a)(5) and 42 CFR section 431.61(b)(7).

Funds in this policy change will also serve to pay counties, and Qualified Health Information Organizations (QHIO) on behalf of counties, for costs incurred to comply with the real-time data sharing requirements DHCS is implementing beyond the interoperability rules. In order to meet these real-time data sharing requirements, QHIOs, which are governed by the California Data Exchange Framework, will need to facilitate real-time data exchange for plans who do not have the technological infrastructure or staff to do so. Funds going to QHIOs will directly support BHPs’ compliance with CMS-0057-F and with real-time data sharing requirements through onboarding, education and outreach, technical assistance and support, and actual facilitation of data exchange, including event notifications and member rosters.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is due to a shift in the start of payments from September 2025 to July 2026, due to delays in county claiming.

The change in FY 2026-27, from the prior estimate, is a net increase due to the following:

- Lower projected costs for the Interoperability and Patient Access Final Rule due to delays in county claiming, and
- The addition of Interoperability and Prior Authorization Final Rule costs.

The change in the current estimate, from FY 2025-26 to FY 2026-27, is due to no Interoperability Final Rule costs allocated in FY 2025-26.

Methodology:

1. Assume reimbursements to counties for incurred expenses related to the CMS Interoperability and Patient Access Final Rule will begin in July 2026.

2. Assume implementation of the CMS Interoperability and Prior Authorization Final Rule will also begin in July 2026.

COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE

3. The estimated payments in FY 2026-27, on a cash basis, are as follows:

(Dollars in Thousands)

FY 2026-27	TF	GF	FF	CF
Patient Access Final Rule	$8,470	$2,339	$3,792	$2,339
Prior Authorization Final Rule	$7,136	$3,568	$3,568	$0
Total	$15,606	**$5,907**	**$7,360**	$2,339

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

DRUG MEDI-CAL PARITY RULE ADMINISTRATION

FISCAL REFERENCE NUMBER:2206

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$5,875,000**	**$5,875,000**
FEDERAL FUNDS	$3,917,000	$3,917,000
GENERAL FUND	$1,958,000	$1,958,000
OTHER FUNDS	$0	$0

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 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 is no change from the prior estimate for FY 2025-26 and FY 2026-27.

There is no change from FY 2025-26 to FY 2026-27 in the current estimate.

Methodology:
1. Assume payments for the Parity Rule activities will begin in March 2026.

DRUG MEDI-CAL PARITY RULE ADMINISTRATION

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 2025-26 and FY 2026-27 are:

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

FY 2026-27	**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)

PACES

FISCAL REFERENCE NUMBER:1972

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$3,761,000**	**$4,318,000**
FEDERAL FUNDS	$2,772,450	$3,182,950
GENERAL FUND	$988,550	$1,135,050
OTHER FUNDS	$0	$0

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.

<u>PACES Interfaces and New Data Sources</u>
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 expanded 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 allows the Department to monitor the networks within those models.

Reason for Change:
The change from the prior estimate, for FY 2025-26, is a slight increase due to updated actuals and adjusted projections. The change from the prior estimate, for FY 2026-27, and from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to adjusted projections.

PACES

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 2025-26	TF	GF	FF
M&O	$3,231,000	$850,000	$2,381,000
Cloud Services	$530,000	$139,000	$391,000
Total	**$3,761,000**	**$989,000**	**$2,772,000**

FY 2026-27	TF	GF	FF
M&O	$3,788,000	$996,000	$2,792,000
Cloud Services	$530,000	$139,000	$391,000
Total	**$4,318,000**	**$1,135,000**	**$3,183,000**

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)

CALAIM - INMATE PRE-RELEASE PROGRAM ADMIN

FISCAL REFERENCE NUMBER:2413

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$2,746,000**	**$2,746,000**
FEDERAL FUNDS	$1,373,000	$1,373,000
GENERAL FUND	$1,373,000	$1,373,000
OTHER FUNDS	$0	$0

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:

- 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.

CALAIM - INMATE PRE-RELEASE PROGRAM ADMIN

- 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 2025-26 and FY 2026-27. There is no change from FY 2025-26 to FY 2026-27 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 2025-26 and FY 2026-27 are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2025-26	$2,746	$1,373	$1,373
FY 2026-27	$2,746	$1,373	$1,373

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

STATEWIDE VERIFICATION HUB

FISCAL REFERENCE NUMBER:2358

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$112,000**	**$0**
FEDERAL FUNDS	$100,800	$0
GENERAL FUND	$11,200	$0
OTHER FUNDS	$0	$0

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 A01

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:

- 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.

STATEWIDE VERIFICATION HUB

- 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 with several updates to both APD and IA occurring over the years in order to continue approvals all the way through September 2026.

Reason for Change:
There is a decrease in FY 2025-26, from the prior estimate, due to updated actuals and the decision not to pursue a new technical service contract. There is no change in FY 2026-27 from the prior estimate. There is a decrease from FY 2025-26 to FY 2026-27, in the current estimate, due to decision not to pursue a new technical service contract.

Methodology:
1. Assume Design, Development, and Implementation cost for the Medicaid Management Information System are budgeted at 90% FF / 10% GF.

2. The Department estimates SVH costs for FY 2025-26 and FY 2026-27 to be:

Fiscal Years	TF	GF	FF
FY 2025-26	$112,000	$11,000	$101,000
FY 2026-27	$0	$0	$0

Funding:
90% FF/10% GF (4260-101-0890/0001) (Design, Development, and Implementation of Medicaid Management Information System)

DATA ANALYTICS

FISCAL REFERENCE NUMBER:1902

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$3,357,000**	**$5,641,000**
FEDERAL FUNDS	$2,427,000	$3,812,000
GENERAL FUND	$930,000	$1,829,000
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates costs to support Medi-Cal and the California Health Interview Survey (CHIS) contract services and other data analytics as necessary.

Authority:
Interagency Agreement (IA) 21-10053 A1
IA 23-30378
IA 25-50161
IA-CalHHS, OTSI (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.

The Department is in the process of developing a new interagency agreement with University of California Berkeley (UCB). This collaboration with UCB will assist with data analysis and evidence-based policy and programming solutions. The collaboration will enable senior Medi-Cal leadership to draw on expertise from the UCB-University of California, San Francisco Computational Precision Health program and the Center for Healthcare Marketplace Innovation to assist the Department with analysis of multiple data streams to identify trends and impacts of

DATA ANALYTICS

changes in procedure, programming and reimbursement, and offer evidence-based options to strengthen effective and equitable response.

The Department is in the process of developing a new interagency agreement with the California Health and Human Services (CalHHS), Office of Technology and Solutions Integration (OTSI). The Department will reimburse OTSI for the Department's share of cost for work associated with addressing data strategies and solutions that directly benefit the Department including, but not limited to: evaluating and supporting responsive data analytics opportunities across CalHHS departments and offices to support public reporting requirements; supporting agency-wide efforts to integrate data; and collaboratively establishing data governance practices that enable secure, appropriate data sharing in alignment with department and CalHHS goals.

Reason for Change:
The change from the previous estimate, for FY 2025-26 and FY 2026-27, is an increase due to the inclusion of the IA-CalHHS, OTSI. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to a full year of IA-UCB and IA-CalHSS, OTSI costs in FY 2026-27.

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. Beginning FY 2025-26, the amount on an accrual basis for the IA-UCB is $583,444 FF, but on a cash basis is $97,000 FF.

4. Beginning FY 2025-26, the amount on an accrual basis for the IA-CalHSS, OTSI is $2,370,000, but on a cash basis is $1,185,000 TF.

5. The estimated administrative costs reimbursements for CHIS, the Caregiving Module, IA-UCB, and the IA-CalHHS, OTSI for FY 2025-26 and FY 2026-27, on a cash basis, are:

FY 2025-26	TF	GF	FF
FY 2024-25 Claims	$350,000	$0	$350,000
FY 2025-26 Claims	$1,050,000	$0	$1,050,000
FY 2024-25 Caregiving Module	$99,000	$50,000	$50,000
FY 2025-26 Caregiving Module	$576,000	$288,000	$288,000
FY 2025-26 IA - UCB	$97,000	$0	$97,000
FY 2025-26 IA – CalHHS, OTSI	$1,185,000	$592,500	$592,500
Total	**$3,357,000**	**$930,000**	**$2,427,000**

DATA ANALYTICS

FY 2026-27	TF	GF	FF
FY 2025-26 Claims	$350,000	$0	$350,000
FY 2026-27 Claims	$1,050,000	$0	$1,050,000
FY 2025-26 Caregiving Module	$192,000	$96,000	$96,000
FY 2026-27 Caregiving Module	$451,000	$225,500	$225,500
FY 2025-26 IA-UCB	$583,000	$0	$583,000
FY 2025-26 IA – CalHHS, OTSI	$1,185,000	$592,500	$592,500
FY 2026-27 IA – CalHHS, OTSI	$1,830,000	$915,000	$915,000
Total	**$5,641,000**	**$1,829,000**	**$3,812,000**

*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

FISCAL REFERENCE NUMBER:2321

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$2,200,000**	**$2,200,000**
FEDERAL FUNDS	$1,100,000	$1,100,000
GENERAL FUND	$1,100,000	$1,100,000
OTHER FUNDS	$0	$0

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 Cal MediConnect (CMC) Independent Ombudsman, which offered ombudsperson services to CMC members. An amendment to this contract has been executed to extend services until December 31, 2026. An additional amendment is expected to be made to extend vendor services beyond the December 31, 2026, contract end date.

Reason for Change:
There is no change from the prior estimate for FY 2025-26 and FY 2026-27. There is no change from FY 2025-26 to FY 2026-27 in the current estimate.

Methodology:

1. Annual contract costs are $2,200,000 TF in FY 2025-26 and FY 2026-27.

2. The contract began in January 2023.

MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM

3. The anticipated costs for FY 2025-26 and FY 2026-27 of this contract are:

Fiscal Year	TF	GF	FF
FY 2025-26	$2,200,000	$1,100,000	$1,100,000
FY 2026-27	$2,200,000	$1,100,000	$1,100,000

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

MFP/CCT SUPPLEMENTAL FUNDING

FISCAL REFERENCE NUMBER:2392

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$1,871,000**	**$1,952,000**
FEDERAL FUNDS	$1,871,000	$1,952,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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-A3

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 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 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 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

MFP/CCT SUPPLEMENTAL FUNDING

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.

In November 2025, CMS tentatively approved additional MFP funding to continue supporting the Department's implementation of the federal HCBS Quality Measure Set and related Access Rule requirements. This funding is intended to assist the Department with reporting on the required LTSS measures (LTSS-1, LTSS-2, LTSS-6, LTSS-7, and LTSS-8), administering a statewide consumer experience survey, and developing and implementing required quality improvement plans. The additional funding recognizes the scale and complexity of California's HCBS delivery system and the ongoing need for sustained analytic, data, and technical assistance support to achieve and maintain federal compliance.

Reason for Change:
The change in FY 2025-26 and FY 2026-27, from the prior estimate, is a decrease based on updated actuals. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to updated actuals.

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 was awarded funding in CY 2024 for the amended Mathematica contract to implement the new CMS Access Rule requirements.

3. Assume the Department was awarded funding in CY 2025 for the amended Mathematica contract for continued support in implementing the required performance improvement projects in the MFP demonstration.

4. Total supplemental funding costs for MFP are as follows:

Fiscal Year	TF
FY 2025-26	$1,871,000
FY 2026-27	$1,952,000

Funding:
MFP Federal Grant (4260-106-0890)

T-MSIS

FISCAL REFERENCE NUMBER:1768

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$1,849,000**	**$1,887,000**
FEDERAL FUNDS	$1,403,950	$1,413,250
GENERAL FUND	$445,050	$473,750
OTHER FUNDS	$0	$0

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 A02

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.

On May 28, 2025, CMS issued a State Health Official (SHO) letter #25-002 reaffirming CMS expectations regarding the quality of Medicaid and Children's Health Insurance Program (CHIP) data in T-MSIS and outlining the compliance impact of deviating from T-MSIS reporting requirements. In this letter CMS refers to CMS SHO Letter #18-008, dated August 18, 2018, and March 18, 2019, CMS and CHIP Services Information Bulletin (CIB) addressing T-MSIS State Compliance, reminded states of the potential for reduced Federal Financial Participation (FFP) for state systems that fail to produce T-MSIS data in a manner that complies with applicable federal requirements.

Furthermore, eligibility for enhanced FFP for Medicaid Enterprise System (MES) systems expenditures requires states to meet federal reporting requirements and maintain compliance with federal regulations, including 42 CFR 433.116. T-MSIS data must be:

- Submitted and received by CMS in a required format for processing,

T-MSIS

- Complete, timely, and accurate, and
- Submitted and recorded without deleting or degrading historical data submissions

SHO Letter 25-002 emphasizes T-MSIS Data Quality (DQ) Compliance, stating that in January 2022, the Outcomes Based Assessment (OBA) methodology replaced the T-MSIS Priority Items (TPI), as the new DQ assessment methodology. SHO 25-002 rescinds the use of TPIs established in CMS SHO Letter #18-008 as the assessment framework for T-MSIS data quality compliance and replaces it with the OBA framework.

The process of assessing DQ compliance begins with CMS monitoring a state's DQ assessment. If a state's DQ assessment does not meet quality targets for two consecutive monthly reporting periods, CMS will notify the state about the potential risk of a compliance action for failure to meet T-MSIS submission requirements.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is an increase due to updated actuals and adjusted projections. The change in FY 2026-27, from the prior estimate, is an increase due to adjusted projections. The change from FY 2025-26 to FY 2026-27, in the current estimate, is a slight increase due to adjusted projections.

Methodology:
1. CMS approved FFY 2024-25 IAPD in April 2024 for enhanced funding of 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. The Department submitted an IAPDU for FFY 2025-26 and is awaiting CMS approval.

2. The SOP testing contract began on April 3, 2023, and will end on April 2, 2027. This is for DDI (90% Title XIX/10% GF) activities.

FY 2025-26	TF	GF	FF
DD&I	$1,547,000	$407,000	$1,140,000
M&O	$302,000	$38,000	$264,000
Total	**$1,849,000**	**$445,000**	**$1,404,000**

FY 2026-27	TF	GF	FF
DD&I	$1,724,000	$453,000	$1,271,000
M&O	$163,000	$21,000	$142,000
Total	**$1,887,000**	**$474,000**	**$1,413,000**

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)

SSA COSTS FOR HEALTH COVERAGE INFO.

FISCAL REFERENCE NUMBER:237

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$1,800,000**	**$1,820,000**
FEDERAL FUNDS	$900,000	$910,000
GENERAL FUND	$900,000	$910,000
OTHER FUNDS	$0	$0

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 the SSA. The SSA bills the Department quarterly for this activity.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is due to:

- An increase calculated using the average projection of the actual billed amounts from the SSA for FY 2023-24, FY 2024-25, and Q1 and Q2 for FY 2025-26.

The change in FY 2026-27, from the prior estimate, is due to:

- An increase calculated using the average projection of the actual billings amounts from SSA for FY 2023-24, FY 2024-25, and Q1 and Q2 for FY 2025-26.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to FY 2025-26 including two quarters of actuals that are lower than the projected quarters while FY 2026-27 uses only the higher projected quarterly averages.

Methodology:

1. The following projections are averaged based upon the most current actual billings from the SSA.

SSA COSTS FOR HEALTH COVERAGE INFO.

Fiscal Year	TF	GF	FF
FY 2025-26	$1,800,000	$900,000	$900,000
FY 2026-27	$1,820,000	$910,000	$910,000

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

MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)

FISCAL REFERENCE NUMBER:1441

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$1,022,000**	**$994,000**
FEDERAL FUNDS	$729,000	$715,000
GENERAL FUND	$293,000	$279,000
OTHER FUNDS	$0	$0

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 partners. The California Department of Technology (CDT) houses MEDS and charges the Department for all associated data storage, processing, networking, data archiving, and backup

MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)

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 2025-26, is a decrease due to updated actuals and adjusted projections. The change from the prior estimate, for FY 2026-27, and from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease due to lower costs for system tracking and M&O functions.

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 2025-26 and FY 2026-27 are:

FY 2025-26	TF	GF	FF
Reporting and Tracking (50% FF / 50% GF)	$150,000	$75,000	$75,000
Maintenance & Operations (75% FF / 25% GF)	$872,000	$218,000	$654,000
Total	**$1,022,000**	**$293,000**	**$729,000**

FY 2026-27	TF	GF	FF
Reporting and Tracking (50% FF / 50% GF)	$122,000	$61,000	$61,000
Maintenance & Operations (75% FF / 25% GF)	$872,000	$218,000	$654,000
Total	**$994,000**	**$279,000**	**$715,000**

Funding:
50% Title XIX / 50% GF (4260-101-0890/0001)
75% Title XIX / 25% GF (4260-101-0890/0001)

FAMILY PACT PROGRAM ADMIN.

FISCAL REFERENCE NUMBER:1675

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$1,568,000**	**$1,100,000**
FEDERAL FUNDS	$784,000	$550,000
GENERAL FUND	$784,000	$550,000
OTHER FUNDS	$0	$0

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
Interagency Agreement 25-50070
AB 1464 (Chapter 21, Statutes of 2012)

Interdependent Policy Changes:
Not Applicable

Background:
The Family PACT program has two main objectives, to increase (1) access to services for low-income women and men, including adolescents; and (2) the number of providers who serve these clients. Education and support services are provided to the Family PACT providers and potential providers, as well as clients and potential clients. Services include, but are not limited to:

- Public education, awareness, and direct client outreach;
- Provider enrollment, recruitment, and training;
- Training and technical assistance for medical and non-medical staff;
- Education and counseling services;
- Preventive clinical services;
- Sexually transmitted infection/human immunodeficiency virus training and technical assistance services; and
- Toll-free referral number.

Reason for Change:
There is an increase for FY 2025-26, from the prior estimate, based on actual paid invoices. There is no change for FY 2026-27 from the prior estimate. There is a decrease from FY 2025-26 to FY 2026-27, in the current estimate, due to assuming invoicing will return to historical levels in FY 2026-27.

Methodology:
1. The administrative costs for the Family PACT program are estimated in the table below:

FAMILY PACT PROGRAM ADMIN.

Fiscal Years	TF	GF	FF
FY 2025-26	$1,568,000	$784,000	$784,000
FY 2026-27	$1,100,000	$550,000	$550,000

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

RECOVERY INCENTIVES CONTINGENCY MANAGEMENT ADMIN

FISCAL REFERENCE NUMBER:2362

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$1,046,000**	**$1,275,000**
FEDERAL FUNDS	$1,046,000	$1,275,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

Purpose:
This policy change, previously titled "HCBS SP – Contingency Management Admin.," estimates the administrative costs of adding the Recovery Incentives Program 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.

Authority:
Budget Act of 2021 [SB 129 (Chapter 69, Statutes of 2021)]
CalAIM 1115 Demonstration Waiver

Interdependent Policy Changes:
Not Applicable

Background:
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. This benefit was originally approved in the 2021 Budget Act, funded by the Home & Community-Based American Rescue Plan (HCBS ARP) Fund.

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). Counties can voluntarily opt-in to this benefit, and those who do will be responsible for the non-federal share of payments.

The Department will seek federal approvals to extend the CM benefit in the next CalAIM 1115 Demonstration waiver renewal.

Reason for Change:
There is no change from the prior estimate for FY 2025-26 and FY 2026-27.

The change in the current estimate, from FY 2025-26 to FY 2026-27, is an increase due to the transition from the pilot phase to full program implementation, reflecting anticipated expansion into additional DMC-ODS counties.

RECOVERY INCENTIVES CONTINGENCY MANAGEMENT ADMIN

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. Updated forecast using the costs for CM services and recovery incentives as the basis to estimate associated administrative costs.

4. Total estimated administrative costs for CM, on a cash basis, is as follows:

(Dollars in Thousands)

Contingency Management Admin	TF	FF	CF
FY 2025-26	$2,092	**$1,046**	$1,046
FY 2026-27	$2,550	**$1,275**	$1,275

Funding:

100% Title XIX (4260-101-0890)

MMA - DSH ANNUAL INDEPENDENT AUDIT

FISCAL REFERENCE NUMBER:266

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$444,000**	**$613,000**
FEDERAL FUNDS	$222,000	$306,500
GENERAL FUND	$222,000	$306,500
OTHER FUNDS	$0	$0

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 2025-26, from the prior estimate, is a net decrease due to:

- Actual invoice payments for July 2025 being higher than previously assumed, and
- Actual invoice payments for August 2025 through December 2025 being lower than previously assumed.

There is no change in FY 2026-27 from the prior estimate.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to:

- An increase in projected invoice payment amounts for FY 2026-27.

MMA - DSH ANNUAL INDEPENDENT AUDIT

Methodology:

1. The DSH Audit contract began on March 1, 2025, and is valid through June 30, 2029. The initial contract period is 28 months with an estimated budget of $1,551,000, and two optional 12-month extensions (estimated budget of $705,000 and $799,000, respectively), for a total contract cost of $3.06 million.

2. In FY 2025-26, the Department will make payments for the FY 2021-22 and FY 2022-23 audit invoices.

3. In FY 2026-27, the Department will make payments for the FY 2022-23 and FY 2023-24 audit invoices.

Fiscal Year	TF	GF	FF
FY 2025-26	$444,000	$222,000	$222,000
FY 2026-27	$613,000	$306,000	$307,000

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

HEALTH INFORMATION EXCHANGE INTEROPERABILITY

FISCAL REFERENCE NUMBER:2159

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$250,000**	**$2,750,000**
FEDERAL FUNDS	$218,300	$2,400,600
GENERAL FUND	$31,700	$349,400
OTHER FUNDS	$0	$0

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)
CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F)

Interdependent Policy Changes:
Not Applicable

Background:
In FY 2022-23, the Department piloted the Authorization to Share Confidential Medi-Cal Information (ASCMI) Form and consent management service pilot, an initiative to streamline consent-to-share processes and improve health information exchange (HIE) across key areas, including substance use disorder (SUD). The Department also developed 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.

To continue building on the efforts of 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 Centers for Medicare and Medicaid Services (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 and Prior Authorization Rule, finalized by CMS in 2024, 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. Since both APIs require Medi-Cal to

HEALTH INFORMATION EXCHANGE INTEROPERABILITY

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 is 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 has been approved at 90 percent enhanced federal financial participation (FFP) from CMS by updating the Interoperability Advance Planning Document (APD) through September 2026. An APD update requesting enhanced FFP through September 2027 will be submitted in July 2026.

Reason for Change:
The change from the prior estimate is a decrease for FY 2025-26 and an increase for FY 2026-27 due to the delay in start of the contract. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to increase in development costs needed for interoperability APIs.

Methodology:

FY 2025-26	TF	GF	FF
Title XIX 90% FFP/10% GF	$227,000	$23,000	$204,000
Title XXI 65% FFP/35% GF	$22,000	$8,000	$14,000
100% State GF	$1,000	$1,000	$0
Total	**$250,000**	**$32,000**	**$218,000**

FY 2026-27	TF	GF	FF
Title XIX 90% FFP/10% GF	$2,491,000	$249,000	$2,242,000
Title XXI 65% FFP/35% GF	$244,000	$85,000	$159,000
100% State GF	$15,000	$15,000	$0
Total	**$2,750,000**	**$349,000**	**$2,401,000**

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

CCT OUTREACH - ADMINISTRATIVE COSTS

FISCAL REFERENCE NUMBER:1556

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$364,000**	**$364,000**
FEDERAL FUNDS	$364,000	$364,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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 California Department of Aging oversees and administers the ADRC programs. The costs were 100% federally funded.

Beginning January 1, 2016, the Department began allocating 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

The Consolidated Appropriations Act of 2021 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 Consolidated Appropriations Act of 2023 appropriated 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, for FY 2025-26 and FY 2026-27, from the prior estimate. There is no change, in the current estimate, from FY 2025-26 to FY 2026-27.

Methodology:
1. Assume $364,000 from the MFP grant administrative funding is expected to be paid in FY 2025-26 and FY 2026-27.

2. In January 2024, the contract was amended for Calendar Year (CY) 2024. The contract was amended for CY 2025.

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,
   - Minimum Data Set (MDS) 3.0 Section Q referrals policy development,
     - MDS is a federally-mandated process for assessing members receiving care in certified skilled nursing facilities. The process provides a comprehensive assessment of member’s current health conditions, treatments, abilities, and plans for discharge. It is administered to all members upon admission, quarterly, yearly, and whenever there is a significant change in a member’s condition. Section Q is the part of the MDS designed to explore meaningful opportunities for nursing facility residents to return to community settings.
   - MDS/Options counseling training sessions, and
     - One or more local contact agency (LCA) in the ADRC network provides individualized Hospital-to-Home or Nursing Facility-to-Home transition services. LCA staff will be trained to provide Options Counseling to nursing home members who have expressed interest in returning to the community.
   - ARDC Workgroup.

CCT OUTREACH - ADMINISTRATIVE COSTS

FY 2025-26	**TF**	**GF**	**FF**
CCT Costs PC:			
Regular CCT Population	$98,078,000	$22,021,000	$76,057,000
State-Funded CCT Population	$273,000	$70,000	$203,000
ALW Transition Costs	$13,408,000	$2,695,000	$10,713,000
Total Costs	$111,759,000	$24,786,000	$86,973,000
CCT Savings:			
Total GF savings and Total FFP	($30,512,000)	($15,884,000)	($14,627,000)
CCT Fund Transfer to CDSS PC:	$736,000	$0	$736,000
CCT Outreach - Admin costs PC:	**$364,000**	**$0**	**$364,000**
Total of CCT PCs including savings	$82,347,000	$8,902,000	$73,446,000

*The savings are included in the total, however, they are fully reflected in the base estimates.

FY 2026-27	**TF**	**GF**	**FF**
CCT Costs PC:			
Regular CCT Population	$114,505,000	$25,655,000	$88,850,000
ALW Transition Costs	$13,408,000	$2,696,000	$10,712,000
Total Cost	$127,913,000	$28,351,000	$99,562,000
CCT Savings:			
Total GF savings and Total FFP	($79,869,000)	($41,580,000)	($38,289,000)
CCT Fund Transfer to CDSS PC:	$736,000	$0	$736,000
CCT Outreach - Admin costs PC:	**$364,000**	**$0**	**$364,000**
Total of CCT PCs including savings	$49,144,000	($13,229,000)	$62,373,000

*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

FISCAL REFERENCE NUMBER:2438

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$186,000**	**$152,000**
FEDERAL FUNDS	$93,000	$76,000
GENERAL FUND	$0	$0
OTHER FUNDS	$93,000	$76,000

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)
Contract # 23-30321

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:
There is no change from the prior estimate for FY 2025-26 and FY 2026-27. The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease due to the completion of the evaluations.

Methodology:
Total costs are estimated to be:

Fiscal Year	TF	GF Reimb.	FF
FY 2025-26	$186,000	$93,000	$93,000
FY 2026-27	$152,000	$76,000	$76,000

HEALTH PLAN OF SAN MATEO DENTAL INTEGRATION EVAL

Funding:

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**

FY 2026-27	TF	GF Reimb.	FF
100% Title XIX FF (4260-101-0890)	$76,000	$0	$76,000
Reimbursement GF (4260-601-0995)	$76,000	$76,000	$0
Total	**$152,000**	**$76,000**	**$76,000**

CMS DEFERRED CLAIMS - OTHER ADMIN

FISCAL REFERENCE NUMBER:2123

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	-$582,438,000	-$145,000,000
GENERAL FUND	$582,438,000	$145,000,000
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the repayment of administrative deferred claims to the Centers for Medicare and Medicaid Services (CMS).

Authority:
Title 42, Code of Federal Regulations (CFR), 430.40

Interdependent Policy Changes:
Not Applicable

Background:
CMS reviews claims submitted by state Medicaid agencies to ensure federal financial participation (FFP) eligibility. Claims for which CMS questions the FFP eligibility are deferred and the state Medicaid agency is issued a deferral notice. Upon receipt of the deferral notice, the state Medicaid agency has 120 days to resolve the deferred claim.

When CMS issues a deferral to the state Medicaid agency, in accordance with the timelines set forth in 42 CFR 430.40, the state Medicaid agency must immediately return the deferred FFP to the applicable Payment Management System (PMS) subaccount while the deferral is being resolved. As part of the resolution process, the state Medicaid agency submits documentation in support of the deferred claim to CMS for review. If CMS determines the deferred claim is allowed, then the deferral is released, the funds are returned to the appropriate PMS subaccount, and the state Medicaid agency is notified that the funds are available to be redrawn.

The administrative deferred claims are included in this policy change and are separate from the CMS Deferred Claims policy change. See the CMS Deferred Claims policy change for more information.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is due to:

- Actual deferral received for FFY 2025 Quarter 4, and
- Estimating an administrative deferral will be received for FFY 2026 Quarter 1 in FY 2025-26.

The change in FY 2026-27, from the prior estimate, is due to estimating one quarter of deferrals will be received in FY 2026-27 for FFY 2026 Quarter 2 whereas the prior estimate assumed no CMS deferrals received or resolved deferrals in FY 2026-27.

CMS DEFERRED CLAIMS - OTHER ADMIN

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to FY 2025-26 includes three quarters of actual deferrals and one additional quarter of projected deferrals while FY 2026-27 includes one quarters of projected deferrals.

Methodology:

1. In FY 2025-26, the Department estimates to repay a total of $582.438 million FF, which includes actual administrative deferrals for FFY 2025 Quarter 1, Quarter 3 and Quarter 4, and an estimated administrative deferral for FFY 2026 Quarter 1.

2. In FY 2026-27, the Department estimates to repay $145 million FF for FFY 2026 Quarter 2.

3. The Department will repay the following estimated administrative deferred claims:

(Dollars in Thousands)

FY 2025-26	Total Estimated Repayment
FFY 2025 Quarter 1 (Oct-Dec 2024)	$221,534
FFY 2025 Quarter 3 (April-June 2025)	$61,441
FFY 2025 Quarter 4 (Jul-Sep 2025)	$154,463
FFY 2026 Quarter 1 (Oct-Dec 2025)	$145,000
Total FY 2025-26	**$582,438**

(Dollars in Thousands)

FY 2026-27	Total Estimated Repayment
FFY 2026 Quarter 2 (Jan-Mar 2026)	$145,000
Total FY 2026-27	**$145,000**

Funding:

100% Title XIX FFP (4260-101-0890)
100% Title XIX GF (4260-101-0001)

DESIGNATED STATE HEALTH PROGRAMS

FISCAL REFERENCE NUMBER:2459

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$178,255,000	$346,856,000
GENERAL FUND	-$178,255,000	-$346,856,000
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the federal financial participation (FFP) received for Certified Public Expenditures (CPEs) from certain Designated State Health Programs (DSHP) 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:
On January 26, 2023, the Centers for Medicare and Medicaid Services (CMS) approved DSHP within the CalAIM Section 1115 Demonstration renewal effective January 1, 2023, to December 31, 2026. On December 16, 2024, CMS approved a new Medicaid Section 1115 Demonstration, BH-CONNECT, effective January 1, 2025, to December 31, 2029, to increase access to and improve behavioral health services for Medi-Cal members statewide.

The Department will utilize additional FFP received through DSHP to support the CalAIM Providing Access and Transforming Health (PATH) Supports and the 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.

DSHP are funded by state funds. 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 for the approved DSHPs listed below, and the State must contribute $114.075 million in original, non-freed up DSHP funds over the 5-year demonstration period towards PATH. The BH-CONNECT waiver authorizes the Department to claim up to a total of $807.5 million in FFP over a five-year period for the expenditures of the Department of Developmental Services under the Lanterman Act, and the State must contribute $142.5 million in original, non-freed up DSHP funds over the 5-year demonstration period towards BH-CONNECT.

DESIGNATED STATE HEALTH PROGRAMS

The total amount of DSHP FFP that the State may claim in all demonstration years combined may not exceed the non-federal share of amounts actually expended by the State for the DSHP-funded initiatives.

State Only Medical Programs
California Children Services (CCS)
Genetically Handicapped Persons Program (GHPP)
Medically Indigent Adult Long Term Care (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)

Reason for Change:
There is no change in FY 2025-26 and FY 2026-27, from the prior estimate.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to estimating a full year of DSHP BH-CONNECT claiming in FY 2026-27.

Methodology:

1. DSHP CalAIM claiming is effective January 1, 2023.

2. DSHP BH-CONNECT claiming is effective January 1, 2025, and claiming will commence in the April-June quarter of 2026.

3. CMS does not intend to approve new or extend existing requests for federal matching funds for DSHP. Thus, any DSHP claiming reflected in this estimate which occurs after the end of the approved demonstration period, is solely the cash basis for claiming qualified expenditures during the approved period.

4. The estimated total net impact on a cash basis is:

(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**

DESIGNATED STATE HEALTH PROGRAMS

(Dollars in Thousands)

FY 2026-27	TF	GF	FF
DSHP CalAIM	$0	($161,606)	$161,606
DSHP BH-CONNECT	$0	($185,250)	$185,250
Total DSHP	**$0**	**($346,856)**	**$346,856**

Funding:
100% GF (4260-101-0001)
100% Health Care Support Fund (4260-601-7503)

MEDICAL FI BO & IT COST REIMBURSEMENT

FISCAL REFERENCE NUMBER:2115

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$63,944,000**	**$65,381,000**
FEDERAL FUNDS	$46,226,150	$47,187,050
GENERAL FUND	$17,717,850	$18,193,950
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the cost reimbursements for the Medical Fiscal Intermediary (FI) Business Operations and Information Technology, Maintenance and Operations (IT M&O) 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 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 is five years with two one-year optional extensions from October 1, 2023 through September 30, 2025. The IBM amendment #3 will update the FI contract for two additional one-year extensions from October 1, 2025 through September 30, 2027.

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.

- Equipment and Services (personal computers, monitors, printers, related equipment, and software)

MEDICAL FI BO & IT COST REIMBURSEMENT

    - 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.

    - 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.

- 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.

    - Audits and Research are annual audits for the Electronic Data Processing Application System will 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.

MEDICAL FI BO & IT COST REIMBURSEMENT

- Change Order and/or Amendments pertains to 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 2025-26 and FY 2026-27, from the prior estimate, is a net increase due to higher cost estimates for Equipment & Services and Consultant Contracts, and decreased estimates for Postage and Other Cost Reimbursable Items.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a net increase due to higher cost estimates for all cost line items except Facilities Improvements and Telecommunications & Data Center.

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 2025-26	TF	GF	FF
Postage	$2,268,000	$1,110,000	$1,158,000
Parcel Services & Common Carriers	$423,000	$207,000	$216,000
Equipment & Services	$10,267,000	$2,699,000	$7,568,000
Facilities Improvement & Modification	$10,181,000	$2,677,000	$7,504,000
Consultant Contracts	$36,516,000	$9,600,000	$26,916,000
Telecommunications & Data Center	$2,106,000	$578,000	$1,528,000
Other Cost Reimbursable Items	$2,183,000	$847,000	$1,336,000
Total	**$63,944,000**	**$17,718,000**	**$46,226,000**

FY 2026-27	TF	GF	FF
Postage	$2,381,000	$1,165,000	$1,216,000
Parcel Services & Common Carriers	$444,000	$217,000	$227,000
Equipment & Services	$10,664,000	$2,804,000	$7,860,000
Facilities Improvement & Modification	$9,951,000	$2,616,000	$7,335,000
Consultant Contracts	$37,305,000	$9,808,000	$27,497,000
Telecommunications & Data Center	$2,105,000	$577,000	$1,528,000
Other Cost Reimbursable Items	$2,531,000	$1,007,000	$1,524,000
Total	**$65,381,000**	**$18,194,000**	**$47,187,000**

MEDICAL FI BO & IT COST REIMBURSEMENT

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

FISCAL REFERENCE NUMBER:2117

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$41,156,000**	**$36,601,000**
FEDERAL FUNDS	$30,333,850	$26,978,700
GENERAL FUND	$10,822,150	$9,622,300
OTHER FUNDS	$0	$0

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

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 IBM amendment #3 will update the FI contract for two additional one-year extensions from October 1, 2025 through September 30, 2027.

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.

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.

MEDICAL FI BO & IT CHANGE ORDERS

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.

Effective October 1, 2025, the IBM amendment shifts ongoing expenses for File Maintenance, RAIS Extension Support, Formulary Liaison Services, TPL Liaison Services, and API Connect Change Orders from this policy change to the Medical FI BO IT Development and Operations Services policy change.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is a net decrease due to:

- Lower anticipated costs for Contract Innovations, Stabilization, RAIS Extension, Surge Phase 2 - Softsole, and SURGE Phase 2 - IBM SG,
- No costs budgeted for CO-23 Drug Rebate,
- Higher anticipated costs for Security Services and Turnover Data Center, and
- New anticipated costs for SURGE Application Migration Support to AWS and SURGE Environment and MQ Server Extension.

The change in FY 2026-27, from the prior estimate, is a net increase due to:

- Lower anticipated costs for Contract Innovations,
- No costs budgeted for CO-23 Drug Rebate,
- Higher anticipated costs for Stabilization, and
- New anticipated costs for Cybersecurity Transition and Turnover Data Center.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a net decrease due to the following:

- Lower anticipated costs for Contract Innovations and Testing Services,
- No anticipated costs in FY 2026-27 for SURGE Phase 2 - SoftSole, SURGE Phase 2 - IBM SG, Qradar Licenses,
- Higher than anticipated costs for Contract Innovations, CO-22 Out of Pocket NMT Costs, Stabilization Level 1 Help Desk, and COGNOS, and
- The shift of ongoing COs for File Maintenance, RAIS Extension Support, Formulary Liaison Services, TPL Liaison Services, and API Connect from this policy change to the Medical FI BO IT Development and Operations Services policy change.

Methodology:

1. Certain costs, such as software and travel expenses, can be paid through cost reimbursements. 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

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 2025-26	TF	GF	FF
Alternative Format C0-16 (Conlon & Braille)	$468,000	$123,000	$345,000
Contract Innovations	$205,000	$54,000	$151,000
CO-19 Facilities	$492,000	$129,000	$363,000
CO-22 Out of Pocket NMT Costs	$141,000	$37,000	$104,000
Stabilization	$6,339,000	$1,667,000	$4,672,000
Level 1 Help Desk	$1,102,000	$290,000	$812,000
COGNOS	$292,000	$77,000	$215,000
File Maintenance	$1,766,000	$464,000	$1,302,000
Security Services	$5,431,000	$1,428,000	$4,003,000
Testing Services	$8,258,000	$2,171,000	$6,087,000
Formulary Liaison Services	$579,000	$152,000	$427,000
FOAG	$2,200,000	$578,000	$1,622,000
TPL Liaison	$124,000	$33,000	$91,000
API Connect	$47,000	$12,000	$35,000
RAIS Extension	$459,000	$121,000	$338,000
SURGE Phase 2 - SoftSole	$5,075,000	$1,334,000	$3,741,000
SURGE Phase 2 - IBM SG	$4,663,000	$1,226,000	$3,437,000
Cybersecurity Transition	$1,261,000	$332,000	$929,000
Turnover PM + Dallas Data Center Tape Data Erasure	$991,000	$261,000	$730,000
Qradar Licenses - Qradar	$357,000	$94,000	$263,000
SURGE Application Migration Support to AWS	$86,000	$23,000	$63,000
SURGE Environment & MQ Server Extension	$820,000	$216,000	$604,000
Total	**$41,156,000**	**$10,822,000**	**$30,334,000**

MEDICAL FI BO & IT CHANGE ORDERS

FY 2026-27	TF	GF	FF
Alternative Format C0-16 (Conlon & Braille)	$468,000	$123,000	$345,000
Contract Innovations	$213,000	$56,000	$157,000
CO-19 Facilities	$492,000	$129,000	$363,000
CO-22 Out of Pocket NMT Costs	$178,000	$47,000	$131,000
Stabilization	$16,721,000	$4,396,000	$12,325,000
Level 1 Help Desk	$1,122,000	$295,000	$827,000
COGNOS	$312,000	$82,000	$230,000
Security Services	$6,256,000	$1,645,000	$4,611,000
Testing Services	$7,319,000	$1,924,000	$5,395,000
FOAG	$2,300,000	$605,000	$1,695,000
Cybersecurity Transition	$720,000	$189,000	$531,000
Turnover PM + Dallas Data Center Tape Data Erasure	$500,000	$131,000	$369,000
Total	**$36,601,000**	**$9,622,000**	**$26,979,000**

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 FI IT DEVELOPMENT AND OPERATIONS SERVICES

FISCAL REFERENCE NUMBER:2119

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$45,487,000**	**$50,974,000**
FEDERAL FUNDS	$33,527,100	$37,572,000
GENERAL FUND	$11,959,900	$13,402,000
OTHER FUNDS	$0	$0

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 contract requires the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal members. The Contract Effective Date (CED) for the FI IT Maintenance and Operations (IT M&O) contract started in October 2018. The FI contract term is five years with two one-year optional extensions from October 1, 2023 through September 30, 2025. The IBM amendment #3 will update the FI contract for two additional one-year extensions from October 1, 2025 through September 30, 2027.

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

Effective October 1, 2025, the IBM amendment shifts on-going expenses for File Maintenance, RAIS Extension Support, Liaison Services, TPL Liaison Services, and API Connect Change Orders from the Medical FI BO IT Change Orders policy change to this policy change.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is a decrease due to a system costs shift to HR 1 Prohibited Entities – Systems Costs policy change.

There is no change from the prior estimate for FY 2026-27.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to higher ongoing costs related to the IBM amendment updates in FY 2026-27.

MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES

Methodology:

1. Costs are paid under an hourly rate or via a fixed price negotiated during the procurement phase of the contract.

FY 2025-26	TF	GF	FF
Application Development Services	$21,987,000	$5,781,000	$16,206,000
Application M&O Services	$15,183,000	$3,992,000	$11,191,000
Project Management Office	$8,317,000	$2,187,000	$6,130,000
Total	**$45,487,000**	**$11,960,000**	**$33,527,000**

FY 2026-27	TF	GF	FF
Application Development Services	$23,784,000	$6,253,000	$17,531,000
Application M&O Services	$18,645,000	$4,902,000	$13,743,000
Project Management Office	$8,545,000	$2,247,000	$6,298,000
Total	**$50,974,000**	**$13,402,000**	**$37,572,000**

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 INFRASTRUCTURE & DATA MGT SVCS

FISCAL REFERENCE NUMBER:2118

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$44,894,000**	**$35,744,000**
FEDERAL FUNDS	$33,092,050	$26,348,050
GENERAL FUND	$11,801,950	$9,395,950
OTHER FUNDS	$0	$0

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 2025-26, from the prior estimate, is a net increase due to managed network services and software.

The change in FY 2026-27, from the prior estimate, is a decrease due to managed network services and software costs.

MEDICAL INFRASTRUCTURE & DATA MGT SVCS

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease due to decreased costs for all service categories.

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 2025-26	TF	GF	FF
Mainframe Data Center Operations Services	$4,646,000	$1,221,000	$3,425,000
Midrange Data Center Operations Services	$2,602,000	$684,000	$1,918,000
Midrange Storage Operations Services	$228,000	$60,000	$168,000
Managed Network Services	$15,128,000	$3,977,000	$11,151,000
Disaster Recovery	$1,639,000	$431,000	$1,208,000
Service Delivery Mgmt, Asset Mgmt, and Facilities	$3,383,000	$889,000	$2,494,000
Fixed Security Services	$1,663,000	$437,000	$1,226,000
Hardware and Refresh	$409,000	$108,000	$301,000
Software	$15,196,000	$3,995,000	$11,201,000
Total	**$44,894,000**	**$11,802,000**	**$33,092,000**

FY 2026-27	TF	GF	FF
Mainframe Data Center Operations Services	$4,063,000	$1,068,000	$2,995,000
Managed Network Services	$13,773,000	$3,621,000	$10,152,000
Disaster Recovery	$979,000	$257,000	$722,000
Service Delivery Mgmt, Asset Mgmt, and Facilities	$1,145,000	$301,000	$844,000
Fixed Security Services	$989,000	$260,000	$729,000
Hardware and Refresh	$108,000	$28,000	$80,000
Software	$14,687,000	$3,861,000	$10,826,000
Total	**$35,744,000**	**$9,396,000**	**$26,348,000**

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 BO OTHER ESTIMATED COSTS

FISCAL REFERENCE NUMBER:2112

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$26,475,000**	**$26,951,000**
FEDERAL FUNDS	$18,521,150	$18,852,250
GENERAL FUND	$7,953,850	$8,098,750
OTHER FUNDS	$0	$0

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.

- Provide Litigation Support - The Contractor's litigation support includes, but is not limited to, planning, tracking, and coordinating litigation support tasks, developing responses to

MEDICAL FI BO OTHER ESTIMATED COSTS

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 2025-26, from the prior estimate, is a decrease due to the Consumer Price Index (CPI) adjustment.

The change in FY 2026-27, from the prior estimate, is a decrease due to the undervaluation of the family health allocation for the Conduct Provider Outreach and Education cost line item to the Family Health policy changes in the prior estimate.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to the CPI adjustment.

MEDICAL FI BO OTHER ESTIMATED COSTS

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 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	$3,092,000	$8,668,000
Publish Provider Communication Materials	$3,814,000	$1,607,000	$2,207,000
Conduct Provider Outreach and Education	$5,476,000	$1,440,000	$4,036,000
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	**$26,475,000**	**$7,954,000**	**$18,521,000**

FY 2026-27	TF	GF	FF
Process Appeals	$954,000	$251,000	$703,000
Support Audits	$203,000	$53,000	$150,000
Process Drug Rebates	$1,444,000	$380,000	$1,064,000
Provide Litigation Support	$208,000	$55,000	$153,000
Service Delivery Support	$11,972,000	$3,148,000	$8,824,000
Publish Provider Communication Materials	$3,884,000	$1,637,000	$2,247,000
Conduct Provider Outreach and Education	$5,575,000	$1,466,000	$4,109,000
Print and Mail Medi-Cal Information	$2,495,000	$1,052,000	$1,443,000
Perform Proactive Provider Research	$216,000	$57,000	$159,000
Total	**$26,951,000**	**$8,099,000**	**$18,852,000**

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

FISCAL REFERENCE NUMBER:2116

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$19,370,000**	**$19,718,000**
FEDERAL FUNDS	$13,571,000	$13,815,400
GENERAL FUND	$5,799,000	$5,902,600
OTHER FUNDS	$0	$0

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)

Reason for Change:
The change in FY 2025-26, from the prior estimate, is a decrease due to lower estimated Provider Customer Services, Member Customer Services, and Financial Services expenditures.

The change in FY 2026-27, from the prior estimate, is an increase due to the Consumer Price Index (CPI) adjustment.

MEDICAL FI BO TELEPHONE SERVICE CENTER

The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to the CPI adjustment in FY 2026-27.

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 2025-26	TF	GF	FF
TSC – Provider Customer Services	$10,506,000	$3,145,000	$7,361,000
TSC – Member Customer Services	$6,881,000	$2,060,000	$4,821,000
TSC – Financial Services	$1,983,000	$594,000	$1,389,000
Total	**$19,370,000**	**$5,799,000**	**$13,571,000**

FY 2026-27	TF	GF	FF
TSC – Provider Customer Services	$10,695,000	$3,202,000	$7,493,000
TSC – Member Customer Services	$7,004,000	$2,097,000	$4,907,000
TSC – Financial Services	$2,019,000	$604,000	$1,415,000
Total	**$19,718,000**	**$5,903,000**	**$13,815,000**

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

FISCAL REFERENCE NUMBER:2111

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$17,655,000**	**$17,972,000**
FEDERAL FUNDS	$13,005,450	$13,238,150
GENERAL FUND	$4,638,550	$4,722,850
OTHER FUNDS	$11,000	$11,000

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

- 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 2025-26, from the prior estimate, is a decrease due to the Consumer Price Index (CPI) adjustment.

The change in FY 2026-27, from the prior estimate, is an increase due to the CPI adjustment.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to the CPI adjustment.

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), General Fund (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

5. County Medi-Cal Services Program (CMSP) is billed annually for services agreed upon in the Incoming Funds Request (IFR) agreement # 22-20044.

- FY 2025-26 cost estimate includes services for FY 2025-26.
- FY 2026-27 cost estimate includes services for FY 2026-27.

FY 2025-26	TF	GF	FF	Reimbursement
Process Paper Claims	$9,723,000	$2,556,000	$7,167,000	$0
Process Suspended Claims	$3,865,000	$1,016,000	$2,849,000	$0
Manage Records	$1,519,000	$399,000	$1,120,000	$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**

FY 2026-27	TF	GF	FF	Reimbursement
Process Paper Claims	$9,898,000	$2,602,000	$7,296,000	$0
Process Suspended Claims	$3,935,000	$1,035,000	$2,900,000	$0
Manage Records	$1,547,000	$407,000	$1,140,000	$0
Process Member Card Requests	$2,133,000	$561,000	$1,572,000	$0
Process Paper TAR	$448,000	$118,000	$330,000	$0
Contract #22-20044				
FY 2026-27	$11,000	$0	$0	$11,000
Total	**$17,972,000**	**$4,723,000**	**$13,238,000**	**$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

FISCAL REFERENCE NUMBER:2113

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$12,768,000**	**$12,998,000**
FEDERAL FUNDS	$9,411,150	$9,580,800
GENERAL FUND	$3,356,850	$3,417,200
OTHER FUNDS	$0	$0

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.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is a decrease due to the Consumer Price Index (CPI) adjustment.

There is no change in FY 2026-27 from the prior estimate.

MEDICAL FI BO HOURLY REIMBURSEMENT

The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to the CPI adjustment.

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 2025-26	TF	GF	FF
Medical Review Services	$7,246,000	$1,905,000	$5,341,000
Service Changes	$5,522,000	$1,452,000	$4,070,000
Total	**$12,768,000**	**$3,357,000**	**$9,411,000**

FY 2026-27	TF	GF	FF
Medical Review Services	$7,377,000	$1,939,000	$5,438,000
Service Changes	$5,621,000	$1,478,000	$4,143,000
Total	**$12,998,000**	**$3,417,000**	**$9,581,000**

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

FISCAL REFERENCE NUMBER:2114

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$1,199,000**	**$1,189,000**
FEDERAL FUNDS	$869,900	$863,150
GENERAL FUND	$329,100	$325,850
OTHER FUNDS	$0	$0

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, 22-20086 and 23-30195

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

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 2025-26 and FY 2026-27, from the prior estimate, is due to a decrease in SCO reimbursement rates.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to a decrease in the IA claims for the Provider Verification files.

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 2025-26	TF	GF	FF
Interagency Agreements	$1,199,000	$329,000	$870,000
Total	**$1,199,000**	**$329,000**	**$870,000**

FY 2026-27	TF	GF	FF
Interagency Agreements	$1,189,000	$326,000	$863,000
Total	**$1,189,000**	**$326,000**	**$863,000**

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)

HCO OPERATIONS

FISCAL REFERENCE NUMBER:2051

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$36,760,000**	**$36,638,000**
FEDERAL FUNDS	$18,655,700	$18,593,800
GENERAL FUND	$18,104,300	$18,044,200
OTHER FUNDS	$0	$0

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 2025-26, is a decrease due to updated actuals and adjusted projections. The change from the prior estimate, for FY 2026-27, is a decrease due to adjusted projections. The change from FY 2025-26 to FY 2026-27, in the current estimate, is a slight decrease due to adjusted projections.

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

FY2025-26	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced Title XXI	Enhanced Title XXI
Transactions	$6,983,000	$3,317,000	$3,317,000	$122,000	$227,000
Packet Mailings	$6,985,000	$3,318,000	$3,318,000	$122,000	$227,000
BDA/Call Center	$22,792,000	$10,826,000	$10,826,000	$399,000	$741,000
Total	**$36,760,000**	**$17,461,000**	**$17,461,000**	**$643,000**	**$1,195,000**

FY 2026-27	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced Title XXI	Enhanced Title XXI
Transactions	$6,960,000	$3,306,000	$3,306,000	$122,000	$226,000
Packet Mailings	$6,962,000	$3,307,000	$3,307,000	$122,000	$226,000
BDA/Call Center	$22,716,000	$10,790,000	$10,790,000	$398,000	$738,000
Total	**$36,638,000**	**$17,403,000**	**$17,403,000**	**$642,000**	**$1,190,000**

Funding:
FI 50%Title XIX / 50% GF (4260-101-0001/0890)
FI 65% Title XXI / 35% GF (4260-101-0001/0890)

HCO COST REIMBURSEMENT

FISCAL REFERENCE NUMBER:2052

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$34,987,000**	**$40,621,000**
FEDERAL FUNDS	$17,749,250	$20,531,450
GENERAL FUND	$17,237,750	$20,089,550
OTHER FUNDS	$0	$0

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 2025-26, is a slight increase due to updated actuals and adjusted projections. The change from the prior estimate, for FY 2026-27, is a slight increase due to adjusted projections. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to adjusted projections and the execution of a new service contract, and vendor takeover/turnover activities.

Methodology:

1. Takeover and turnover costs for Cost Reimbursement, ESR Hourly Reimbursement, and Operations policy changes are captured in the Cost Reimbursement policy change for the new HCO program contract effective March 1, 2026.

2. Contract costs are shared between GF and FF.

HCO COST REIMBURSEMENT

FY 2025-26	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced Title XXI	Enhanced Title XXI
Postage	$17,314,000	$8,224,000	$8,224,000	$303,000	$563,000
Printing	$5,095,000	$2,420,000	$2,420,000	$89,000	$166,000
Materials Maintenance and Development	$4,232,000	$2,010,000	$2,010,000	$74,000	$138,000
Mass Mailings	$1,341,000	$637,000	$637,000	$23,000	$44,000
Other Cost Reimb.	$1,693,000	$804,000	$804,000	$30,000	$55,000
Additional Systems Group Staff	$3,644,000	$1,731,000	$1,731,000	$64,000	$118,000
Miscellaneous	$770,000	$366,000	$366,000	$13,000	$25,000
Takeover Costs	$36,000	$18,000	$18,000	$0	$0
Turnover Costs	$862,000	$431,000	$431,000	$0	$0
Total	**$34,987,000**	**$16,641,000**	**$16,641,000**	**$596,000**	**$1,109,000**

FY 2026-27	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced Title XXI	Enhanced Title XXI
Postage	$14,956,000	$7,104,000	$7,104,000	$262,000	$486,000
Printing	$4,400,000	$2,090,000	$2,090,000	$77,000	$143,000
Materials Maintenance and Development	$3,655,000	$1,736,000	$1,736,000	$64,000	$119,000
Mass Mailings	$1,158,000	$550,000	$550,000	$20,000	$38,000
Other Cost Reimb.	$1,461,000	$694,000	$694,000	$26,000	$47,000
Additional Systems Group Staff	$3,149,000	$1,496,000	$1,496,000	$55,000	$102,000
Miscellaneous	$838,000	$419,000	$419,000	$0	$0
Takeover Costs	$10,338,000	$5,169,000	$5,169,000	$0	$0
Turnover Costs	$40,621,000	$19,574,000	$19,574,000	$516,000	$957,000
Total	**$40,621,000**	**$19,574,000**	**$19,574,000**	**$516,000**	**$957,000**

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

FISCAL REFERENCE NUMBER:2053

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$15,590,000**	**$15,590,000**
FEDERAL FUNDS	$7,912,000	$7,912,000
GENERAL FUND	$7,678,000	$7,678,000
OTHER FUNDS	$0	$0

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 2025-26, is a slight increase due to updated actuals and adjusted projections. The change from the prior estimate, for FY 2026-27, is a slight increase due to adjusted projections. There is no change from FY 2025-26 to FY 2026-27, in the current estimate.

Methodology:
1. The hourly reimbursement costs are fixed price hourly rates for full-time equivalent ESR staff at county offices statewide.
2. The estimated costs for FY 2025-26 and FY 2026-27 are based on 217.5 ESRs.

HCO ESR HOURLY REIMBURSEMENT

FY 2025-26	TF	GF	FF
Title XXI (65% FF / 35% GF)	$14,810,000	$7,405,000	$7,405,000
Title XIX (50% FF / 50% GF)	$780,000	$273,000	$507,000
Total	**$15,590,000**	**$7,678,000**	**$7,912,000**

FY 2026-27	TF	GF	FF
Title XXI (65% FF / 35% GF)	$14,810,000	$7,405,000	$7,405,000
Title XIX (50% FF / 50% GF)	$780,000	$273,000	$507,000
Total	**$15,590,000**	**$7,678,000**	**$7,912,000**

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

FISCAL REFERENCE NUMBER:2380

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$162,882,000**	**$132,472,000**
FEDERAL FUNDS	$119,318,500	$96,907,000
GENERAL FUND	$43,563,500	$35,565,000
OTHER FUNDS	$0	$0

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.

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. 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.

Operations constitute 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 in 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 costs, 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:

DENTAL FI-DBO ADMIN 2022 CONTRACT

- 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 is a decrease for FY 2025-26 and an increase for FY 2026-27 due to updated invoice data. The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease due to the delayed payment of prior year invoice costs being paid in FY 2025-26.

Methodology:
1. Operations cost are a combination of fixed price and fixed plus variable price for defined payment categories under the FI-DBO contract.

2. 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.

3. Operations Costs:

Fiscal Year	TF	GF	FF
FY 2025-26	$148,722,000	$37,181,000	$111,541,000
FY 2026-27	$119,896,000	$29,974,000	$89,922,000

DENTAL FI-DBO ADMIN 2022 CONTRACT

4. Cost Reimbursements:

Fiscal Year	TF	GF	FF
FY 2025-26	$11,372,000	$5,686,000	$5,686,000
FY 2026-27	$9,788,000	$4,894,000	$4,894,000

5. Billable Labor Costs:

Fiscal Year	TF	GF	FF
FY 2025-26	$2,788,000	$697,000	$2,091,000
FY 2026-27	$2,788,000	$697,000	$2,091,000

6. Total Administration Costs:

Fiscal Year	TF	GF	FF
FY 2025-26	$162,882,000	$43,564,000	$119,318,000
FY 2026-27	$132,472,000	$35,565,000	$96,907,000

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

FISCAL REFERENCE NUMBER:2006

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$18,474,000**	**$18,760,000**
FEDERAL FUNDS	$13,838,500	$14,062,000
GENERAL FUND	$4,635,500	$4,698,000
OTHER FUNDS	$0	$0

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
9. Cost Reimbursement Invoice

DENTAL FI ADMINISTRATION 2016 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. The hourly reimbursed area consists of the Systems Group (SG). A Notice of Change (NOC) was executed June 10, 2024, which increased the total number of approved SG Hours.

Costs related to Printing, Parcel Service and Common Carriers, and Postage have completely shifted 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 is a slight decrease for FY 2025-26 and FY 2026-27 due to updated invoice data. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an 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 2025-26	TF	GF	FF
Scanned Claims/TAR	$9,447,000	$2,362,000	$7,085,000
Check Write	$276,000	$68,000	$208,000
Total	**$9,723,000**	**$2,430,000**	**$7,293,000**

FY 2026-27	TF	GF	FF
Scanned Claims/TAR	$9,357,000	$2,339,000	$7,018,000
Check Write	$283,000	$71,000	$212,000
Total	**$9,640,000**	**$2,410,000**	**$7,230,000**

3. Cost reimbursements are based on actual invoices.

Fiscal Year	TF	GF	FF
FY 2025-26	**$68,000**	**$34,000**	**$34,000**
FY 2026-27	**$32,000**	**$16,000**	**$16,000**

4. Hourly Reimbursables:

System Group	TF	GF	FF
FY 2025-26	**$8,683,000**	**$2,171,000**	**$6,512,000**
FY 2026-27	**$9,088,000**	**$2,272,000**	**$6,816,000**

DENTAL FI ADMINISTRATION 2016 CONTRACT

5. Total Administration Cost:

Fiscal Year	TF	GF	FF
FY 2025-26	$18,474,000	$4,635,000	$13,839,000
FY 2026-27	$18,760,000	$4,698,000	$14,062,000

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

FISCAL REFERENCE NUMBER:236

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$598,333,000**	**$653,534,000**
FEDERAL FUNDS	$598,333,000	$653,534,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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 a decrease from the prior estimate for FY 2025-26 and FY 2026-27, and an increase from FY 2025-26 to FY 2026-27 in the current estimate, due to updated expenditure data provide by CDSS.

Methodology:
1. On an accrual basis, CDSS estimated FY 2025-26 expenditures at $550,863,000 FFP and FY 2026-27 expenditures at $566,528,000 FFP.

PERSONAL CARE SERVICES

2. On a cash basis, the estimates below were provided by CDSS.

(Dollars in Thousands)

FY 2025-26	TF	DHCS FFP	CDSS GF/ County Match
EW Time & Health Related	$1,057,456	$528,728	$528,728
CMIPS II	$139,210	$69,605	$69,605
Total	$1,196,666	**$598,333**	$598,333
FY 2026-27	**TF**	**DHCS FFP**	**CDSS GF/ County Match**
EW Time & Health Related	$1,204,117	$602,058	$602,059
CMIPS II	$102,951	$51,476	$51,475
Total	$1,307,068	**$653,534**	$653,534

*Totals may differ due to rounding.

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

HEALTH-RELATED ACTIVITIES - CDSS

FISCAL REFERENCE NUMBER:233

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$241,720,000**	**$804,896,000**
FEDERAL FUNDS	$241,720,000	$804,896,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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 a decrease for FY 2025-26 and an increase for FY 2026-27, from the prior estimate, due to invoices shifting from FY 2025-26 to FY 2026-27 for payment.

There is an increase from FY 2025-26 to FY 2026-27, in the current estimate, due to invoices shifting from FY 2025-26 to FY 2026-27 for payment.

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

HEALTH-RELATED ACTIVITIES - CDSS

(Dollars in Thousands)

FY 2025-26	TF	DHCS FFP	CDSS GF/ County Match
CWS	$247,745	$123,872	$123,873
CWS/CMS	$11,019	$5,509	$5,510
CSBG/APS	$224,676	$112,338	$112,338
Total	$483,439	**$241,720**	$241,719
FY 2026-27	**TF**	**DHCS FFP**	**CDSS GF/ County Match**
CWS	$838,159	$419,080	$419,079
CWS/CMS	$11,501	$5,751	$5,750
CSBG/APS	$760,132	$380,066	$380,066
Total	$1,609,792	**$804,896**	$804,896

*Totals may differ due to rounding.

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

CALHEERS DEVELOPMENT

FISCAL REFERENCE NUMBER:1679

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$173,104,000**	**$227,558,000**
FEDERAL FUNDS	$126,973,500	$165,525,100
GENERAL FUND	$46,130,500	$62,032,900
OTHER FUNDS	$0	$0

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 # 22-20089
Contract # 24-40004
Contract # 24-40172
Contract # 25-50173

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 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 and

CALHEERS DEVELOPMENT

implemented technology solutions for the ongoing maintenance of MEDS and Health Exchange Medi-Cal Interface (HEMI) web services.

The Affordable Care Act (ACA), enacted in 2010, 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 submitted an As Needed Advance Planning Document (IAPDU) for CalHEERS to increase funding in FFY 2025 and FFY 2026 and newly introduced funding for FFY 2027 as well as an informational update to the Sponsor cost share between the Department (86.53%) and Covered California (13.67%). The Department submitted an IADPU for the HEMI project in August 2025 to request additional funding for FFY 2025 and FFY 2026. Centers for Medicare & Medicaid Services (CMS) approved the FFY 2026-27 annual OAPD on September 30, 2025. The Department added one new HEMI contract for Mainframe Programmers. Approval for enhanced federal funding will remain in effect until September 30, 2027.

Reason for Change:
<u>CalHEERS</u>
There is no change in FY 2025-26 from the prior estimate. The change in FY 2026-27, from the prior estimate, is an increase due to the change in Verify Current Income (VCI) software-as-a-service provider. The change from FY 2025-2026 to FY 2026-2027, in the current estimate, is an increase due to shifting VCI-related costs from the CMS Hub Service to a direct software-as-a-service provider and changing the cost allocation from shared with Covered California to fully covered by the Department.

<u>HEMI</u>
The change in FY 2025-26, from the prior estimate, is a decrease due to updated actuals, adjusted projections, lower reconciliation costs, and delayed contract start and payment dates. The change in FY 2026-27, from the prior estimate, is a slight increase due to adjusted projections. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase to adjusted projections and a new HEMI Software Engineer contract.

The overall change in FY 2025-26, from the prior estimate, is a slight decrease due to HEMI updated actuals, adjusted projection calculations, lower reconciliation costs, and delayed contract start and payment dates. The overall change in FY 2026-2027, from the prior estimate, and from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to adjusted projections and administrative costs necessary for M&O for the CalHEERS system.

Methodology:

1. CalHEERS' costs are shared between Covered California and Medi-Cal based on the approved Cost Allocation Plan.
    - 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;

CALHEERS DEVELOPMENT

- Effective October 1, 2024, the 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 are as follows:

FY 2025-26	TF	GF	FF
Title XIX (90% FF / 10% GF)	$29,749,000	$2,975,000	$26,774,000
Title XIX (75% FF / 25% GF)	$112,680,000	$28,170,000	$84,510,000
Title XXI (65% FF / 35% GF)	$21,611,000	$7,564,000	$14,047,000
100% State GF	$6,835,000	$6,835,000	$0
CalHEERS Subtotal	$170,875,000	$45,544,000	$125,331,000
75% Title XIX FF / 25% GF	$1,934,000	$484,000	$1,450,000
65% Title XXI FF / 35% GF	$295,000	$103,000	$192,000
ETS Subtotal	$2,229,000	$587,000	$1,642,000
Total	**$173,104,000**	**$46,131,000**	**$126,973,000**

CALHEERS DEVELOPMENT

FY 2026-27	TF	GF	FF
Title XIX (90% FF / 10% GF)	$30,122,000	$3,012,000	$27,110,000
Title XIX (75% FF / 25% GF)	$157,435,000	$39,359,000	$118,076,000
Title XXI (65% FF / 35% GF)	$28,728,000	$10,055,000	$18,673,000
100% State GF	$9,012,000	$9,012,000	$0
CalHEERS Subtotal	$225,297,000	$61,438,000	$163,859,000
75% Title XIX FF / 25% GF	$1,962,000	$490,000	$1,472,000
65% Title XXI FF / 35% GF	$299,000	$105,000	$194,000
ETS Subtotal	$2,261,000	$595,000	$1,666,000
Total	**$227,558,000**	**$62,033,000**	**$165,525,000**

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

FISCAL REFERENCE NUMBER:234

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$90,793,000**	**$114,846,000**
FEDERAL FUNDS	$90,793,000	$114,846,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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.
- 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-

MATERNAL AND CHILD HEALTH

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 2025-26, is a decrease due to updated actuals and adjusted projections of anticipated payments. The change from the prior estimate, for FY 2026-27, and from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to the projection 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 2025-26 are estimated to be $90,793,000 Federal Funds and $114,846,000 Federal Funds for FY 2026-27.

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

CDDS ADMINISTRATIVE COSTS

FISCAL REFERENCE NUMBER:243

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$143,008,000**	**$129,193,000**
FEDERAL FUNDS	$143,008,000	$129,193,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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), Targeted Case Management (TCM), and the Life Outcomes Improvement System (LOIS) project.

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 2025-26, from the prior estimate, is a decrease due to updated expenditure trend data.

The change in FY 2026-27, from the prior estimate, is an increase due to updated expenditure trend data and the implementation of the LOIS project.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a net decrease due to a lower estimated expenditure trend for FY 2026-27 and the implementation of the LOIS project in FY 2026-27.

Methodology:
CDDS provides the following cash estimates of its administrative cost components:

CDDS ADMINISTRATIVE COSTS

FY 2025-26		DHCS FFP	CDDS GF	IA #
1	DC/SOF Medi-Cal Admin.	$702,000	$702,000	03-75282/83
2	DC/SOF Medi-Cal Elig	$763,000	$763,000	01-15378
3	HCBS Waiver Admin.	$61,669,000	$61,669,000	01-15834
4	RC Medicaid Admin.	$53,747,000	$17,916,000	03-75734
5	NHR Admin.	$623,000	$623,000	03-75285
6	TCM Headquarters Admin.	$24,866,000	$24,866,000	03-75284
7	TCM HIPAA	$638,000	$638,000	03-75284
	Total	**$143,008,000**	$107,177,000	

FY 2026-27		DHCS FFP	CDDS GF	IA #
1	DC/SOF Medi-Cal Admin.	$820,000	$820,000	03-75282/83
2	DC/SOF Medi-Cal Elig	$783,000	$783,000	01-15378
3	HCBS Waiver Admin.	$58,110,000	$58,110,000	01-15834
4	RC Medicaid Admin.	$28,055,000	$9,352,000	03-75734
5	NHR Admin.	$673,000	$673,000	03-75285
6	TCM Headquarters Admin.	$17,000,000	$17,000,000	03-75284
7	TCM HIPAA	$638,000	$638,000	03-75284
8	LOIS Project	$23,114,000	$2,568,000	25-50421
	Total	**$129,193,000**	$89,944,000	

Funding:
100% Title XIX (4260-101-0890)
100% HIPAA FFP (4260-117-0890)

DEPARTMENT OF SOCIAL SERVICES ADMIN COST

FISCAL REFERENCE NUMBER:256

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$57,744,000**	**$60,356,000**
FEDERAL FUNDS	$57,744,000	$60,356,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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 members.

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 25-50079
Public Inquiry and Response IA 16-93213
Medicaid Disability Evaluation Services IA 16-93215
Estate Recovery Claims IA 20-10026
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 (EVV), and the California Community Transitions-Money Follows the Persons. The Department provides FFP to CDSS for services related to Medi-Cal members. CDSS budgets the matching General Fund (GF). Beginning in FY 2025-26 EVV costs shifted into the Electronic Visit Verification M&O Costs policy change.

Reason for Change:
There is a decrease from the prior estimate for FY 2025-26 and FY 2026-27, and an increase from FY 2025-26 to FY 2026-27 in the current estimate, due to updated expenditure data provided by CDSS.

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

DEPARTMENT OF SOCIAL SERVICES ADMIN COST

FY 2025-26	TF	DHCS FFP	CDSS GF
IHSS PCSP	$24,000,000	$12,000,000	$12,000,000
IHSS Health Related	$600,000	$300,000	$300,000
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	$1,800,000	$900,000	$900,000
Medi-Cal State Hearings	$73,324,000	$36,662,000	$36,662,000
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
Income and Eligibility Verification	$927,000	$464,000	$463,000
TOTAL	$115,487,000	**$57,744,000**	$57,743,000

FY 2026-27	TF	DHCS FFP	CDSS GF
IHSS PCSP	$24,000,000	$12,000,000	$12,000,000
IHSS Health Related	$600,000	$300,000	$300,000
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	$1,800,000	$900,000	$900,000
Medi-Cal State Hearings	$78,548,000	$39,274,000	$39,274,000
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
Income and Eligibility Verification	$927,000	$464,000	$463,000
TOTAL	$120,711,000	**$60,356,000**	$60,355,000

*Totals may differ due to rounding.

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

HCPCFC CASE MANAGEMENT

FISCAL REFERENCE NUMBER:246

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$74,400,000**	**$74,400,000**
FEDERAL FUNDS	$55,800,000	$55,800,000
GENERAL FUND	$4,929,000	$4,929,000
OTHER FUNDS	$13,671,000	$13,671,000

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 former 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

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 former CHDP Program county budget allocation to fund the administrative costs of the HCPCFC, making HCPCFC a standalone program. Remaining portions of the former CHDP Program county budget allocation were 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.

Reason for Change:
The change from the prior estimate, for FY 2025-26 and FY 2026-27, is an increase due to higher county utilization and due to shifting invoices from FY 2024-25 into FY 2025-26 for payment. There is no change, from FY 2025-26 to FY 2026-27, in the current estimate.

Methodology:
1. CDSS provides the annual Local Revenue Fund of $13,671,000 for FY 2025-26 and FY 2026-27.

(Dollars in Thousands)

FY 2025-26	TF	GF	FF
Base Allocation	$32,682	$8,171	$24,511
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 2026-27	**TF**	**GF**	**FF**
Base Allocation	$32,682	$8,171	$24,511
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.

HCPCFC CASE MANAGEMENT

2. Assume CDSS reimburses the GF to the Department 60 days after the end of each fiscal quarter. On a cash basis, all program costs are estimated to be:

(Dollars in Thousands)

Fiscal Year	TF	DHCS GF	FF	GF Reimb.	CDSS GF	CF*
FY 2025-26	**$74,400**	**$4,929**	**$55,800**	**$13,671**	$13,671	$14,058
FY 2026-27	**$74,400**	**$4,929**	**$55,800**	**$13,671**	$13,671	$14,058

*County funds and CDSS GF are not included in the Total Fund.

Funding:
100% GF (4260-101-0001)
100% Title XIX FFP (4260-101-0890)
GF Reimbursement (4260-601-0995)

HCPCFC ADMIN COSTS

FISCAL REFERENCE NUMBER:2455

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$23,757,000**	**$23,757,000**
FEDERAL FUNDS	$11,878,500	$11,878,500
GENERAL FUND	$11,878,500	$11,878,500
OTHER FUNDS	$0	$0

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) 24-40002
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 former CHDP Program 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 former CHDP Program local positions through the exploration of new partnerships and roles and/or through bolstering existing programs that can leverage the former CHDP Program expertise.

Where the former CHDP Program was the source of funding for HCPCFC administrative activities, the HCPCFC operates autonomously to cover allowable non-clinical expenses and existing non-clinical local positions. Remaining portions of the former CHDP Program county budget allocation was redirected to the CCS Program to fund county workload due to the implementation of CCS Monitoring and Oversight, effective July 1, 2025. Counties received the funds in FY 2024-25 to assist with implementation activities. Counties continue to receive funds in FY 2025-26 to support CCS Program administrative functions.

HCPCFC ADMIN COSTS

SB 108 extended flexibility from FY 2024-25 to FY 2025-26 to the counties regarding appropriate staffing necessary to implement and operationalize the HCPCFC Program Manual requirements.

Reason for Change:
There is no change, for FY 2025-26 and FY 2026-27, from the prior estimate. This is no change, from FY 2025-26 to FY 2026-27, 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 2025-26	$23,757,000	$11,879,000	$11,878,000
FY 2026-27	$23,757,000	$11,879,000	$11,878,000

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

FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS

FISCAL REFERENCE NUMBER:1192

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$8,761,000**	**$13,656,000**
FEDERAL FUNDS	$8,761,000	$13,656,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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 10-87042 A02
IA 23-30396
IA 24-40245
IA 07-65642
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 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

FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS

Project Waiver.

Reason for Change:
The change from the prior estimate, for FY 2025-26, is an increase due to updated actuals and adjusted projections of anticipated payments. The change from the prior estimate, for FY 2026-27, and from FY 2025-26 to FY 2026-27, in the current estimate, is an increase 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 2025-26	TF	FF
FY 2023-24 Claims	$1,728,000	$1,728,000
FY 2024-25 Claims	$6,281,000	$6,281,000
FY 2025-26 Claims	$752,000	$752,000
Total	**$8,761,000**	**$8,761,000**

FY 2026-27	TF	FF
FY 2024-25 Claims	$686,000	$686,000
FY 2025-26 Claims	$11,127,000	$11,127,000
FY 2026-27 Claims	$1,843,000	$1,843,000
Total	**$13,656,000**	**$13,656,000**

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

DEPARTMENT OF AGING ADMINISTRATIVE COSTS

FISCAL REFERENCE NUMBER:253

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$7,570,000**	**$8,200,000**
FEDERAL FUNDS	$7,570,000	$8,200,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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) and Multipurpose Senior Services Program (MSSP).

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 implemented the Medicaid Electronic Visit Verification (EVV) in conjunction with the Department and the Office of Systems Integration. CDA will receive an enhanced matching rate for this project. Beginning in FY 2025-26 EVV costs shifted into the Electronic Visit Verification M&O Costs policy change.

Reason for Change:
There is an increase from the prior estimate for FY 2025-26 and FY 2026-27, and from FY 2025-26 to FY 2026-27 in the current estimate, due to updated expenditure data provided by CDA.

Methodology:
1. Assume EVV costs shifted into the Electronic Visit Verification M&O Costs policy change beginning in FY 2025-26.

DEPARTMENT OF AGING ADMINISTRATIVE COSTS

2. The estimates below were provided by CDA on a cash basis.

Program Support	FY 2025-26		FY 2026-27	
CBAS Support	**CDA GF**	**FFP**	**CDA GF**	**FFP**
FY 2024-25 DOS	$1,079,000	$1,273,000	$0	$0
FY 2025-26 DOS	$3,255,000	$3,524,000	$3,124,000	$593,000
FY 2026-27 DOS	$0	$0	$2,734,000	$4,394,000
Total CBAS	$4,334,000	$4,797,000	$5,858,000	$4,987,000
MSSP Support				
FY 2024-25 DOS	$551,000	$795,000	$0	$0
FY 2025-26 DOS	$1,381,000	$1,978,000	$696,000	$835,000
FY 2026-27 DOS	$0	$0	$3,011,000	$2,378,000
Total MSSP	$1,932,000	$2,773,000	$3,707,000	$3,213,000
Grand Total	$6,266,000	**$7,570,000**	$9,565,000	**$8,200,000**

*Totals differ due to rounding.

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

FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG

FISCAL REFERENCE NUMBER:2244

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$8,052,000**	**$8,391,000**
FEDERAL FUNDS	$8,052,000	$8,391,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the federal reimbursement process between the Department and the Department of Health Care Access and Information (HCAI) for the Healthcare Payments Database 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:
There is no change from the prior estimate, for FY 2025-26. The change from the prior estimate, for FY 2026-27, and the change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to additional data collection requirements resulting in increased costs for staffing, data storage, and analytics.

Methodology:
1. Costs are estimated at $8,052,000 for FY 2025-26 and $8,391,000 for FY 2026-27.

Fiscal Years	TF	GF	FF
FY 2025-26	$8,052,000	$0	$8,052,000
FY 2026-27	$8,391,000	$0	$8,391,000

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

CLPP CASE MANAGEMENT SERVICES

FISCAL REFERENCE NUMBER:239

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$6,502,000**	**$13,726,000**
FEDERAL FUNDS	$6,502,000	$13,726,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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 2025-26, is a decrease due to updated actuals and adjusted projections of anticipated payments. The change from the prior estimate, for FY 2026-27, and from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to anticipated expenditure growth, higher costs for new contracts, additional Local Health Jurisdiction (LHJ) participation, and staffing and payroll.

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

3. The costs for FY 2025-26 are estimated to be $6,502,000 and $13,726,000 for FY 2026-27.

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

CALIFORNIA SMOKERS' HELPLINE

FISCAL REFERENCE NUMBER:1680

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$2,353,000**	**$3,564,000**
FEDERAL FUNDS	$2,353,000	$3,564,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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 2025-26, is a decrease due to updated actuals and adjusted projections of anticipated payments. The change from the prior estimate, for FY 2026-27, and from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to adjusted projections 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.

3. The estimated administrative cost reimbursements, for FY 2025-26 and FY 2026-27, on a cash basis are:

CALIFORNIA SMOKERS' HELPLINE

FY 2025-26	TF	FF
FY 2024-25 Claims	$953,000	$953,000
FY 2025-26 Claims	$1,400,000	$1,400,000
Total	**$2,353,000**	**$2,353,000**

FY 2026-27	TF	FF
FY 2025-26 Claims	$1,475,000	$1,475,000
FY 2026-27 Claims	$2,089,000	$2,089,000
Total	**$3,564,000**	**$3,564,000**

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

CALHHS AGENCY HIPAA FUNDING

FISCAL REFERENCE NUMBER:257

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$1,749,000**	**$1,908,000**
FEDERAL FUNDS	$874,500	$954,000
GENERAL FUND	$874,500	$954,000
OTHER FUNDS	$0	$0

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 A1

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. An amendment to IA 23-30066 to add $500,000 to FY 2025-26 for increased HIPAA Compliance Project Management team contract costs was executed on February 27, 2025.

Reason for Change:
There is no change from the prior estimate for FY 2025-26 and FY 2026-27. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to a full year of the subcontractor cost.

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 2025-26	$1,749,000	$874,500	$874,500
FY 2026-27	$1,908,000	$954,000	$954,000

Funding:
50% HIPAA FF/ 50% HIPAA GF (4260-117-0890/0001)

MEDI-CAL INPATIENT SERVICES FOR INMATES

FISCAL REFERENCE NUMBER:1665

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$1,144,000**	**$1,189,000**
FEDERAL FUNDS	$1,144,000	$1,189,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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 #25-50004

Interdependent Policy Changes:
Not Applicable

Background:
AB 1628 (Chapter 729, Statutes of 2010) authorizes the Department and the CDCR/CCHCS to:

- Claim federal reimbursement for inpatient hospital services to Medi-Cal eligible adult inmates in State correctional facilities when these services are provided off the grounds of the facility. As part of these provisions, the CCHCS is claiming federal financial participation (FFP) for their administrative costs to operate the Inmate Eligibility Program. The federal funds provided to the CCHCS are included in the Medi-Cal inpatient hospital costs policy changes.

SB 1399 (Chapter 405, Statutes of 2010) authorizes the Board of Parole Hearings to:

- Grant medical parole to permanently medically incapacitated State inmates. State inmates granted medical parole are potentially eligible for Medi-Cal. When a State inmate is granted medical parole, the CCHCS submits a Medi-Cal application to the Department to determine eligibility. Previously these services were funded through the CDCR with 100% GF.

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

- Claim FFP for inpatient hospital services provided to Medi-Cal eligible juvenile inmates in State and county correctional facilities when these services are provided off the grounds of the facility. Previously, these services were paid 100 percent by the CDCR or the county. The County Administration Allocation Policy Change covers the county FFP associated with Medi-Cal eligibility determination activities for county inmates.

MEDI-CAL INPATIENT SERVICES FOR INMATES

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 2025-26 and FY 2026-27. There is a slight increase from FY 2025-26 to FY 2026-27, in the current estimate, due to an increase in contract costs.

Methodology:

1. Implementation of the Inmate Eligibility Program began April 1, 2011.

2. Effective FY 2025-26, administrative costs are in accordance with Interagency Agreement #25-50004.

3. Reimbursements for administrative costs began in March 2011.

4. The federal share of ongoing administrative costs is **$1,144,000** in **FY 2025-26** and **$1,189,000** in **FY 2026-27**.

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

VETERANS BENEFITS

FISCAL REFERENCE NUMBER:232

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$1,100,000**	**$1,100,000**
FEDERAL FUNDS	$1,100,000	$1,100,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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 2025-26 and FY 2026-27. There is no change from FY 2025-26 to FY 2026-27 in the current estimate.

Methodology:
1. The contract amount is estimated to be $1,100,000 for FY 2025-26 and FY 2026-27. The non-federal match is budgeted by CDVA.

FY	FY 2025-26			FY 2026-27		
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

FISCAL REFERENCE NUMBER:1774

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$883,000**	**$883,000**
FEDERAL FUNDS	$879,000	$879,000
GENERAL FUND	$4,000	$4,000
OTHER FUNDS	$0	$0

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 25-50021

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 2025-26 and FY 2026-27. There is no change from FY 2025-26 to FY 2026-27 in the current estimate.

Methodology:
1. On a cash basis, the estimated cost to deliver records data is $1,167,000 TF in FY 2025-26 and $1,167,000 TF in FY 2026-27. 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).

2. On a cash basis, the annual contract to provide certified copies is $8,000 TF ($4,000 GF).

VITAL RECORDS

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 2025-26 and FY 2026-27 on a cash basis are:

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**

FY 2026-27	TF	HSSF	GF	FF
FY 2025-26 Records Data	$292,000	$73,000	$0	$219,000
FY 2025-26 Certified Copies	$2,000	$0	$1,000	$1,000
FY 2026-27 Records Data	$875,000	$219,000	$0	$656,000
FY 2026-27 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

FISCAL REFERENCE NUMBER:249

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$108,000**	**$83,000**
FEDERAL FUNDS	$108,000	$83,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

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 2025-26, from the prior estimate, is due to a decrease in the number of kits distributed as a result of shipping contract delays.

The change in FY 2026-27, from the prior estimate, is due to a decrease in the number of kits distributed following a change in the contracted services entity.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to the implementation of a new request for proposals process to change the contracted services entity.

Methodology:
1. An estimated 31,700 kits are estimated to be distributed in FY 2025-26. An estimated 24,300 kits are estimated to be distributed in FY 2026-27. Of these kits, 43.38% are expected to be distributed to Medi-Cal eligible newborns.

2. Each kit, basic or custom, costs $15.63.

3. In prior years, CCFC invoiced DHCS on a yearly basis. In FY 2022-23, CCFC started invoicing on a quarterly basis.

KIT FOR NEW PARENTS

4. 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 2025-26	31,700	43.38%	13,751	$15.63	$215,000
FY 2026-27	24,300	43.38%	10,541	$15.63	$165,000

5. Assume the Department will pay $108,000 TF in FY 2025-26 and $83,000 TF in FY 2026-27 for kits to new parents of Medi-Cal eligible newborns.

FY 2025-26	TF
FY 2025-26	$215,000
FFP Total (50%)	**$108,000**

FY 2026-27	TF
FY 2026-27	$165,000
FFP Total (50%)	**$83,000**

Fiscal Year	TF	FF
FY 2025-26	**$108,000**	**$108,000**
FY 2026-27	**$83,000**	**$83,000**

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

MERIT SYSTEM SERVICES FOR COUNTIES

FISCAL REFERENCE NUMBER:263

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$202,000**	**$211,000**
FEDERAL FUNDS	$101,000	$105,500
GENERAL FUND	$101,000	$105,500
OTHER FUNDS	$0	$0

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 2025-26 and FY 2026-27. There is no change from FY 2025-26 to FY 2026-27 in the current estimate.

Methodology:
1. CalHR provided the estimates on a cash basis.

2. The estimated reimbursement is $202,000 TF ($101,000 GF) in FY 2025-26 and $211,000 TF ($105,000 GF) in FY 2026-27.

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

PIA EYEWEAR COURIER SERVICE

FISCAL REFERENCE NUMBER:1114

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$726,000**	**$894,000**
FEDERAL FUNDS	$363,000	$447,000
GENERAL FUND	$363,000	$447,000
OTHER FUNDS	$0	$0

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 2025-26 and FY 2026-27, from the prior estimate, is due to fewer boxes shipped.

The change from FY 2025-26 to FY 2026-27 in the current estimate is due to a projected increase in the number of boxes shipped in FY 2026-27.

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 rate per box, 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 rate per box changed each quarter in FY 2025-26 with an effective rate of $3.07:
   - First quarter: $2.95
   - Second quarter: $3.12
   - Third quarter: $3.25
   - Fourth quarter: $2.95

3. The PIA courier contract delivery rate of $3.25 per box is effective for all four quarters in FY 2026-27.

PIA EYEWEAR COURIER SERVICE

4. The program contract is expected to be extended for two years through June 30, 2028.

5. The costs for the estimated boxes in FY 2025-26 and FY 2026-27 are assumed below:

Fiscal Year	Total Boxes	Rate per Box	**TF**	**GF**	**FF**
FY 2025-26	235,822	$3.07	**$726,000**	**$363,000**	**$363,000**
FY 2026-27	275,000	$3.25	**$894,000**	**$447,000**	**$447,000**

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

EPTP - STATEWIDE LEARNING COLLABORATIVE

FISCAL REFERENCE NUMBER:2562

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$6,900,000**	**$2,900,000**
FEDERAL FUNDS	$3,450,000	$1,450,000
GENERAL FUND	$3,450,000	$1,450,000
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the costs of the Equity & Practice Transformation Payments – Statewide Learning Collaborative.

Authority:
Budget Act of 2022 – AB 179 (Chapter 249, Statutes of 2022)

Interdependent Policy Changes:
N/A

Background:
The Department administers the Equity and Practice Transformation (EPT) Payments Program, which supports 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 Population Health Learning Center to provide the learning collaborative and serve as the program office to do the following: run the EPT program day-to-day; advance health equity; address gaps in preventive, childhood, birth-related, and behavioral health care measures; 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 in EPT are paid based on performance on relevant EPT deliverables and measures.

The Statewide Learning Collaborative was previously a part of the Equity & Practice Transformation Payments policy change. This item has been moved into its own policy change as per compliance guidance.

Reason for Change:
There is no change in FY 2025-26 from the prior estimate.

There is no change in FY 2026-27 from the prior estimate.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is due to reduced amounts of spending related to Equity & Practice Transformation Payments in FY 2026-27 as the program is anticipated to end.

Methodology:
1. The estimated costs in FY 2025-26 are as follows:

EPTP - STATEWIDE LEARNING COLLABORATIVE

FY 2025-26	TF	GF	FF
Statewide Learning Collaborative	$6,900,000	$3,450,000	$3,450,000
Total FY 2025-26	**$6,900,000**	**$3,450,000**	**$3,450,000**

2. The estimated costs in FY 2026-27 are as follows:

FY 2026-27	TF	GF	FF
Statewide Learning Collaborative	$2,900,000	$1,450,000	$1,450,000
Total FY 2026-27	**$2,900,000**	**$1,450,000**	**$1,450,000**

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

STATE ONLY CLAIMING ADJUSTMENTS - ADMIN.

FISCAL REFERENCE NUMBER:2559

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	-$622,631,000	-$600,000,000
GENERAL FUND	$622,631,000	$600,000,000
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the costs related to correctly accounting for state-only local assistance administrative expenditures related to members with unsatisfactory immigration status (UIS).

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
The Department has initiated a comprehensive review of its methodologies and systems for allocating and claiming Medicaid administrative costs related to state-only funded services. 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. Non-emergency and non-pregnancy related services are paid using state-only funds. When federal funds are incorrectly claimed for these populations, such funding must be returned to CMS.

The Department has implemented an interim downward adjustment to its administrative claiming methodology beginning with the administrative claim for the quarter ended March 31, 2025. Specifically, a portion of administrative costs that have previously been funded with federal funds and state funds, will now be funded 100% General Fund.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is based on the most recent actual adjustments and including an additional quarter of adjustments in FY 2025-26.

There is no change in FY 2026-27 from the prior estimate.

The change in FY 2025-26 to FY 2026-27, in the current estimate, is a slight decrease due to a fewer number of quarterly adjustments estimated in FY 2026-27.

Methodology:
1. The Department will prospectively reduce administrative claims to CMS based on a rough estimate of expenditures that should be state-only, while examining administrative claim methodologies in greater detail to refine the amount of expenditure that should be funded as state-only. The roughly estimated annual impact of these prospective adjustments is $600 million.

STATE ONLY CLAIMING ADJUSTMENTS - ADMIN.

2. The FY 2025-26 and FY 2026-27 prospective adjustments are estimated to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2025-26	$0	$622,631	($622,631)
FY 2026-27	$0	$600,000	($600,000)

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

TRANSFORMING MATERNAL HEALTH PROVIDER INFR PYMT

FISCAL REFERENCE NUMBER:2552

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$1,750,000**
FEDERAL FUNDS	$0	$1,750,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates federal funding provided for Transforming Maternal Health Provider Infrastructure Payments to participating providers within a five-county region in California's Central Valley.

Authority:
Budget Act of 2026

Interdependent Policy Changes:
Not Applicable

Background:
The Transforming Maternal Health (TMaH) is a ten-year Medicaid and Children's Health Insurance Program delivery and payment model designed to improve maternal health outcomes, reduce costs, and address serious gaps in health care. TMaH is funded and implemented through a cooperative agreement with the Centers for Medicare and Medicaid Services (CMS). This policy change budgets the use of the allocated funding for provider infrastructure payments as specified in the federal cooperative agreement. Additionally, these payments address one of the key pillars of the TMaH model by assisting providers in building the infrastructure needed to participate in a value-based payment model.

Reason for Change:
There is no change from prior estimate for FY 2025-26. The change from the prior estimate, for FY 2026-27, is a decrease due to a modified payment schedule. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to provider infrastructure payments starting in FY 2026-27.

Methodology:
1. The total costs for TMaH Infrastructure Payments are 100% federally funded and estimated to be $1,750,000 FF in FY 2026-27.

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

HR 1 - PROHIBITED ENTITIES SYSTEMS COSTS

FISCAL REFERENCE NUMBER:2564

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$547,000**	**$137,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$547,000	$137,000
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the system costs to implement H.R. 1, Section 71113 (2025), which prohibits federal financial participation (FFP) for providers that meet the definition of a "prohibited entity."

Authority:
H.R. 1, 119th Cong., Section 71113 (2025)

Interdependent Policy Changes:
Not Applicable

Background:
H.R. 1, Section 71113 (2025), enacted on July 4, 2025, prohibits FFP for providers that meets the definition of a "prohibited entity." System changes are anticipated in FY 2025-26 and FY 2026-27 to implement this requirement.

Reason for Change:
The change in FY 2025-26, from the prior estimate, is a decrease due to a recalibration of when anticipated payments for system costs will be made.

The change in FY 2026-27, from the prior estimate, is due to estimating the final payments to occur in FY 2026-27.

The change from FY 2025-26 to FY 2026-27, in the current estimate, is a decrease as most of the system costs are anticipated to be completed in FY 2025-26 with the remaining payments to occur in FY 2026-27.

Methodology:
1. Assume the system costs to implement the changes, for FY 2025-26 and FY 2026-27, are:

Fiscal Years	TF	GF
FY 2025-26	$547,000	$547,000
FY 2026-27	$137,000	$137,000

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

HR 1 - HEALTH ENROLLMENT NAVIGATORS

FISCAL REFERENCE NUMBER:2567

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$4,000,000**
FEDERAL FUNDS	$0	$2,000,000
GENERAL FUND	$0	$0
OTHER FUNDS	$0	$2,000,000

Purpose:
This policy change estimates the funding for providing appropriate health navigation to Community Health Centers (CHCs) and Regional Clinic Associations (RCAs) due to House Resolution 1 (H.R. 1) to ensure Medi-Cal eligible individuals enroll or retain coverage.

Authority:
Budget Act of 2026

Interdependent Policy Changes:
Not Applicable

Background:
CHCs and RCAs 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 as H.R. 1 implements.

Reason for Change:
There is no change from the prior estimate for FY 2025-26 and FY 2026-27. The change from FY 2025-26 to FY 2026-27, in the current estimate, is an increase due to the program implementing in FY 2026-27.

Methodology:

1. Assume this policy implements in FY 2026-27.

(Dollars in Thousands)

Fiscal Year	TF	GF Reimb.	FF
FY 2026-27	**$4,000**	**$2,000**	**$2,000**

Funding:
100% Title XIX FFP (4260-101-0890)
Reimbursement GF (4260-601-0995)

HR 1 - COUNTY ADMINISTRATION ALLOCATION

FISCAL REFERENCE NUMBER:2580

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$262,101,000**
FEDERAL FUNDS	$0	$188,242,500
GENERAL FUND	$0	$73,858,500
OTHER FUNDS	$0	$0

Purpose:
This policy change reflects the costs of providing additional administrative funding and resources to counties for H.R. 1 implementation.

Authority:
Welfare & Institutions Code 14154
SB 159 (Chapter 40, Statutes of 2024)
H.R. 1, 119th Cong., Section 71107 (2025)
H.R. 1, 119th Cong., Section 71109 (2025)
H.R. 1, 119th Cong., Section 71112 (2025)
H.R. 1, 119th Cong., Section 71119 (2025)
42, Code of Federal Regulations 435.945(j)

Interdependent Policy Changes:
Not Applicable

Background:
County Administration Request
Under H.R. 1, counties must comply with provisional requirements, including but not limited to administrative costs for work and community engagement requirements, bi-annual redeterminations for the Affordable Care Act Modified Adjusted Gross Income New Adult Group population, State Fair Hearings & Appeals, and restrictions on immigrant eligibility. This new workload requires additional administrative costs, as estimated with input from a County Welfare Directors Association of California survey. This policy change estimates those additional administrative costs, starting July 1, 2026.

County Surge Staffing
Due to new federal and state eligibility changes, estimated costs in association with issuing a limited term contracted “strike team” managed by state staff are included in this policy change, and will help alleviate county backlog and workload by offering assistance in counties where new federal and state changes are causing a surge in workload and additional contracted staff are needed on a short-term basis.

Reason for Change:
This is a new policy change.

Methodology:
1. Assume implementation begins no sooner than July 1, 2026.

2. The estimated costs for FY 2025-26 and FY 2026-27 on a cash basis are:

HR 1 - COUNTY ADMINISTRATION ALLOCATION

Fiscal Years	TF	GF	FF
FY 2025-26	$0	$0	$0
FY 2026-27	$262,101,000	$73,859,000	$188,242,000

*Totals may differ due to rounding.

Funding:
Enhanced CA 75/25 (4260-101-0890/0001)
50% Title XIX FF / 50% GF (4260-101-0890/0001)
Medicaid Management Information Systems Enhanced Funding identified in the Enhanced Federal Funding policy change

RECONCILIATION - ADMIN

FISCAL REFERENCE NUMBER:2592

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**-$81,400,000**
FEDERAL FUNDS	$0	-$7,700,000
GENERAL FUND	$0	-$7,700,000
OTHER FUNDS	$0	-$66,000,000

Purpose: This policy change reconciles the May 2026 Medi-Cal Estimate.

This adjustment includes an adjustment to balance to the May 2026 Medi-Cal Estimate.

(Dollars in Thousands)

FY 2026-27	TF	GF	FF	SF
Adjustment	($81,400)	($7,700)	($7,700)	($66,000)

Funding:
Health Care and Accountability Subfund (4260-601-3443)
50% Title XIX / 50% GF (4260-101-0001/0890)

PROPOSITION 35 FUNDING – CYBHI & BH-CONNECT

FISCAL REFERENCE NUMBER:2593

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$0**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$0	-$66,000,000
OTHER FUNDS	$0	$66,000,000

Purpose:
This policy change estimates the adjustment of funds from the from the Healthcare Oversight & Accountability Subfund (HCO&A) to the General Fund (GF) to support increases in various behavioral health program costs.

Authority:
Protect Access to Health Care Act of 2024 (Proposition 35)

Interdependent Policy Changes:
CalAIM – BH-CONNECT Demonstration Admin
CYBHI – BH Services and Supports Platform

Background:
The Department proposes to use the HCO&A Subfund to support a portion of the non-federal share of costs for the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration and the Children and Youth Behavioral Health (CYBHI) – Behavioral Health (BH) Services and Supports Platform.

These costs are budgeted in the CalAIM – BH-CONNECT Admin and CYBHI – BH Services and Supports Platform policy changes using General Fund as the non-federal share. Because of technical limitations in DHCS's fiscal systems, the non-federal share of Medi-Cal expenditures must be first charged to the General Fund in a "clearing account" capacity before being adjusted to the correct special funding sources. This PC adjusts the applicable costs to the HCO&A Subfund.

These expenditures reflect an expansion of health care benefits, services, workforce, and payments above and beyond those in effect or in existence as of January 1, 2024.

Reason for Change:
This is a new policy change.

Methodology:

1. The amount of General Fund that is adjusted to the Healthcare Oversight & Accountability Subfund is estimated to be:

PROPOSITION 35 FUNDING – CYBHI & BH-CONNECT

(Dollars in Thousands)

FY 2026-27	TF	GF	SF (3443 Fund)
BH-CONNECT Demonstration Admin	$0	($12,600)	$12,600
CYBHI – BH Services and Supports Platform	$0	($53,400)	$53,400
Total	**$0**	**($66,000)**	**$66,000**

Funding:
Healthcare Oversight & Acct. Subfund (4260-601-3443)
100% GF (4260-101-0001)

UIS MEMBER TRANSITION TO FFS SYSTEMS COSTS

FISCAL REFERENCE NUMBER:2594

	FY 2025-26	FY 2026-27
TOTAL IMPACT		
TOTAL FUNDS	**$0**	**$33,300,000**
FEDERAL FUNDS	$0	$0
GENERAL FUND	$0	$33,300,000
OTHER FUNDS	$0	$0

Purpose:
This policy change estimates the costs for the Unsatisfactory Immigration Status (UIS) member transition to Fee-for-Service (FFS) to address the required systems costs changes.

Authority:
Budget Act of 2026

Interdependent Policy Changes:
Not Applicable

Background:
The Department proposes to transition members identified as UIS to the FFS delivery system in FY 2026-27. System changes are anticipated to implement this change.

Reason for Change:
This is a new policy change.

Methodology:
1. The estimated costs in FY 2026-27 are:

FY 2026-27	TF	GF
UIS to FFS systems costs	$33,300,000	$33,300,000
Total	**$33,300,000**	**$33,300,000**

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

TABLE OF CONTENTS

ADDITIONAL INFORMATION

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

MEDI-CAL INFORMATION ONLY 1-64

INTRODUCTION 1
FEE-FOR-SERVICE BASE ESTIMATES 1-2
FEE-FOR-SERVICE SERVICE CATEGORIES 2-4
CHANGES TO ESTIMATE 5
AFFORDABLE CARE ACT 6
HOME AND COMMUNITY BASED SERVICES 7-26
1115 WAIVER-MH/UCD, BTR, & MEDI-CAL 2020 CALAIM 1915(B) WAIVER 27
MANAGED CARE 28-34
PROVIDER RATES 35-38
AMERICAN RESCUE PLAN 39-44

INFORMATION ONLY 45-50
ELIGIBILITY 45
AFFORDABLE CARE ACT 45
BENEFITS 45-46
HOME AND COMMUNITY-BASED SERVICES 46
BREAST AND CERVICAL CANCER TREATMENT 46
PHARMACY 46-47
DRUG MEDI-CAL 47
MENTAL HEALTH 48
1115 WAIVER-MH/UCD & BTR/WAIVER 2020 48-49
MANAGED CARE 50
PROVIDER RATES 50
SUPPLEMENTAL PAYMENTS 50
COVID-19 50

OTHER 51-57
AUDITS AND LAWSUITS 51-55
REIMBURSEMENTS 55-56
RECOVERIES 56
MISCELLANEOUS 56-57

FISCAL INTERMEDIARY 57-58
MEDICAL 57
HEALTH CARE OPTIONS 57
DENTAL 57-58

DISCONTINUED POLICY CHANGES 59-64
FULLY INCORPORATED INTO BASE DATA 59-60
TIME LIMITED/NO LONGER AVAILABLE 61-62
WITHDRAWN 63-64

MEDI-CAL INFORMATION ONLY
May 2026
FISCAL YEARS 2025-26 & 2026-27

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 6 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

- Community Based Adult Services (CBAS)
- 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)

CHANGES TO ESTIMATE

Aid Categories Regrouping and Other Changes to Estimate:

Starting in November 2025, several changes were made to the Estimate:

- Aid categories used for estimating enrollment and expenditures were reduced from 18 to six to better align with categories used for managed care rate setting. Below is a crosswalk between the old and new aid categories.

New Aid Category	Old Aid Category
Title 19 Children (0 to 20 years)	PA-AFDC, MN-AFDC, MI-C, POV 185, POV 133
Title 19 Adults (21 years and older)	PA-AFDC, H-PE, MN-AFDC, MI-C, MI-A, POV 185
Title 21	POV 250, POV 100
ACA Expansion	Newly
Seniors and Persons with Disabilities (SPDs)	PA-OAS, PA-ATD, MN-OAS, MN-ATD
Long Term Care (LTC) Aid Codes	LT-OAS, LT-ATD, MI-A

- County Administration and Other Administration were consolidated into one category, Administration.
- The policy changes for the eleven Fee-For-Service Base (FFS Base) categories (Physicians to Home Health) now include the federal financial participation (FFP) for certain populations. This includes ACA expansion population at 90% FFP, Children's Health Insurance Program (CHIP) at 65% FFP, Designated Public Hospitals (DPHs) at 100% FFP and non-emergency services for individuals without satisfactory immigration status at 100% General Fund. Previously, the FFS Base was budgeted at the 50% FFP and technical adjustments were built into the Estimate through policy changes.

AFFORDABLE CARE ACT

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 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.

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 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 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 (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 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 members who are developmentally disabled. These 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 and Community-Based Services (HCBS) to persons with developmental disabilities (DD) who are Regional Center consumers but do not meet nursing facility level of care criteria required for enrollment in the HCBS Waiver of Persons with DD. As of February 1, 2016, Behavioral Health Treatment (BHT) services for 1915(i) participants under the age of 21 is a state plan benefit and paid through the managed care delivery system or fee-for-service for members not eligible to enroll into managed care. The 1915(i) State Plan Amendment (SPA) was approved from October 1, 2011, through September 30, 2016. The Department 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.

HOME AND COMMUNITY BASED SERVICES

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.

HOME AND COMMUNITY BASED SERVICES

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.

On June 26, 2024, CMS approved SPA 24-0005. This amendment added group homes for children with special health care needs as a new provider of community living arrangement services. Moreover, the amendment added participant-direction as a service delivery method for self-directed support services. The effective date is July 1, 2024.

On September 24, 2024, the Department submitted SPA 24-0028 to:

- Implement the final round of rate increases from a 2019 rate study,
- Add a new service called Person-Centered Future Planning,
- Increase the rate for Financial Management Services, and
- Allow participant-direction for Community Living Arrangement Services.

CMS approved the amendment on December 19, 2024, with an effective date of January 1, 2025.

On November 25, 2025, the Department submitted SPA 25-0040 to:

- **Implement final rate adjustments as a result of rate reform,**
- **Add Trainer as a new provider type and payment methodology under Communication Aides, and**
- **Add a new service titled Remote Support Services and a corresponding provider type and payment methodology for the service.**

HOME AND COMMUNITY BASED SERVICES

New 1915(i) HCBS State Plan Optional Benefits

The Department plans to implement two new 1915(i) HCBS SPAs. Effective January 1, 2027, the Department will be transitioning the CBAS benefit from its current 1115 Demonstration federal authority to a new 1915(i) HCBS state plan service. This transition reflects the Department's commitment to CBAS as an ongoing Medi-Cal benefit and will establish CBAS as an entitlement for all Medi-Cal members meeting the eligibility and needs-based criteria established in the 1915(i). The transition intends to directly shift the 1115 Demonstration authority to the 1915(i) with minimal impact to members, providers, and managed care plans. There will be no change in CBAS eligibility criteria or the CBAS services. As a 1915(i) HCBS state plan benefit, CBAS will remain available in both FFS and managed care delivery systems and there will be no impact to existing managed care plan contracts with CBAS center providers or member authorizations. The Department plans to submit the new CBAS 1915(i) HCBS SPA to the Centers for Medicare and Medicaid Services (CMS) by July 2026 and it will be posted for a public comment period in advance of submission to CMS.

Effective January 1, 2028, the Department will be transitioning the Continuous Nursing Supportive Services (CNSS) benefit provided by Congregate Living Health Facility (CLHF) providers from the 1915(c) Home and Community-Based Alternatives (HCBA) to a new a separate new 1915(i) HCBS state plan service. This transition reflects the Department's commitment to expand access to CLHF services by placing in a 1915(i) and establishing the CLHF CNSS service as a managed care plan benefit. Transition to a 1915(i) will establish the CLHF CNSS service as an entitlement for all members meeting the eligibility and needs-based criteria established in the 1915(i). The January 1, 2028, implementation timeline provides necessary planning time as the CLHF CNSS service is currently only available through the FFS HCBA Waiver and this transition will be carving it into the managed care delivery system. The Department is not planning changes in eligibility criteria or the CLHF CNSS service in transitioning it to a new 1915(i) HCBS state plan service. The Department plans to submit the new CLHF 1915(i) HCBS SPA to CMS by July 2027 and it will be posted for a public comment period in advance of submission to CMS.

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 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

HOME AND COMMUNITY BASED SERVICES

Persons with DD. A member may be enrolled in only one HCBS waiver at a time. If a member is eligible for services from more than one waiver, the member may choose the waiver that is best suited to 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.

On October 27, 2021, the Department submitted an ALW technical amendment to increase the maximum number of waiver slots by 7,000 to CMS for approval with a retroactive implementation date of July 1, 2021. Through California's HCBS Spending Plan, 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 7,000 slots have been released for transitioning members for placement into the ALW.

On February 16, 2024, CMS approved a new five-year waiver term for the ALW effective March 1, 2024. CMS also approved an ALW technical amendment to increase the maximum number of waiver slots for waiver year (WY) 5 of the 2019-2024 waiver term on January 22, 2024. This amendment increases the number of waiver slots for waiver year 5 by 1,800 and had a retroactive effective date of January 1, 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 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

On October 30, 2024, the Department submitted an ALW amendment to increase the WY 1 slots to align with the WY 2 capacity due to continued growth of the program. On November 12, 2024, CMS approved the amendment, and WY 1 slots are now 16,344, as opposed to 14,544.

The Department intends to submit an additional ALW amendment to CMS for approval in early 2026. This amendment will update the provisions and guidance for providers when providing services via telehealth. This amendment will also provide additional guidance for providing Residential Habilitation services. Following the approval of this

HOME AND COMMUNITY BASED SERVICES

amendment, DHCS intends to submit a subsequent amendment. This amendment will enforce the emergency preparedness requirements of the newly enacted SB 582.

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 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 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 California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 demonstration waiver for a five-year renewal, with an amendment. ~~This new~~ **The** waiver period is December 31, 2021, through December 31, 2026, and maintains the CBAS benefit. **Although the CalAIM 1115 waiver renewal is in progress, the CBAS benefit will be transitioned to a new 1915(i) SPA. This transition will support members' ability to continuously access services while also ensuring the cost neutrality for California.**

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 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 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

HOME AND COMMUNITY BASED SERVICES

Act of 2021 removed this suspension. The 2022 Governor's Budget shifted the state funding source of these supplemental payments to the General Fund.

Assembly Bill (AB) 119 (Chapter 13, Statutes of 2023) authorized a Managed Care Organization (MCO) Provider Tax effective April 1, 2023, through December 31, 2026. MCO tax revenues were expected to be used to support the Medi-Cal program's new targeted provider rate increases and other investments that advance access, quality, and equity for Medi-Cal members and promote provider participation in the Medi-Cal program. Pursuant to the 2023 Budget Act and AB 118 (Chapter 42, Statutes of 2023), the Department implemented the first phase of Targeted Rate Increases, effective January 1, 2024.

The 2024 Budget Act and Senate Bill (SB) 159 (Chapter 40, Statutes of 2024) authorized new targeted Medi-Cal provider rate increases from the MCO Tax to be effective January 1, 2025, and January 1, 2026. However, Proposition 35 on the November 2024 ballot was approved by voters, a measure that implements the existing tax on managed health care insurance plans to be permanent. The MCO Tax initiative investments that were planned to be effective in 2025 and 2026 became inoperable since both cannot be fiscally sustained.

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: 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-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

HOME AND COMMUNITY BASED SERVICES

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.

On March 13, 2025, CMS approved an additional waiver amendment. With this amendment, the Department is increasing the number of paid sick leave hours available for Waiver Personal Care Services (WPCS). The effective date of the amendment is July 1, 2024. **On November 14, 2025, CMS approved a subsequent waiver amendment with an effective date of December 1, 2025. With this amendment, the Department is updating the provisions and guidance for providers when providing services via telehealth. The state is also updating the Early and Periodic Screening, Diagnostic, and Treatment (EPDST) language to reflect federal requirements.**

Medi-Cal Waiver Program (MCWP)

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

Members eligible for the program must be Medi-Cal 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. 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.

HOME AND COMMUNITY BASED SERVICES

Multipurpose Senior Services Program (MSSP) Waiver

The 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. Members eligible for the program must be 60 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, not be simultaneously enrolled in another Medi-Cal HCBS Waiver or receive other Medi-Cal Managed Care Plan Enhanced Care Management (ECM) services benefits, and can be certified for placement in a nursing facility. Services provided by MSSP include adult day care 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) HCBS 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 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. The MSSP renewal application was submitted to CMS on March 29, 2024. Following the renewal application submission, CMS issued three rounds of subsequent requests for additional information and granted a 90-day extension ~~set for~~ **from June 30, 2024, to** September ~~29~~ **28**, 2024. The Department provided responses to all requests for additional information, and on September ~~25~~ **26**, 2024, the Department and CDA received CMS' approval of the renewed MSSP waiver to be effective between July 1, 2024, through June 30, 2029.

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 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 support 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 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 SERVICES

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. 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, 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 numerous Waiver Amendments to reflect state regulatory changes. For instance, 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 add Speech-Language Pathologist Assistant as a provider type for Speech, Hearing, and Language services. The amendment also adds services to transition members placed at Institutions for Mental Diseases into alternative community settings. The amendment was approved with an effective date of January 19, 2021.

HOME AND COMMUNITY BASED SERVICES

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.

An additional amendment was submitted to add telehealth as a delivery method for specific services, group homes for children with special health needs, and participant-direction as a service method. The amendment was approved by CMS and became effective July 1, 2024.

HOME AND COMMUNITY BASED SERVICES

On September 24, 2024, the Department submitted a waiver amendment to:

- Implement the final round of rate increases from a 2019 rate study,
- Add a new service called Person-Centered Future Planning,
- Increase the rate for Financial Management Services, and
- Allow participant-direction for Community Living Arrangement Services.

CMS approved the amendment on December 19, 2024, with an effective date of January 1, 2025.

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.

~~The Department submitted several Appendix Ks from April 2024 – January 2025. Eighteen Appendix Ks focused on retainer payments for participants' services that may have been impacted by California wildfires. While one Appendix K focused on retainer payments for participants' services that may have been impacted by a northern California earthquake.~~

The Department submitted an Appendix K to provide emergency flexibilities for individuals impacted by the Pier Fire in Tulare County. Effective April 25 through May 25, 2024, the amendment authorized temporary measures such as absence billing and retainer payments to maintain services for approximately 3,877 waiver participants during the declared State of Emergency. CMS approved the Appendix K on July 17, 2024.

The Department submitted an Appendix K to provide emergency flexibilities for individuals affected by the Thompson Fire in Butte County. The amendment, effective July 2 through August 2, 2024, allowed temporary measures such as absence billing and retainer payments to maintain services for approximately 2,105 waiver participants during the declared State of Emergency. CMS approved the Appendix K on August 13, 2024.

The Department submitted an Appendix K to provide emergency flexibilities for individuals impacted by the Shelly Fire in Siskiyou County. Effective July 3 through August 2, 2024, the amendment authorized temporary measures such as absence billing and retainer payments to maintain services for approximately 3,877 waiver participants during the declared State of Emergency. CMS approved the Appendix K on July 17, 2024.

The Department submitted an Appendix K to provide emergency flexibilities for individuals impacted by the Park and Gold Complex Fires in Butte, Tehama, and Plumas Counties. Effective July 26 through August 25, 2024, the amendment authorized absence billing and related measures to maintain services for approximately 4,544 waiver participants during the declared State of Emergency. CMS approved the Appendix K on August 30, 2024.

HOME AND COMMUNITY BASED SERVICES

The Department submitted an Appendix K to provide emergency flexibilities for individuals impacted by the Borel Fire in Kern County. Effective July 30 through August 29, 2024, the amendment authorized absence billing and retainer payments for services such as Community Living Arrangements, Behavioral Intervention, and Day Services to support approximately 3,877 waiver participants during the declared State of Emergency. CMS approved the Appendix K on August 13, 2024.

The Department submitted an Appendix K to provide emergency flexibilities for individuals impacted by the Bear Fire in Siskiyou County. Effective September 2 through October 2, 2024, the amendment authorized temporary measures such as absence billing and retainer payments to maintain services for approximately 3,877 waiver participants during the declared State of Emergency. CMS approved the Appendix K on July 17, 2024.

The Department submitted an Appendix K to provide emergency flexibilities for individuals impacted by the Rancho Palos Verdes land movement in Los Angeles County. Effective September 3, 2024, through October 3, 2025, the amendment authorized temporary measures such as absence billing and retainer payments to maintain services for approximately 3,877 waiver participants during the declared State of Emergency. CMS approved the Appendix K on October 4, 2024.

The Department submitted an Appendix K to provide emergency flexibilities for individuals impacted by the San Bernadino County Line Fire in Kern County. Effective September 5 through October 5, 2024, the amendment authorized temporary measures such as absence billing and retainer payments to maintain services for approximately 3,877 waiver participants during the declared State of Emergency. CMS approved the Appendix K on October 4, 2024.

The Department submitted an Appendix K to provide emergency flexibilities for individuals impacted by the Los Angeles County and San Bernadino County Bridge and Orange County and Riverside County Airport Fires in Trinity and Siskiyou Counties. Effective September 11 through October 11, 2024, the amendment authorized temporary measures such as absence billing and retainer payments to maintain services for approximately 3,877 waiver participants during the declared State of Emergency. CMS approved the Appendix K on October 4, 2024.

The Department submitted an Appendix K to provide emergency flexibilities for individuals impacted by the Victoria Island Levee Incident in San Joaquin County. Effective October 21 through November 21, 2024, the amendment authorized temporary measures such as absence billing and retainer payments to maintain services for approximately 9,000 waiver participants during the declared State of Emergency. CMS approved the Appendix K on July 17, 2025.

The Department submitted an Appendix K to provide emergency flexibilities for individuals impacted by the Lake County Boyles Fire in Kern County. Effective September 29 through October 29, 2024, the amendment authorized temporary measures such as absence billing and retainer payments to maintain services for approximately

HOME AND COMMUNITY BASED SERVICES

3,877 waiver participants during the declared State of Emergency. CMS approved the Appendix K on October 23, 2024.

The Department submitted an Appendix K to provide emergency flexibilities for individuals impacted by the Northern California Earthquake in Humboldt County. Effective December 5, 2024, through January 4, 2025, the amendment authorized temporary measures such as absence billing and retainer payments to maintain services for approximately 3,877 waiver participants during the declared State of Emergency. CMS approved the Appendix K on January 7, 2025.

The Department submitted an Appendix K to provide emergency flexibilities for individuals impacted by the Mountain Fire in Siskiyou County. Effective November 6 through December 6, 2024, the amendment authorized temporary measures such as absence billing and retainer payments to maintain services for approximately 3,877 waiver participants during the declared State of Emergency. CMS approved the Appendix K on July 17, 2024.

The Department submitted an Appendix K to provide emergency flexibilities for individuals impacted by the Franklin Fire in San Joaquin County. Effective December 9, 2024, through January 18, 2025, the amendment authorized temporary measures such as absence billing and retainer payments to maintain services for approximately 60,000 waiver participants during the declared State of Emergency. CMS approved the Appendix K on July 17, 2025.

The Department submitted an Appendix K to provide emergency flexibilities for individuals impacted by the Trinity County Storms in Trinity County. Effective December 15, 2024, through January 29, 2025, the amendment authorized temporary measures such as absence billing and retainer payments to maintain services for approximately 5,000 waiver participants during the declared State of Emergency. CMS approved the Appendix K on July 17, 2025.

The Department submitted an Appendix K to provide emergency flexibilities for individuals impacted by the Santa Cruz Coastal Storm in Santa Cruz County. Effective December 23, 2024, through January 23, 2025, the amendment authorized temporary measures such as absence billing and retainer payments to maintain services for approximately 13,000 waiver participants during the declared State of Emergency. CMS approved the Appendix K on March 27, 2025.

The Department submitted an Appendix K to provide emergency flexibilities for individuals impacted by the Palisades Fire in Los Angeles County. Effective January 7, 2025, through January 7, 2026, the amendment authorized temporary measures such as absence billing and retainer payments to maintain services for approximately 3,877 waiver participants during the declared State of Emergency. CMS approved the Appendix K on January 17, 2025.

HOME AND COMMUNITY BASED SERVICES

The Department submitted an Appendix K to provide emergency flexibilities for individuals impacted by the February Storms in multiple Northern California counties. Effective January 31 through March 17, 2025, the amendment authorized temporary measures such as absence billing and retainer payments to maintain services for approximately 14,000 waiver participants during the declared State of Emergency. CMS approved the Appendix K on September 3, 2025.

The Department submitted an Appendix K to provide emergency flexibilities for individuals impacted by the late-March Winter Storms in multiple Northern California counties. Effective March 30 through May 1, 2025, the amendment authorized temporary measures such as absence billing and retainer payments to maintain services for approximately 5,000 waiver participants during the declared State of Emergency. CMS approved the Appendix K on September 3, 2025.

The Department submitted an Appendix K to provide emergency flexibilities for individuals impacted by the TCU Complex Fires in Trinity County. Effective September 2 through October 13, 2025, the amendment authorized temporary measures such as absence billing and retainer payments to maintain services for waiver participants during the declared State of Emergency. CMS approved the Appendix K on October 24, 2025.

The Department submitted a Waiver Amendment on November 25, 2025that proposes final adjustments following rate reform, introduces Trainer as a new provider type under Communication Aides with an associated payment methodology, adds a new service called Remote Support Services along with its provider type and payment structure, and includes supplemental payments for excess mileage. The amendment is currently pending approval.

The Department is preparing to submit an Appendix K to provide emergency flexibilities for individuals impacted by the Pack Fire in Mono County. Effective November 13, 2025, the amendment authorized absence billing during the declared State of Emergency to maintain services for approximately 6,100 waiver participants affected by evacuations and infrastructure damage.

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.

HOME AND COMMUNITY BASED SERVICES

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.

The SDP five-year period is set to end on June 30, 2026. The Department is preparing to submit a formal renewal to CMS on March 30, 2026. The renewed SDP Waiver term will be effective July 1, 2026, through June 30, 3031.

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 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 CCT in California. 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 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 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-term care system transformation

HOME AND COMMUNITY BASED SERVICES

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 start 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 qualified healthcare inpatient facility 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. Also, per the Consolidated Appropriations Act of 2021, days that a beneficiary received short-term rehabilitative services are allowed to be counted towards the minimum stay requirement.

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 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 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 rollout of a state-funded 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 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 PHE. Additionally, on September 30, 2022, SB 281 was approved by the Governor and chaptered by the Secretary of State. Approval of SB 281 allowed for the state-funded CCT-like program to have a requirement for the Department to cease the enrollment of beneficiaries commencing January 1, 2026, and to cease providing those services commencing January 1, 2027. The repeal date, per SB 281, is January 1, 2028.

On December 29, 2022, the President signed the Consolidated Appropriations Act of 2023 into law, which ~~extends~~ **extended** the MFP grant ~~indefinitely~~ and appropriates additional funding for each ~~fiscal year~~ **FFY** through 2024-27**, which are awarded annually on a calendar year**

HOME AND COMMUNITY BASED SERVICES

basis. Unexpended grant funds awarded for any fiscal year can continue to be spent for up to four additional years, **being** through ~~September 30~~ **December 31**, 2031.

The population that is eligible for the state-funded program are residents of qualified healthcare inpatient facilities who meet the eligibility criteria to enroll in the federally-funded MFP Rebalancing Demonstration, with one exception. To be eligible for the federally-funded program, a member is required to have been a resident of a qualified healthcare inpatient facility for at least 60 days**, while** the state-funded program removes the 60-day eligibility criteria to provide transition coordination services to members residing in a qualified healthcare inpatient facility 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 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.

Per the approval of SB 281 on September 30, 2022, and the requirements of California Welfare and Institutions Code, Sections 14196.2 - 14196.6, the state-funded CCT-like program will cease the enrollment of beneficiaries commencing January 1, 2026, and to cease providing those services commencing January 1, 2027. The repeal date is January 1, 2028. As of January 1, 2026, all eligible beneficiaries must meet the federal enrollment requirements of residing in a qualified healthcare inpatient facility for at least 60 consecutive days, with at least one day being funded by Medicaid.

1115 WAIVER-MH/UCD, BTR, MEDI-CAL 2020, AND CALAIM 1915(b) WAIVER

1115 Waiver—MH/UCD & BTR 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 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 **and ongoing**, 100% of the rate, except for select services, are risk adjusted **at the regional average level**. In addition, the CY 2024 rating period rates for 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

MANAGED CARE

Behavioral Health Treatment (BHT) for children. BHT supplemental payments are discontinued and 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

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~~ **was received on December 20, 2024, from** CMS.

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~~ **is pending CMS approval for an implementation date of** 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.~~ **Future cohorts have been suspended until operating authority has been determined.**

CY 2024 Medical Loss Ratio

Effective for contract rating periods commencing on or after July 1, 2023, a Medi-Cal MCP shall provide a remittance for a Medical Loss Ratio (MLR) reporting year if the ratio for that MLR reporting year does not meet the minimum MLR standard of 85 percent. As rates are set on a Calendar Year (CY) basis, the MCPs' first rating period would be CY 2024. 42 CFR § 438.8 requires MCPs to submit an MLR report twelve months after the close of the reporting period, and 42 CFR § 438.8 (m) requires plans to resubmit their MLR if there is a retroactive change to their capitation payment. As the majority of the hospital's State Directed Payments, which are included in the MLR calculation, are calculated and paid out no less than 15 months later, MLR remittances will not be finalized until FY 2027-28.

MANAGED CARE

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 eligibles 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 members. Medi-Cal services that are not delegated to contracting health plans remain the responsibility of the Medi-Cal FFS program. When a 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 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 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 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 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.

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.

MANAGED CARE

~~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 Medi-Cal Managed Care Plan (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

~~**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 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.~~

MANAGED CARE

~~**Directed Payments**~~

~~Effective with the CY 2026 rating period and authorized by SB 177 (2023-24), a Cost-Based Reimbursement Clinics Directed Payment shall be implemented. This directed payment would shift program funds from existing pass-through payment programs. Payments are not expected to occur by 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 Hospital Quality Assurance Fee (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.

Value Strategy for Hospital Payments in Medi-Cal Managed Care

The Department is developing a new hospital payment strategy for Medi-Cal managed care that focuses on rewarding quality care. Given that Pass-Through Payments are time-limited and subject to federal phasedown and sunset timelines, the Department has requested funding and staffing resources develop, publish, implement, and sustain a comprehensive value strategy for hospital SDPs that is designed to sustainably advance access to high-quality inpatient and outpatient hospital services, financially incentivize appropriate care delivery, and improve health outcomes for Medi-Cal members starting in FY 2025-26. This is a multi-year plan with funding through FY 2028-29, and a requested ongoing budget beginning in FY 2029-30.

MANAGED CARE

Skilled Nursing Facility Value Strategy - Medi-Cal Long-Term Care Reimbursement Act

The Department is developing a comprehensive value strategy for Skilled Nursing Facilities (SNF) services for service periods on or after January 1, 2027. This includes a transition from facility-specific cost-based reimbursement to actuarially sound acuity-based rates. In addition, a value-based payment program framework will apply that adjusts annually and incorporates quality and accountability measures. The proposal supports continued rate development, data analysis, and oversight activities necessary to ensure fair and effective payments to long-term care providers. Funding begins in FY 2025-26 and continues through FY 2027-28 and ongoing, ensuring the program remains aligned with legislative intent and federal requirements.

Emergency Services FMAP for UIS Members

CMS published State Medicaid Director Letter (SMDL) # 25-003 on September 30, 2025, reinterpreting section 1903(v) of the Social Security Act to prohibit states from claiming federal funds for emergency services coverage provided to UIS members through at-risk capitation payments. The SMDL indicates that CMS "generally does not expect to take enforcement action" until the start of first Medicaid managed care rating period beginning one year after the publication date, i.e., January 1, 2027, for California. DHCS is analyzing the programmatic, operational, and other implications of this SMDL and potential compliance options.

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.

PROVIDER RATES

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~~ **were** 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 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~~ **modified** 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~~ **identified** and ~~implement~~ **implemented** screening and transition of care tools that ~~shall be~~ **are** used to determine the appropriate level of care for mental health services, effective January 1, 2023**, which was subsequently updated in June 2025**.

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 member must document

AMERICAN RESCUE PLAN ACT

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,~~ **The Department released a Concept Paper on the integration in January 2023 and is** 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 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 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 Monitoring and Oversight

   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 members are best served when their care is delivered in a standardized and consistent manner across the ~~State~~ **state**. Through the CalAIM initiative, the ~~State~~ **state** shall ~~ensure~~ **support** consistent ~~high-quality standard of~~ care, compliant with federal and ~~State~~ **state** guidelines, is provided to all qualified 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~~ **including**, 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~~ **quarterly and annual reports and surveys** (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,~~

AMERICAN RESCUE PLAN ACT

~~performance measures,~~ **compliance activities,** and milestones to ensure counties are ~~conducting provider oversight and providing the necessary medical and dental care for members~~ **administering the CCS program compliant with state and federal guidelines**. The Department will also enter into a Memorandum of Understanding with each county ~~that will outline~~ **outlining** the ~~State~~ **state** and county responsibilities to hold both entities accountable for action/in-action. The initial MOU implementation date of July 1, 2025**,** has been deferred to a date yet to be determined based on further county and stakeholder engagement.

Until the MOU is executed, the Department will continue to monitor counties to ensure ~~high-quality~~ consistent care with strategic compliance oversight in order to preserve and improve the overall health and well-being of this vulnerable population. Toward this effort, until an MOU is executed, counties can voluntarily opt to participate in the newly established additional monitoring and oversight functions ~~to be eligible to invoice the state for additional monitoring and oversight funding~~. **In the interim period, counties' ability to invoice for their CCS M&O allocations in full is not impacted.**

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

AMERICAN RESCUE PLAN ACT

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.

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 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 periods, with calculations starting no sooner than 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.

AMERICAN RESCUE PLAN ACT

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 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

AMERICAN RESCUE PLAN ACT

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).

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

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 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 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.

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 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 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) Program

   On July 1, 2024, the Department discontinued the CHDP program. Foster children and youth will continue to receive services through the Health Care Program for Children in Foster Care (HCPCFC), which was preserved as a standalone, locally self-administered program.

INFORMATION ONLY

In addition, the Department launched the Children's Presumptive Eligibility (CPE) Program to replace CHDP Gateway. The CPE Program 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 an MCP, through which they will receive covered medically necessary benefits. This aligns with the Department's goal under CalAIM to reduce administrative complexities. This transition clarifies that care management responsibilities for children/youth fall under Population Health Management requirements as provided under the Medi-Cal MCP contract with the Department.

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 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. Pharmacy Clinical Laboratory Improvement Amendments (CLIA)-Waived Tests

The Department plans to allow pharmacy providers that possess a CLIA Certificate of Waiver to be billed and reimbursed on a medical claim for CLIA-waived tests within their scope of practice as defined by the California State Board of Pharmacy. CLIA-waived tests are low complexity or simple point-of-care tests. Section 493, Title 42 of the Code of Federal Regulations and the Clinical Laboratory Improvement Amendments of 1988 allow waived tests to be performed in settings that have obtained a CLIA Certificate of Wavier from the federal Centers for Medicaid and Medicaid Services (CMS).

California Business and Professions Code Section 4052.4 expanded the scope of pharmacists to perform specific Food and Drug Administration (FDA)-approved and

INFORMATION ONLY

authorized CLIA-waived tests. Pharmacists must have completed necessary training, and the pharmacy must be appropriately licensed by California Department of Public Health.

2. Value Based Purchasing

The Department is exploring opportunities to enhance state supplemental drug rebate agreements by implementing new value-based purchasing (VBP) agreements on cell and gene (CGT) treatments and other high-cost therapies.

The Department received federal Centers for Medicare and Medicaid Services (CMS) approval on May 22, 2024, for its VBP agreement template through SPA 24-0009. The Department has identified at least two CGT and other high-cost therapies that may be good candidates for VBP agreements and has engaged those manufacturers to further discuss and negotiate terms. The Department intends to execute at least these two VBP agreements, but potentially others as well, sometime in late 2025, which would then start yielding rebates in mid-2026.

In addition, the Department submitted an application for participation in CMS' CGT Access Model, which will allow for outcomes-based agreements (OBAs) for two sickle cell disease (SCD) therapies, Bluebird (LYFGENIA) and Vertex (CASGEVY). The pricing and outcome measures negotiated by CMS and the pharmaceutical manufactures will allow Medi-Cal to collect both federal (statutory) rebates and state supplemental rebates for these two SCD therapies. Assuming Medi-Cal members begin receiving these CGT therapies beginning in fiscal year 2025-26, the Department can then expect to receive rebates in late 2025 or early 2026.

DRUG MEDI-CAL

1. Traditional Healers and Natural Helpers

~~The Department proposes to add~~ **CMS approved, until December 31, 2026,** 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 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.~~

INFORMATION ONLY

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 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 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.

INFORMATION ONLY

- 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.

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.

INFORMATION ONLY

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 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.~~ **Telehealth Fiscal Estimates for Federally Qualified Health Centers and Rural Health Clinics**

   The Centers for Medicare & Medicaid Services (CMS) has extended the validity of the existing policy guidance regarding telehealth services for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) through December 31, 2027. Effective January 1, 2028, FQHC and RHC Telehealth services will require members to be in a medical facility or in a rural area to receive telehealth services, with the exception of behavioral health. Behavioral health services require an in-person, non-telehealth visit within six months prior to the first mental health telehealth service. We do not anticipate or expect significant fiscal impacts as a result of Medicare's updated telehealth policy.

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.

COVID-19

1. No additional information.

INFORMATION ONLY

OTHER: AUDITS AND LAWSUITS

1. 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. The parties reached a settlement after several years of discussions and mediation. Under the settlement agreement, the Department agreed to pay Plaintiffs' attorneys fees in the amount of $1.55 million. On December 20, 2024, the court granted preliminary approval of the settlement agreement and certified the settlement class. The court has approved the settlement agreement.

2. 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. 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 for 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. 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. Judgment was entered on September 9, 2024, and the Department filed a Notice of Appeal on November 1, 2024. The Department has filed its opening **appellate** brief. The

INFORMATION ONLY

Respondent's brief ~~is due for filing~~ **was filed** on ~~November 21, 2025~~ **February 17, 2026. The Department's reply brief is due on April 24, 2026.**

3. 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. 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.

4. 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 January 6, 2025, the court narrowed the issues presented in the case to one, by granting the Department's Motion for Summary Judgment. In favor of the Department, the court found that budget neutrality is not required of the APR-DRG program under the statute, that the program is neither arbitrary nor capricious, and that it does not violate the Due Process Clause. The court further held that the outlier policy does not violate the contract clause of the state and federal Constitutions. Leaving one issue for resolution, the court granted petitioners' Motion for Summary Adjudication, in part, finding that the Department failed to properly notice the legislature prior to posting Bulletin 518, before properly posting Bulletin 531 one year later.

   On March 19, 2025, the court heard oral arguments on the parties' supplemental briefing submitted in response to the court's questions regarding: (i) whether the Department can reissue Bulletin 518 and retain the overpayments; and (ii) whether Bulletin 531 is similarly void due to its internal reference to Bulletin 518. On May 30, 2025, the court issued its order and decision granting petitioners' writ of mandate in part. In its decision, the court held Bulletin 518 is invalid and ordered the Department to return, with interest, funds recouped

INFORMATION ONLY

from and payments made to hospitals due to the Outlier Recalculation Policy for SFY 2016-17. The court further held Bulletin 531 is valid.

5. 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.

   The Department, CHHSA, CDSS, and Los Angeles County previously filed motions to dismiss. These motions were granted in part and denied in part. Plaintiffs filed a Second Amended Complaint on August 12, 2024. Defendants again filed motions to dismiss. On March 3, 2025, the court took the matter under submission. Los Angeles County filed a motion to certify for interlocutory appeal the District Court's order denying its motion to dismiss for lack of subject matter jurisdiction, which was granted. The Ninth Circuit accepted Los Angeles County's appeal and stayed further trial court proceedings.

6. Highland Outpatient Clinic Administrative Audit Appeal

   Highland Outpatient Clinic (Highland), a division of Alameda Health System, filed an administrative audit appeal challenging the Department's 2012 fiscal period audit adjustments of Federally Qualified Health Center (FQHC) encounter visits and the allocation of hospital-based costs. While the appeal was pending, Highland submitted fee-for-service medical and dental claims and received supplemental hospital reimbursement for services that may have been considered FQHC visits but for the Department's adjustments. Highland would like the Department to reverse FQHC audit adjustments to the reported encounter visits, adjust annual FQHC reconciliation payments based on the new FQHC payment rate, and convert any fee-for-service claims paid while the appeal was pending to FQHC visits paid at a Prospective Payment System (PPS) rate. Highland has been unable to provide verifiable data that would allow the Department to determine which paid fee-for-service claims could have been billed as FQHC visits. The parties have reached a tentative agreement in principle for an agreed upon adjusted PPS rate and Highland agrees to accept the fee-for-service payments and supplemental reimbursements as payment in full for the claims made via fee-for-service.

INFORMATION ONLY

7. 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 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.

8. In the matter of Liberty Dental Plan of California, Inc. (Appeal # MC24-0224-756-MF)

   Liberty Dental filed a notice of dispute as to the Department's Medi-Cal dental managed care plan rates for Contract Years 2022, 2023, and 2024 due to the addition of the lab-processed crowns benefit, and appealed the Department's Contracting Officer Decision affirming those rates to OAHA. The legislature added lab-processed crowns as a Medi-Cal dental benefit effective July 1, 2022. In its appeal, Liberty Dental argues that this new benefit required the Department to redetermine the Contract Year 2022 rate. Liberty Dental also asserts that the Contract Year 2023 and 2024 rates do not adequately consider this benefit, so the rates are not actuarially sound. Liberty projected that the cost impact is $534,000 for Contract Year 2022, $1,150,000 for Contract Year 2023, and $504,000 for Contract Year 2024, totaling $2.2 million. The parties have reached an agreement for Liberty Dental to withdraw their appeal in exchange for a payment of $870,000 for the lab-processed crowns benefit for Contract Year 2022.

9. **Mission City Community Network, Inc. v. Department of Health Care Services**

   In June 2019, the Department issued a temporary payment suspension and a temporary suspension against Mission City Community Network, Inc. (MCCN) because it was under criminal investigation by the California Department of Justice's Division of Medi-Cal Fraud and Elder Abuse (DMFEA). The criminal investigation subsequently concluded without charges filed by DMFEA, and the Department promptly lifted both suspensions in December 2020. In 2022, MCCN filed a civil lawsuit against the Department, alleging that the Department's suspensions were improper and contending it provided approximately $9.9 million in services to Medi-Cal members during the suspensions that would have otherwise been reimbursed by Medi-Cal. After several rounds of motion practice, the two remaining causes of action against the Department were negligence and breach of contract. MCCN was seeking $9.9 million in damages against the Department. MCCN and the Department negotiated a settlement of $495,000 to resolve the lawsuit.

INFORMATION ONLY

10. **<u>Vale Operating Company, LP v. Department of Health Care Services, et al.</u>**

    <u>The underlying case involves Petitioner's transfer of a patient from its facility to a hospital without following the proper discharging processes. The Department's Office of Administrative Hearings and Appeals ordered Petitioner to follow the proper discharging processes and conduct discharge planning for the patient. Petitioner argues that it does not have authority to conduct discharge planning because the patient is no longer in their care and a temporary restraining order prohibited the patient from returning to the facility. Petitioner paid the original penalty amount, $75,000, in full. The parties reached a settlement agreement in which the penalty amount was reduced to $22,500. This will result in a $52,500 refund to the provider. The settlement agreement is currently being finalized and pending signatures.</u>

11. **<u>Lopez v. State of California, et. al.</u>**

    <u>This case involves a class action on behalf of individuals whose protected health information/personally identifiable information (PHI/PII) was exposed to unauthorized third parties because of a data breach in which BenefitsCal, a website containing information relating to Medi-Cal and other benefit programs, was accessed by unauthorized individuals. Named Defendants include the Department, the State of California, the California Statewide Automated Welfare System, the Department of Social Services, and undetermined Does. Plaintiffs allege that a "preventable cyberattack" of BenefitsCal was discovered on February 9, 2024, in which "unauthorized actors infiltrated Defendants' inadequately protected systems and accessed highly sensitive PHI/PII" between March 1, 2023, and February 13, 2024, and did not inform victims until March 26, 2024.</u>

OTHER: REIMBURSEMENTS

1. <u>Federal Upper Payment Limit</u>

   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. <u>Accrual Costs Under Generally Accepted Accounting Principles</u>

   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

INFORMATION ONLY

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 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 previous RAC contract 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

INFORMATION ONLY

copies of birth, death, marriage, divorce, and fetal death records of Medi-Cal 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), CDA, and the California Department of Public Health (CDPH).

   The State implemented two EVV systems, Case Management Information and Payrolling System (CMIPS) and 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 IHSS and WPCS. CalEVV for PCS was implemented on January 1, 2022, and January 1, 2023, for HHCS, via a new CalEVV solution for PCS and HHCS with an agency model. This model includes all PCS and HHCS provided under all Medicaid authorities, including the State Plan, and waiver programs administered by the Department, DDS, CDA, CDSS, and CDPH.

3. Medicare Part A Buy-In Program

   Medi-Cal Eligibility Division (MCED) indicated that the Qualified Medicare Beneficiary (QMB) income disregard associated with Financial Reporting Number (FRN) 2442 – Medicare Part A Buy-In will not be implemented in FY 2026-27.

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

INFORMATION ONLY

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
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
Not applicable.

1115 WAIVER—MH/UCD & BTR
Not applicable.

MANAGED CARE
Not applicable.

PROVIDER RATES
Not applicable.

SUPPLEMENTAL PAYMENTS
Not applicable.

COVID-19
Not applicable.

OTHER: AUDITS AND LAWSUITS
Not applicable.

OTHER: REIMBURSEMENTS
Not applicable.

DISCONTINUED POLICY CHANGES

Fully Incorporated into Base Data/Ongoing

OTHER: RECOVERIES
Not applicable.

OTHER: MISCELLANEOUS
Not applicable.

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
Short-Term Residential Therapeutic Prog / QRTPs

1115 WAIVER—MH/UCD & BTR
Not applicable.

MANAGED CARE
Dental Managed Care MLR Risk Corridor

PROVIDER RATES
Not applicable.

SUPPLEMENTAL PAYMENTS
Not applicable.

COVID-19
Not applicable.

STATE ONLY CLAIMING
Not applicable.

OTHER: AUDITS AND LAWSUITS
Not applicable.

DISCONTINUED POLICY CHANGES

Time Limited/No Longer Available

OTHER: REIMBURSEMENTS
Not applicable.

OTHER: RECOVERIES
Not applicable.

OTHER: MISCELLANEOUS
Not applicable.

FISCAL INTERMEDIARY: MEDICAL
Not applicable.

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS
Not applicable.

FISCAL INTERMEDIARY: DENTAL
Not applicable.

DISCONTINUED POLICY CHANGES

Withdrawn

ELIGIBILITY
HR 1 – ACA Adult Exp Group 6-Month Redetermination

AFFORDABLE CARE ACT
Not applicable.

BENEFITS
Not applicable.

HOME & COMMUNITY-BASED SERVICES
Not applicable.

BREAST AND CERVICAL CANCER
Not applicable.

PHARMACY
Medi-Cal Rx Rebate Aggregator

DRUG MEDI-CAL
Not applicable.

MENTAL HEALTH
Not applicable.

1115 WAIVER—MH/UCD & BTR
Not applicable.

MANAGED CARE
Coordinated Care Initiative Risk Mitigation
Enhanced Care Management Risk Corridor
Prop 56 - Directed Payment Risk Mitigation

PROVIDER RATES
Not applicable.

SUPPLEMENTAL PAYMENTS
Not applicable.

COVID-19
Not applicable.

OTHER: AUDITS AND LAWSUITS
Not applicable.

OTHER: REIMBURSEMENTS

DISCONTINUED POLICY CHANGES

Withdrawn

Not applicable.

OTHER: RECOVERIES
Not applicable.

OTHER: MISCELLANEOUS
Medicare Part A Buy-In Program

FISCAL INTERMEDIARY: MEDICAL
Not applicable.

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS
Not applicable.

FISCAL INTERMEDIARY: DENTAL
Not applicable.